STRENGTH THAT SILENCES: LEARNING FROM THE EXPERIENCES OF BLACK FEMALE COLLEGE STUDENTS WITH MENTAL HEALTH CONCERNS AT A PREDOMINANTLY WHITE INSTITUTION

by

NADIA MONIQUE CAESAR-RICHARDSON

NATALIE ADAMS, COMMITTEE CHAIR
BECKY ATKINSON
BEBE BAREFOOT
NIRMALA EREVELLES
DOVEANNA FULTON-MINOR
KARRI HOLLEY

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ABSTRACT

This qualitative study examines first person accounts of college experiences provided by Black female college students with mental health concerns at a predominantly White institution. Utilizing the theoretical frameworks of disability studies and critical race feminism to develop the study and analyze the collected data, this study considers the ways that race, gender, and ability intersect in the lives of the study participants. Data from individual interviews was collected, transcribed, coded and analyzed. Common themes that emerged in the experiences of the study participants are presented.

Research findings indicate that systems of domination use race, gender, class, and ability to encourage mentally distressing performances of strength in the study participants. In addition, claims of inferiority that are informed by racism, sexism, classism, and ableism limit the participants' ability to harness their unique identities to circumvent and challenge the discriminatory socio-political conditions that damage their psyche and threaten their academic persistence. The language of the medical model of disability, which informs the Diagnostic and Statistical Manual of Mental Disorders (DSM), was found to encourage an internalization of negative self-representations that also contribute to mental distress within the study participants.

Implications from this study encourage the application of a critical race feminism and disability theory lens to university policies that impact Black female college students with mental health concerns and reiterate the importance of campus diversity mentoring to mental wellness. Implications for practice and future research are provided and discussed in detail.

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A man's heart plans his way, But the Lord directs his steps.
Proverbs 16:9

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When you're up against a trouble,
Meet it squarely, face to face;
Lift your chin and set your shoulders,
Plant your feet and take a brace.

When it's vain to try to dodge it,
Do the best that you can do;
You may fail, but you may conquer,
See it through.

Black may the be clouds about you
And your future may seem grim
But don't let your nerve desert you;
Keep yourself in fighting trim.

If the worst is bound to happen
Spite of all that you can do,
Running from it will not save you,
See it through.

Even hope may seem but futile,
When with troubles you're best,
But remember you are facing
Just what other men have met.

You may fail, but fall still fighting;
Don't give up, whate'er you do;
Eyes front, head high to the finish.
See it through.

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CHAPTER I

INTRODUCTION

Black female college students currently constitute 65% of the Black student population in the United States (Chronicle of Higher Education, 2008). Despite their presence within higher education institutions, Black female college students continue to be an under-studied population in the field of education (Howard-Hamilton, 2003; O'Connor, Lewis, & Mueller, 2007). Though substantial research has considered the experiences of Black students at predominantly White institutions, little research has considered the impact that race, gender, and ability combined may have on their mental health or their college experience (Neville, Heppner, Ji, & Thye, 2004; Johnson-Bailey, 2004; Sedlacek, 1999). Sociocultural factors that impact the various societal expectations of Black female students are also largely unexplored within traditional research on the experiences or development of college students. Such factors have the potential to negatively or positively impact the retention and mental wellness of Black female college students as they persist through their postsecondary education. Black students continue to utilize mental health services on their college campuses at significantly lower rates than that of their White counterparts (Boesch & Cimbolic, 1994; Duncan & Johnson, 2007; Elms & Nickerson, 1994; Gerard, Phelps, & Taylor, 2001; Measel, 1998). While this reflects the low numbers of Black women who utilize mental health services nationally, it does not consider the sociocultural factors that impact mental wellness (Beauboeuf-Lafontant, 2008). As such, this study describes, examines, and learns from the experiences of Black female college students with mental health

concerns at a predominantly White institution (PWI) in an attempt to fill the need for an investigation of the sociocultural factors that impact mental wellness both on and off college campuses.

Statement of the Problem

Despite the availability of research pertaining to student and faculty perceptions of college students with a mental illness, at present, there is a limited body of research that incorporates the experiences of Black female college students with mental health concerns or reflect the multi-layered reasons why Black women are less likely to utilize mental health services than their White counterparts (U.S. Department of Health and Human Services, 2001). Higher education research on Black college students has traditionally focused on both male and female students and concentrates on student performance, racism, college choice, socialization, retention, and mentoring (Ancis, Griffin, Schwitzer, & Thomas, 1999; Ceja, Solorzano, & Yosso, 2000; Chavous, Cooke, & Sellers, 1998; Douthit & Guiffrida, 2010; Furr & Elling, 2002; Harper & Patton, 2003; Love, 1993; Patton, 2009; Perna, 2000; Sedlacek, 1999). Little research has focused on the mental health of Black college students, especially Black female college students, or on the impact that racism, isolation, sexism, or ableism may have on their experiences. As a result, a need exists to study the experiences of Black female college students with mental health concerns. In addition, previous research on college students with a mental illness has failed to extensively capture the experiences of students who also navigate myriad other social issues, such as oppression and discrimination based on their race, class, gender, and/or sexual orientation. Due to the limited amount of research specifically targeting the experiences of diverse college students with mental health needs, the study is needed to obtain a better

understanding of the experiences of Black female college students with mental health concerns at a PWI.

Purpose of the Study

Data for this study were gathered from Black female college students with diagnosed mental health needs or Black female college students who self-reported as suffering from symptoms commonly associated with mental illnesses such as anxiety, depression, bipolar depression, mood swings, and eating disorders. While this representation of mental illness is broad, it encourages readers to place less emphasis on the diagnosis of mental illness and more emphasis on how the societal understanding of the medical meanings of disability are influenced by such sociocultural factors as race, gender, and class. The data for this study were collected at two PWIs. The purpose of this study was to describe, examine, and learn from the experiences of Black female college students with mental health concerns at a PWI. To increase understanding of the experiences of Black female college students with mental health concerns, this study examines in-depth participant interviews in order to identify the common themes that arise in their experiences. In addition, participant interviews were examined in order to identify factors that influence the experiences of Black female college students with mental health concerns. Consideration of the sociocultural influences that impact the study participants provides a valuable lens through which to view their experiences as well as encourages student mental wellness.

Participants were selected from two predominantly White higher education institutions located in the southeastern region of the United States. A purposeful sampling technique was utilized in order to select study participants. The study also utilized disability studies and critical race feminism to investigate the experiences of Black female college students with mental health

concerns. With the use of these theoretical frameworks, this study examined how race, gender, and ability intersect in the lives of Black female college students with mental health concerns. An analysis of in-depth interviews was used to find themes in participant experiences. Themes that emerged were analyzed in order to illustrate the influence that intersections of race, gender, and ability may have on the experiences of the study participants.

Significance of the Study

By providing a lens through which to explore an under-researched topic, this study contributes to the existing body of research by focusing on and providing a greater understanding of the experiences of Black female college students with mental health concerns at a PWI. In addition, this study explores assumptions that exist about students with a mental illness by providing a snapshot into the experiences of college students with mental health concerns and the various ways in which mental illness and race are criminalized through the generally accepted rhetoric that informs policy with little or no consideration of sociocultural factors that impact mental health.

In his 2008 book, *Urban Narratives: Portraits in Progress*, David J. Connor created a window into the experiences of "eight Black and Latino(a) working-class urban youth, between 18 and 23 years of age" (p. 60). Using the invaluable words of his research participants, Connor used the intersections of race, class, and learning disability in the lives of young adults to demonstrate the need for educators and community members to create spaces of support for students with such disabilities. In a similar manner, this study provides a platform from which to explore the experiences of Black female college students with mental health concerns at a PWI. "Research focusing specifically on the context of Black women's daily struggles against racism, sexism, and classism is needed to reflect sensitivity to the cultural dynamics of the issue" (Heath,

2006, p. 166). Explorations such as this have the potential to initiate conversations on the development of policy that create safe spaces of support for students with mental health concerns to thrive academically and socially.

For the participants of this study, their voices shed light on the racist, sexist, and ableist ideologies inform claims of Black, female, and cognitive inferiority. Their narratives provide examples of how such ideologies limit their ability to express their intersecting identities. Research that explores race, gender, and mental illness often repudiate the psychologically damaging ways in which racist, sexist, and ableist ideologies construct Black people, women, and those deemed mentally disabled in subhuman ways while privileging dominant standards of normalcy. Generally accepted language used within society is often influenced by intersecting claims of inferiority that construct Black women as lazy, feeble-minded, and weak (Beauboeuf-Lafontant, 2008; Danquah, 1998; Erevelles & Minear, 2010; hooks, 1994; Metzl, 2009; Nicki, 2001). This study is unique because it places intersecting identities as the center of its analysis and focuses specifically on the sociocultural factors that impact the experiences of Black female students within the context of postsecondary education. The findings of this study have the potential to consider new ways of encouraging diverse study retention, persistence and mental wellness as well as initiate policy revisions that promote cultural competency that acknowledges unique experiences and intersecting identities.

Research Questions

In order to explore the experiences of Black female college students with mental health concerns at a PWI, the following research questions were utilized to guide the study:

Primary Qualitative Question

1. What are the experiences of Black female college students with mental health concerns at a PWI?

Qualitative Sub-questions

1. What impact do mental health concerns have on the academic experiences of Black female college students at a PWI?
2. What formal and informal methods of support do Black female college students with mental health concerns at a PWI access?
3. How do the intersections of race and gender affect the college experiences of Black female college students with mental health concerns at a PWI?

Organization of the Study

This study is organized into five chapters. The first chapter includes a statement of the problem, purpose of study and research questions. The second chapter includes a review of the literature with a focus on disability issues in higher education, models of disability, mental health issues in higher education, and mental health issues in Black women; specifically Black female college students. The second chapter also presents the theoretical frameworks utilized in the study. Chapter III includes an explanation of data collection, data analysis, and criteria for the selection of participants. Chapter IV includes the results of the study and themes that arose. Finally, Chapter V includes a discussion of the study, study implications, and recommendations for future research.

CHAPTER II

REVIEW OF LITERATURE

Two primary questions were considered during the review of literature for this study: (a) What are the experiences of Black female college students with mental health concerns at a PWI? and (b) What are the factors that influence the experiences of Black female college students with mental health concerns at a PWI? With the understanding that the experiences of Black female college students with mental health concerns are influenced by a number of societal factors, this chapter seeks to address such factors. This chapter also reviews existing research on disability issues in higher education, models of disability, mental health issues in higher education, and mental health issues in Black women; specifically Black female college students. Factors shown to influence the experiences of Black female college students with mental health concerns were identified in the reviewed literature and merged to provide a foundation for the study. Finally, this chapter reviews disability studies and critical race feminism, the theoretical frameworks used to guide the parameters of this study.

Disability Issues in Higher Education

> "Ableism contributes to the construction of a rigid, elitist, hierarchical, and inhumane academic system" (Price, 2011, p. 8).

Access to and successful completion of postsecondary education has become an essential component to attaining employment. This is especially true for individuals with a disability. "Employment rates for persons with disabilities demonstrate a stronger positive correlation between level of education and rate of employment than has been seen in trends for the general

population" (Chang, Harding, Stodden, & Whelley, 2001, p. 191). In their study, Acosta, Anderson, Dowrick, Heyer, and Stodden (2005) found that "the prevalence of negative attitudes toward and low expectations of people with disabilities" served as barriers to the success of individuals with a disability in "postsecondary education and to subsequent employment" (p. 45).

Several federal regulations have prioritized the attainment of higher education for individuals with disabilities. The implementation of the Americans with Disabilities Act (ADA) prohibits discrimination against individuals with a disability. The Individuals with Disabilities Education Act (IDEA) oversees educational services for children with a disability. Finally, Section 504 of the Rehabilitation Act guarantees rights to individuals with a disability. Regulations such as these have facilitated the enrollment of an increasing number of individuals with a disability to higher education institutions (Chang et al., 2001; Paul, 2000). The National Council for Education Statistics (2006) reported that 11% of undergraduate students enrolled in postsecondary education in the United States identify as having a disability, 22% of which reported a mental illness or depression. However, while the enrollment of students with a disability has increased, these students fail to persist and graduate at a rate comparable to their non-disabled classmates (Chang et al., 2001).

As stated by Paul (2000), college students with a disability regularly encounter "both physical and attitudinal barriers" to obtaining their degrees (p. 200). These barriers include faculty and staff unfamiliarity with disabilities or disability services; stress associated with requesting classroom accommodations; discriminatory attitudes from faculty, staff, and students; lack of trained disability services staff; and lack of targeted well-developed support programs (Acosta et al., 2005; Beilke & Yssel, 1999; Chang et al., 2001; Paul, 2000).

While the challenges faced by college students with a disability are well-documented, they are only exacerbated by the perceived visibility of their disability. When a student has a disability that is not easily identifiable, or 'hidden', they are more likely to have any requested accommodations called into question by faculty members who are more willing to assist students whose disabilities are visible (Acosta et al., 2005; Beilke & Yssel, 1999). Students with a 'hidden' disability struggle with these forms of discrimination and, as a result, report having a less rewarding experience in class than students with a visible disability (Aksamit, Morris, & Leuenberger, 1987). Research on 'hidden' disabilities is a growing field of scholarly work. However, as with the study by Aksamit et al. (1987), much of the research being done on 'hidden' disabilities focuses on learning disabilities. As a result, a need exists for a greater exploration of different forms of 'hidden' disabilities such as mental illness.

Models of Disability

Before one can consider the experiences of individuals living with mental health concerns, it is necessary to explore how disability (specifically mental illness) is understood and perceived. Much of the confusion and apprehension that exists regarding individuals with mental health concerns is directly related to a lack of understanding about what a mental illness is. Terms such as mental illness, mental disability, mental disorder, psychiatric disability, and psychosocial disability are often used interchangeably with little explanation of how, or if, they differ. After attempting to find consensus in the use of terms in literature pertaining to mental health, Schinnar, Rothbard, Kanter, and Jung (1990) found numerous terms and definitions of mental illness and concluded that the ways in which mental illness is defined and determined "varies greatly and often depends on the standards in the community within which one resides"

(Granello & Granello, 2000, p. 102). This lack of consensus contributes to a societal lack of understanding when it comes to various forms of disability.

Researchers, such as Price (2011), have admittedly struggled with what terms to use in their studies. In her research on mental disability and academic life, Price considered the power, influence, and impact that some terms had on the individuals she studied as well as the ways in which organized business entities such as health care professionals use these terms to define individuals with mental health concerns and create a form of normalcy that portrays such individuals as abnormal. It has been found that, even among individuals who utilize mental health services, there is no consensus on what terminology best describes their mental health concerns because, regardless of how they are defined, they are often constructed negatively: ill, incurable, incapable, etc. (Beresford, Nettle & Perring, 2010). As a result, it appears that the numerous misunderstood and misused definitions of mental illness have, and still continue to, contribute to the marginalization of individuals who live with mental health needs. In order to understand how mental health is generally perceived by society, it is necessary to explore the models of disability through which an understanding of mental health is constructed. The medical and social models of disability are the two primary models of disability that dominate the ways in which disability is defined and interpreted.

The Medical Model of Disability

The medical model of disability has traditionally been used for the clinical practice of diagnosing and treating an ailment. Concerned exclusively with the development of precise diagnostic criteria, the medical model of disability gave rise to the Diagnostic and Statistical Manual of Mental Disorders (DSM). The DSM is a diagnostic system that provides classification and shared language for the diagnosis and treatment of mental illness. Developed by the

American Psychiatric Association, the DSM is relied on by governmental entities, healthcare companies, and college disability and counseling centers. First published in 1952, the DSM has since released four editions including the DSM-III which was introduced in 1980 and the DSM-IV which was introduced in 1994 and remains in use (Stefan, 2001; Tucker, 1998).

Critics of the medical model of disability view the model as damaging because it traps individuals living with a disability in a deficient patient role and reinforces the stigma that such individuals experience due to their disability (Beresford et al., 2010; Price, 2011). For individuals living with a mental disability, the flaws that some believe exist within the medical model of disability are twofold. First, through the use of the DSM-IV, the uniqueness of each individual living with a mental disability is ignored and precedence is given to identifying symptoms that can be used to make a medical diagnosis (Tucker, 1998). In essence, the patient is not treated; the diagnosis is treated (Tucker, 1998). By focusing on symptoms and diagnosis, no consideration is given to factors that may contribute to one's mental illness if such factors do not fit within the prescribed diagnostic criteria set forth by the DSM-IV (Tucker, 1998). It has been argued that this preoccupation with the search for and diagnosis of symptoms is politically motivated by the interests of businesses (insurance, healthcare, etc.) that utilize exact diagnostic criteria to regulate, assess, and standardize the productivity of healthcare providers; again, focusing on the illness over the patient (Stefan, 2001; Tucker, 1998).

Secondly, the medical model of disability has been criticized for individualizing the experience of living with a disability as a tragic disadvantage while ignoring the social context and conditions in which one's disability is conceived and experienced (Beresford et al., 2010; Crow, 1996; Price, 2011; Stefan, 2001; Tucker, 1998). "The isolation of impairment from its social context means the social and economic causes of impairment often go unrecognized"

(Crow, 1996, p.63). For example, numerous studies have linked mental disabilities to abuse, racism, unemployment, and sexism (Beauboeuf-Lafontant, 2009; Burke, 1984; Fernando, 1984; Klonoff, Landrine, &Ullman, 1999; Stefan, 2001). When viewed in isolation from these sociocultural and environmental factors, mental health concerns are constructed as individual shortcomings alone. In the past, lifestyles and ideas that opposed socially accepted standards of normalcy were discriminatorily deemed as a mental illness. For example, until 1973, homosexuality was a diagnosable mental illness according to the Diagnostic and Statistical Manual of Mental Disorders (DSM) (Price, 2011, p. 232). While nothing medically has changed about homosexuality, there has been a change in the social acceptability and understanding of it. What other social changes would take place if greater attention was placed on the social context under which individuals were deemed disabled?

Through the use of the medical model of disability and, specifically, the DSM-IV, the stories of how individuals live, cope, and adjust with such socially influenced mental health concerns are not considered (Tucker, 1998). Instead, treatment focuses on curing the impairment. Through the medical model of disability, any barriers, disadvantages, or difficulties experienced by individuals with mental disabilities are interpreted as a personal limitation or inadequacy and not the result of discriminatory conditions that socially construct unreachable ideas of normalcy or able-mindedness (Crow, 1996: Price, 2011).

The Social Model of Disability

Developed by the disabled people's movement and in direct opposition to the medical model of disability, the social model of disability shifts the focus of disability from diagnosis and treatment to the experience of individuals living with a disability (Beresford et al., 2010). Through the social model of disability, impairment is viewed as the "functional limitation(s)

which affect a person's body" while disability is viewed as "the loss or limitation of opportunities resulting from direct and indirect discrimination" (Crow, 1996, p. 57). The social model of disability challenges the social construction of impairment as a personal tragedy and focuses instead on the oppressive barriers and discriminatory obstacles that inhibit the quality of life for individuals living with a disability (Beresford et al., 2010; Crow, 1996).

Through the view of the social model of disability, it is not the individual who is disabled but rather the society that inhibits the individual from living life as a fully accepted, unique, and valued member of society. "Social science research confirms that mental illness is one of the most—if not the most—stigmatized of social conditions" (Stefan, 2001, p. 5). Stigma, along with societal efforts that normalize one form of ability while demonizing another, continues to legitimize the discrimination of individuals with mental health concerns. Though widely accepted for its theoretical positioning, the social model of disability is often criticized for failing to acknowledge the biological or physiological systems at play in the lives of individuals living with mental health concerns (Beresford et al., 2010; Crow, 1996; Gilbert, 2002). As a result, there remains a need for a model of disability that considers the physiological as well as social aspects of an individual's experiences with mental health needs. Such a model of disability can potentially place focus on individuals who juggle their concerns with mental health with other aspects of their lives including race and gender.

The Biopsychosocial Approach to Mental Health

In order to consider the multi-layered experiences of Black female college students with mental health concerns at a PWI, disability and illness must be viewed through a model of disability that considers the environmental contributing factors to mental health concerns such as racism and sexism. While the social model of disability seeks to meet this need, the

biopsychosocial approach to disability takes into account the social as well as medical factors that contribute to disability. Developed over 30 years ago by Dr. George Engel, the biopsychosocial model seeks to bridge the divide between medical and social models of illness and disability which have arguably been created through the culturally dominating and widely implemented medical model of disability (Borrell-Carrio, Epstein, & Suchman, 2004; Engel, 1977; Gilbert, 2002). The biopsychosocial model argues that the medical model impedes the holistic care of individuals by operating under the belief that human physiological systems operate autonomously and, thus, are not subject to social, behavioral, or psychological influences (Engel, 1977; Gilbert, 2002). According to Engel, such a belief gives way to a dualistic understanding of health and gives rise to a separation of body and mind that results in the "dehumanization of medicine and disempowerment of" individuals (Borrell-Carrio et al., 2004, pp. 576-577).

The biopsychosocial model does not seek to eliminate or ignore contributing factors to mental health that are biological in nature. Instead, through the use of the biopsychosocial model, attention can be placed on both the biological and social influences on mental health without abandoning the scientific advantages that have been gained through research conducted under the medical model approach (Engel, 1977).

> By evaluating all the factors contributing to both illness and patienthood, rather than giving primacy to biological factors alone, a biopsychosocial model would make it possible to explain why some individuals experience as "illness" conditions which others regard merely as "problems of living," be they emotional reactions to life circumstances or somatic symptoms. (Engel, 1977, p. 133)

Some critics of the biopsychosocial model argue that, through this model, Engel oversimplifies the integration of biological and social influences on health while others argue that efforts to implement a biopsychosocial model have been poorly organized resulting in a return to the

medical model which is the most widely accepted model in the Western world (Engel, 1977; Gilbert, 2002). Despite such criticism, the biopsychosocial model has the potential to change the way disability is defined by placing the same level of value on social factors and medical factors related to mental health.

Ultimately, it remains that disability is largely understood through the medical model and its use of the Diagnostic and Statistical Manual of Mental Disorders (DSM). As a result, the following statements were used to frame an understanding of mental health and disability during this study:

1. The medical model of disability does not consider the psychological, social, or behavioral factors that may contribute to an individual's mental health and, as a result, hinders the ability to view such individuals as unique people by locking them into the role a of tragic, ill-fated patient.

2. Research conducted under the medical model of disability has resulted in significant medical advances and information on mental health. However, without the consideration of psychological, social, and behavioral influences on mental health, the care, concern, and consideration of such individuals will always fall sort of holistically considering their needs and experiences.

3. The biopsychosocial model has the potential to contribute to how mental health is perceived in society by bridging the divide between the medical and social model of disability. However, until it is valued, taught, organized, and implemented to the same extent as the medical model, it will remain limited in its potential.

4. Mental health is understood differently across cultures and, in the Western world, is framed in the medical model. The social model provides an opportunity to focus on the

narratives of individuals living with mental health concerns. Such narratives are needed to consider the experiences of individuals marginalized by the lack of attention placed on social injustices (racism, sexism, classism, etc.) that may or may not contribute to their mental health concerns.

5. A need exists for the study of the experiences of individuals with mental health concerns. As such, through the study of the experiences of Black female college students with mental health concerns at a PWI, this study considers the social factors that influence the experiences of the study participants. Because of its interdisciplinary nature, findings from this study have the potential to contribute to various fields of study. However, findings focus on the impact of disability stigma, gendered roles, racialized expectations, and discrimination on student experience, retention, and persistence.

Mental Health Issues in Higher Education

> "Although the social stigma associated with visible physical disability is high, the stigma associated with nonvisibile disabilities, such as mental illness, is higher" (Stefan, 2001, p. 8).

In 1998, a significant number of large higher education institutions in the Midwestern United States were found to have experienced a 30 to 100% increase in students seeking assistance for psychiatric disabilities (Measel, 1998). Similarly, it was reported by the National Council for Education Statistics (2006) that 11% of undergraduate students enrolled in postsecondary education in the United States reported having a disability, 22% of which reported a mental illness or depression. Such statistics are becoming more prevalent and reflect a growing trend in the United States. Currently, one in four American adults suffers from a mental disorder (Chiu, Demler, Kessler, & Walters, 2005). As research has advanced in the areas of mental health, criteria by which various forms of mental illness have been diagnosed has expanded to

include both severe forms of psychiatric disabilities such as schizophrenia and less severe forms such as anxiety disorders (Blacklock, Benson, Bruininks, Johnson, & Sharpe, 2004).

Despite the advances of medical research on mental illnesses and disabilities, additional research is necessary to explore why 86% of students with psychiatric disabilities withdraw from college before completing their degrees (Collins & Mowbray, 2005). Young adults with a psychiatric illness commonly "find themselves underserved, misunderstood, and mistreated" (Poa, 2006, p. 29). Barriers to the successful retention and transition of college students with a mental illness include media images that develop a misinformed fear of individuals living with mental illnesses, negative campus attitudes towards individuals living with mental illnesses, fear of broken confidentiality, and challenging accessibility of campus accommodations for individual with mental illnesses (Chew-Graham, Rogers, & Yassin, 2003; Deshler, Ellis, & Lenz, 1996; Padron, 2006; Thornton & Wahl, 1996).

Internalized Media Images of Mental Illness

Research has shown that media images of mental illness have perpetuated negative ideas of individuals with psychiatric disabilities. In a study published in the *Journal of Community Psychology*, it was found that "newspaper coverage of dramatic crimes committed by individuals with mental illnesses" stigmatized individuals with such disabilities (Thornton & Wahl, 1996, p. 22). Similar findings arose in a study published in *Social Psychiatry & Psychiatric Epidemiology* (Angermeyer, Dietrich, Heider, & Matschinger, 2006). Both articles found that individuals exposed to negative newspaper images of psychiatric disability were more likely to use terms such as 'violent' and 'dangerous' when referring to individuals living with such disabilities. Also, both articles found that these same individuals were more likely to vocalize a need for societal restrictions on individuals with a mental illness.

Through an analysis of electronic media, Carmichael, Granello, and Pauley (1999) found that negative images of psychiatric disability were dispensed quickly and influenced the perceptions of numerous individuals. As a result, individuals who primarily receive their news through electronic mediums were "more in favor of social restrictiveness, and demonstrated less willingness to support the integration of mental health facilities into the community than did other individuals" (Carmichael et al., 1999, p.105). Though professionals on college campuses, such as faculty members and administrators, are, in theory, more exposed to research and critical thought than the general public, they are not immune to internalizing negative media images of mental illness and to the attitudes that such images can influence.

Campus Attitudes Toward Mental Illness

In a study published in the *Psychiatric Rehabilitation Journal*, faculty and student attitudes, beliefs, and knowledge of students with a psychiatric disability were explored (Becker, Martin, Shern, Wajeeh, & Ward, 2002). Through the use of questionnaires, the study analyzed responses from 315 faculty members and 1,901 college students. The research found that faculty who believe that students with a psychiatric disability are dangerous felt unsafe in their classrooms and uncomfortable interacting with such students (Becker et al., 2002). As a result, faculty members with these attitudes were significantly less likely to refer students to campus services or to make class accommodations that could increase the student's ability to succeed in the class. Further research has found that, in addition to faculty, intolerance toward individuals with mental illnesses has also be exhibited among college students, administrators, and professional staff (Bonnell & Gupta, 1993; Carmichael et al., 1999; Granello & Granello, 2000; Hoffmann & Mastrianni, 1989).The article concluded with the observation that an increase in

faculty knowledge of psychiatric disability will increase confidence in their ability to help students with such disabilities.

Fear of students with a mental illness appears to be a recurring theme in research on campus perspective and attitudes; especially among faculty (Housel & Hickey, 1993). Media portrayals of mental illness reflect and reinforce the lack of understanding of mental health matters (Beresford et al., 2010). In 2007, media coverage of the shooting on the campus of Virginia Polytechnic Institute and State University (Virginia Tech) focused primarily on the criminality of the shooter and sensationalized the status of his mental health diagnosis (Applbaum & Glicka, 2010; Carvalho, 2010). Popular news channels such as Cable News Network (CNN) and the British Broadcasting Corporation (BBC) failed to consider sociocultural factors such as "the militarization and hypermasculinization of culture" (Carvalho, 2010, p. 404) and the possible impact that such factors may have had on the shooter's mental capabilities (Applbaum & Glicka, 2010).

Despite stereotypes and other generally held ideas, most individuals with a mental illness do not commit acts of violence (Abram, Choe, & Teplin, 2008; Monahan, 1992; Price, 2011). "Because serious mental illness is quite rare, it actually contributes very little to the overall rate of violence in the general population; the attributable risk has been estimated to be 3 to 5 percent, much lower than that associated with substance abuse, for example" (Friedman, 2006, p. 2065). The higher the level of faculty fear of and discomfort with students with mental illnesses, the less likely that they will refer such students to take advantage of campus counseling services (Becker et al., 2002). In order for campus professionals to move past discriminatory stereotypes of students with mental illnesses, they must become familiar with the experiences and needs of such students (Becker et al., 2002; Beilke & Yssel, 1999; Greenbaum, Graham, & Scales, 1995).

For faculty who may not possess a feeling of fear toward students with a mental illness, there may still remain a certain level of distrust for such students and their needs. Faculty and administrators can hold "prejudicial attitudes" towards students with hidden disabilities which results in suspecting such students "of using disability as a way to gain preferential treatment" (Beilke & Yssel, 1999, p. 365).

> Professors or instructors may tend to perceive students with mental illness as trying to manipulate them or the university system. Excessive absenteeism challenges university policies when the manifestation of a student's psychological disability interferes with his or her academic performance. (Huefner & Kiuhara, 2008, p. 105)

Again, such perceptions can be challenged and changed when individuals on campus become familiar with needs of students with various hidden disabilities. Campus training workshops that familiarize the campus community with hidden disabilities can equip faculty and staff to assist students with mental health concerns. "Students who view their advisors as advocates and sources of support are more likely to overcome their concerns and disclose a hidden disability" (Quinllin & Rehfuss, 2005, p. 49). Students who are comfortable enough to disclose their mental health concerns are more likely to take advantage of campus resources.

Campus Resources for Students with Mental Health Needs

College students living with a mental illness navigate their higher education institutions with feelings of anxiety and fear. Campus disability service offices are often difficult to locate and typically focus on accommodations appropriate for physical and learning disabilities (Padron, 2006). Disclosing one's mental illness can be embarrassing and stressful, especially when interacting with campus professionals and classmates who have negative ideas of what a mental illness is. Fear of exposure and negative stigma as well as faculty and student ignorance about available services on campus are all factors contributing to students not seeking assistance from disability service offices (Padron, 2006).

In addition to navigating their experiences as college students with a mental illness, other factors such as race, class, and gender influence their identity formation. With this in mind, many students place their mental illness to the side in order to concentrate on other aspects of their identity. Black female college students, who navigate higher education institutions through the convergence of two visible forms of domination, often find themselves in the position of being representatives for the Black community; especially with the decreasing number of Black male students in college (Zamani, 2003). Another reason for nondisclosure of their mental illness could be due to the history of institutional policies that once required students to withdraw if they were found to have a psychiatric disability (Megivern, Mowbray, & Pellerito, 2003). Brockelman and Olney (2003) found several reasons for students to conceal and/or ignore their disability. Their research findings revealed that students concealed their disability because:

1. those with invisible disabilities expressed concern that others would not believe that they had a bona fide disability;
2. participants felt that others would see them as less competent;
3. they wished to be viewed as consistent and trustworthy;
4. they worried that others would see them only as needing help rather than as a peer who can give and take in a relationship. (Brockelman & Olney, 2003, p. 48)

Once young adults reach the legal age of independence and transition from the status of childhood to adulthood, they may experience a change in available mental health services that appropriately address their concerns (Davis, 2003; Poa, 2006). “When students receive help for their psychological problems, counseling can have a positive impact on personal well-being, academic success, and retention” (Kitzrow, 2003). While campus counseling centers can potentially meet the needs of this population of students, there has not been an increase in professional staff that can meet the increased demand for counseling services (Gallagher, Gill, & Sysko, 2000). In addition to a lack of campus staff and resources, experienced and internalized stigma related to one’s mental health concerns serve as reasons for students to reluctantly take

advantage of campus services or opt not to take advantage of services all together (Grannello & Grannello, 2000). Such barriers are compounded for Black female college students when combined with the stress of pursing postsecondary education in a PWI and adhering to cultural norms that construct mental health concerns as a form of weakness.

Race, Gender, and Mental Health Among Black Female College Students

> "While our health is undeniably assaulted by natural forces frequently beyond our control, all too often the enemies of our physical and emotional well-being are social and political" (Davis, 1990, p. 19).

It is estimated that 37% of young adults between the ages of 15 and 24, the traditional age range during which students enter higher education institutions, live with a psychiatric disability (Berglund, Kessler, & Olfson, 1998; Collins, 2000; Huefner & Kiuhara, 2008; Poa, 2006; Unger, 1992). According to the United States Department of Health and Human Services, 7.5 million African Americans have a diagnosed mental illness and an additional 7.5 million African Americans may suffer but remain undiagnosed (Davis, 2005). It has been suggested that African Americans face serious barriers to acknowledging, understanding, and addressing mental illness. Such barriers include internalized stigma that exists within their communities, limited access to health-related services, cultural mistrust of healthcare providers, and contentment in the use of informal coping mechanisms such as church (Ward, Clark, & Hedrich, 2009). For Black female college students attending PWIs, these barriers are compounded with the added stresses of acquiring post-secondary education in PWIs, operating within institutions that have limited knowledge and generally held misconceptions of mental illness, and adhering to the culturally held stereotype of the strong Black woman (Beauboeuf-Lafontant, 2009; Heppner et al., 2004; Kitzrow, 2003; Kiuhara & Huefner, 2008; Loo & Rolison, 1986; Parks, 2010; Sedlacek, 1999; Winkle-Wagner, 2009).

Educational Experiences at Predominantly White Institutions

A research-based exploration of the experiences of Black female college students at PWIs provides a unique opportunity to consider the multiple performances of identity that such women often feel led to juggle. Unlike their White female counterparts or even their Black male counterparts, Black female college students at PWIs simultaneously experience gender as racialized and race as gendered (Winkle-Wagner, 2009). In essence, race and gender "intersect so completely that it is not possible for women to explore their gendered experiences without linking these experiences to race" (Winkle-Wagner, 2009, p. 114). While experiencing racism at PWIs, Black female college students concurrently experience sexism.

The history of higher education in the southern region of the United States, where this study was conducted, is commonly associated with black and white images of the news coverage regarding the forced desegregation of higher education institutions. While racially motivated actions of resistance were at times in direct opposition to the federally forced desegregation of colleges and universities, the practice of racial discrimination within higher education institutions was nationally prevalent at that time and not confined to a particular region or state (Thelin, 2004). The legacy of segregation in the United States, specifically, within higher education institutions, resulted in the creation, administration, and legal enforcement of laws that criminalize various forms of discrimination (racism, sexism, etc.). The presence of laws such as the Civil Rights Act and Affirmative Action serve as societal indicators of the "unfair and unequal opportunities against racial minorities" (Harley, 2008, p. 29). It is within this context of obligatory institutional policies enacted to counter years of discrimination, such as affirmative action, that Black college students pursue their academic goals.

Discrimination on the basis of race has been found to be a prominent component to daily life for Black Americans; a fact that has also been shown to impact mental and emotional performance (Burrow, Driscoll, & Torres, 2010). Black female college students at PWIs are directly impacted by the racism and sexism that they experience off campus as well as on campus. Institutional racism, in particular, is a remnant of the deeply rooted history of segregation in the United States and continues to pervade PWIs through regulations and policies that negatively impact under-represented minorities and contribute to the persistence of racial inequalities within higher education institutions (Bowles, Cervero, Johnson-Bailey, & Valentine, 2009; Harley, 2008; Sedlacek, 1999). For example, primary and secondary school zoning laws have been found to segregate on the basis of socioeconomic factors while a continued focus on social and cultural differences in minority student academic practices and retention discounts the political, social, or economic deficits that impact their foundational educational environments (Silver, 1997; Spears, 1978; Tolsdorf, 2005). Not unlike institutional racism, racial microaggressions, which are ambiguous insults targeted towards individuals of color, are often difficult to decipher and even harder to contest (Ceja, Solorzano, & Yosso, 2000). Microaggressions come in various forms such as the appearance of racial slurs painted on the sidewalks of Civitan University (pseudonym) on two separate occasions in 2011 (Grasgreen, 2011). Racial microaggressions on college campuses are, at times, covert to the extent that levels of anxiety and stress in Black students are heightened as they attempt to decipher whether or not they are imagining their assaults (Ceja et al., 2000).

According to Burrow et al. (2010),

> experiencing racial microaggressions of Underestimation of Personal Ability (negative perceptions regarding one's capacity to succeed in academia), as opposed to Assumptions of Criminality/Second-Class Citizen (being treated like a second-class citizen or criminal) or Cultural/Racial Isolation (being singled out because of race or marginalization due to

> lack of same-race peers), may be more salient and carry a higher mental health risk for African American graduate students and professionals because of the underlying message or stereotype that these events communicate and the potential threat to the individual's goals. (p. 1094)

As Black female college students progress through their studies at PWIs, racially motivated assumptions about their academic ability can contribute to internalized feelings of self-doubt that can negatively impact their persistence towards graduation (Ceja et al., 2000). It has been well documented that Black students, as well as other under-represented minorities at PWIs, report experiences with alienation, racism, isolation, and limited support systems (Allen, 1992; Bowles et al., 2009; Branch Douglas, 1998; Bylsma, Cohen, Fitzgerald, Hyers, & Swin, 2003; Davis et al., 2004; Feagin & Sikes, 1994; Feagin, Vera, & Imani, 1996; Gerard et al., 2001; Sedlacek, 1999; Winkle-Wagner, 2009). In addition, such experiences often lead to a disconnectedness or alienation from the overall university culture and potential withdrawal from the institution (Delphin & Rollock, 1995; Suen, 1983). The psychological and emotional distress that such experiences may trigger in Black female college students often lead them to take advantage of informal systems of support rather than explore potentially beneficial student-focused campus services that are administered by the very institution that they perceive as causing their stress. "Given the clear relationship between level of stress, particularly psychological/interpersonal stress, and psychological distress among Black students, it seems important to further efforts on PWI campuses to find ways to reduce levels of stress" (Heppner et al., 2004, p. 612).

While, historically, Black women faced the same racial discrimination that all Blacks were subjected to during segregation and endured the same forms of institutional racism that presently persist throughout higher education institutions, there is another layer of influence and discrimination that they experience based on their gender. Before the 1954 United States

Supreme Court decision to eradicate segregated education, Black women took advantage of their limited access to education as a means of empowering their communities (Evans, 2006; McKay, 1997). Within many Black communities, education was generally perceived as an acceptable and respectable career path for a woman and, though only a small number of colleges began admitting Black women in the mid-1800s, the establishment of several Black colleges in the mid- to late 1800s increased the number of Black female college graduates (Bell-Scott & Guy-Sheftall, 1989; McKay, 1997). However, many Black women were limited to classes such as home economics and elementary education while courses that were viewed as having greater academic rigor were, at that time, seen as a challenge suitable only for White male students (Evans, 2006; McKay, 1997).

Despite the limitations placed on women during the late 19th and early 20th century, the majority of students currently enrolled in higher education institutions in the United States are women (Allen, Dean, & Bracken, 2008; Goldin, Katz, & Kuziemko, 2006). This newly gained majority status of women on college campuses, however, is not an accurate reflection of minority representation on college campuses. For example, though women constitute 57% of all undergraduate and graduate students for 2008, only 8% identified as African American (Kim, 2011). In addition, at the turn of the 21st century, only 2% of full-time, tenured faculty members at public and private research institutions identified as women of color; a statistic that reflects the combined representation of Black, Hispanic, and Native American female faculty (Evans, 2007). Not only do Black female college students at PWIs often feel isolated and invisible due to the lack of similarities that they share with their classmates, their feelings of isolation are reinforced by the lack of Black female faculty and staff on their campuses and the support that such campus professionals can offer (Winkle-Wagner, 2008).

Faced with the challenge of experiencing higher education as a double minority, Black female college students at PWIs interact in hostile and unreceptive classroom environments with few Black female professional role models available to assist their navigation of the campus (Bell-Scott & Guy-Sheftall, 1989; Hall & Sandler, 1982; Martin, 2000). According to Martin (2000), "the chilly classroom climate for women, the underrepresentation of women in the higher ranks of the professoriate, the backlash against women's studies, and the harassment of feminist scholars and scorn for their scholarship" all serve as filters for female students attending college in an androcentric and racist environment (p. 85). In addition, traditional male-oriented ideas of objectivity, autonomy, competition, and individual achievement continue to force female students to abandon community-focused, activist-oriented research in order to be considered relevant and maintain a relationship with academia (Allen et al., 2008; Guy-Sheftall & Bell-Scott, 1989; Martin, 2000; McKay, 1997). This pressure insists that, in order to achieve success in their post-secondary studies, Black female college students must assimilate into an environment that perceives them, their experiences, and their knowledge as academically and intellectually inferior thus educating them away from their communities and themselves (Guy-Sheftall & Bell-Scott, 1989). Whether or not a student has mental health concerns before beginning their post-secondary education, the combined impact of racism and sexism can threaten the psychological health of Black female college students at PWIs. As a result, campus counseling centers become vital resources that can potentially assist students as they progress through their education. Unfortunately, many Black female college students at PWIs often do not take advantage of their campus counseling centers.

Utilization of Campus Counseling and Mental Health Services

Several studies in the 1970s and 1980s explored the help-seeking habits of Black college students and documented their underutilization of campus counseling or other mental health services (Austin, Carter, & Vaux, 1990; Backner, 1970; Burrell & Rayder, 1971; Davis & Swartz, 1972; Gibbs, 1975; Mackey, 1972; Peoples & Dell, 1975; Ponterotto, Anderson, & Grieger, 1986; Westbrook, Miyares, & Roberts, 1978). Though the use of campus counseling services by college students has increased over the past 20 years, it remains that research indicates a continued underutilization of campus counseling services by Black college students as compared to their White counterparts (Boesch & Cimbolic, 1994; Duncan & Johnson, 2007; Elms & Nickerson, 1994; Gerard et al., 2001; Measel, 1998). "It may be that students who feel alienated from the university are uncomfortable enough to make themselves aware of available psychological services, but their feelings of estrangement from the campus environment lead to the choice not to use them" (Delphin & Rollock, 1995, p. 344). While research continues to focus on the comparison of minority college student utilization of mental health and campus counseling services to that of White students, further research is needed to explore the potential impact that race, gender, and mental health may have on the experiences of minority students and their decisions to utilize or decline available services. This study contributes to this needed research by utilizing the experiences of Black female college students with mental health concerns at PWIs to consider the socio-political factors that construct disability, gender, and strength in the lives of the Black women.

Misconceptions of and stigma related to mental health, cultural mistrust of counselors, and unmet counselor preference have been shown to impact a student's experience with and utilization of campus counseling and mental health services. Social stigma regarding mental

health and the use of psychological assistance hinder many Black college students from taking advantage of campus mental health services (Atkinson, Jennings, & Liongson, 1990; Constantine, Chen, & Ceesay, 1997; Constantine & Wallace, 2005; June, Curry, & Gear, 1990). Fear of exposure and rejection can become heightened by internalized stigma regarding mental health. Such stigma can be fueled by ignorance of mental health as well as culturally-held perceptions of self that conflict with the acknowledgement of one's mental health concerns.

For minority students who choose to take advantage of campus counseling services, mistrust of campus counselors can prove to be a barrier. In their study, Helms, Nickerson, and Terrell (1994) found that cultural mistrust (specifically of White counselors) was "the most consistent and powerful predictor of the help-seeking attitudes of Black students" (p. 382). In addition, Duncan and Johnson (2007) concluded that gender and cultural mistrust impact student's attitudes about counseling when they found that Black female college students preferred Black female counselors. This lack of trust in mental health services and White counselors is representative of the sociopolitical perspective held by some Black college students who generally do not trust institutions that are perceived as traditionally White (Austin et al., 1990).

Considerable research found that the race of a campus counselor has an effect on minority utilization of campus counseling services (Boesch & Cimbolic, 1994; Ponterotto et al., 1986; Thompson & Cimbolic, 1978). Boesch and Cimbolic (1994) found that the percentage of Black college students who saw a counselor doubled when there was at least one Black counselor on staff. Likewise, Atkinson et al. (1990) found that the availability of diverse counselors impacted a student's utilization of campus counseling services because students wanted to meet with a counselor that they perceived as being "culturally similar or culturally

sensitive" (p. 348). Minority college student preference for a culturally similar campus counselor can be influenced by additional factors such as the ethnic composition of the geographic area in which the campus is located, the racial composition of the campus, and the kind of problem that a student is managing (Boesch & Cimbolic, 1994). Despite specific factors contributing to counselor preference, Black student preference for Black counselors is often unmet when pursuing their education on predominantly White campuses.

Though a substantial amount of research exists on Black college student utilization of campus counseling and mental health services, it is important to note that few studies attempt to explore the impact that race and gender may have on a student's attitude toward, perception of, and experience with mental health. In addition, none of the studies mentioned above focus specifically on the experiences of Black female college students at PWIs or employ the use of interview data to explore the layers of influence that potentially contribute to the stigma that Black female college students may experience due to their race, gender, and mental health concerns. Instead, many of the studies reviewed above utilized longitudinal theories of student development, such as Cross's Model of Psychological Nigrescence (1980, 1995), to assess student attitudes toward mental health and habits of help-seeking. Unfortunately, such theories have been found to reinforce exclusionary institutional traditions by ignoring or superficially considering the impact of diverse influences (race, gender, ability, etc.) on student experience and development.

Exclusionary Models of Student Development

Efforts to understand, assess, predict, and influence minority students' persistence through higher education institutions have resulted in various theories and models of student development, transition, and persistence. Two notable theories include Tinto's (1975, 1993)

Student Integration Model and Cross's (1980, 1995) Model of Psychological Nigrescence. Tinto's Student Integration Model asserts that academic and social integration increase educational success for under-represented students in higher education (Tinto, 1975, 1993). This model has been used to inform various programs geared toward the successful persistence of minority students including Black female college students at PWIs (Winkle-Wagner, 2009). However, Tinto's model has been critiqued for its focus on the assimilation of under-represented minority students toward norms that reflect a White, Euro-Centric or majority perspective (Feagin et al., 1996; Tierney, 1999). This assimilation ultimately requires "those who have been underrepresented and historically disadvantaged to change and sometimes lose themselves by assimilating into existing institutions—the same institutions that create race and gender in persistently unequal ways" (Winkle-Wagner, 2009, p. 10).

The pressure to assimilate into the culture of PWIs can incite confusion, marginalization, anxiety, stress, and decreased mental health status in minority college students (Anderson, 1991; Anderson, Bakeman, & Thompson, 2000; Berry, Kim, Minde, & Mok, 1987). Tinto's model, like other models of student identity development, relies on a psychological framework that focuses on stages of progression rather than a sociological framework that focuses on characteristics of social structures such as inequality (Winkle-Wagner, 2009). As a result, the experiences of students, and specifically Black female college students, are lost if they do not fall within a sequence of stages as articulated by the theory being utilized (Winkle-Wagner, 2009).

Cross's Model of Psychological Nigrescence is a model of racial identity that consists of five stages through which a Black person progresses toward his or her racial identification (1980, 1995). Cross (1980) referred to his model as "process of becoming Black" (p. 81). Through the use of his model, Cross unintentionally encouraged educators, counselors, and researchers to

generalize the experiences of Black students and fit those experiences into a pre-determined course of development that results in a fundamental Black experience. While this model has contributed significantly to the field of educational research by initiating conversations about the experiences of Black students, it fails to consider the uniqueness of each student's experience or the influences that contribute to each student's socialization within their own communities thereby ignoring the potential impact of gender, ability, or ethnicity on their mental well-being.

The propensity for grouping Black college students together under the model of a particular theory without addressing the frustrations they may encounter is particularly deleterious to their experiences. The lack of Black and female tenured faculty and the questioned relevance of non-traditional, social justice-oriented research as well as superficial campus commitments to diversity speak volumes to under-represented students. Such students are encouraged to persist toward graduation under the vestiges of institutions that once embraced prejudice (based on race, gender, ability, etc.) and now, through traditionally held campus policies and procedures, live with the legacy of that prejudice. Despite the likely unintentional but exclusionary nature of Cross's model, numerous studies have and continue to utilize his theory to link the counselor preferences of Black students to a particular stage of their racial identity development (Austin et al., 1990; Parham & Helms, 1981).

It has been suggested that Cross's (1980) racial identity theory does not take into account attitudes that do not fall within the characteristic of a specified stage of the theory (Parham & Helms, 1981). For example, Cross's model does not consider the influence of gender on identity and/or the performance of identity. At what stage in Cross's model do women question the inequities that they experience based on their gender or how those inequities exists simultaneously with the inequities that they experience due to their race? While there have been

calls for continued revisions to Cross's model of racial identity theory, no calls take into account the impact of gender and ability (Parham & Helms, 1981). As a result, some campus counselors continue to reference the racial identity theory in order to structure their counseling sessions and treatment plans; a practice supported by findings by Anderson et al. (2000) who suggest that PWIs could tailor counseling treatment plans for students based on their racial identity status.

Ultimately, linear theories such as Tinto (1975, 1993) and Cross (1980, 1995) are the tools upon which many campus professionals are trained to rely as they seek to serve students of color. Most campus professionals are often not trained to be aware or conscious of the multi-layered experiences and expectations that students, specifically Black female students, bring with them to campus nor how those experiences and expectations intersect. In order to holistically assess and treat Black female college students with mental health concerns, it is necessary for campus professionals, and specifically campus counselors, to understand that they come to campus with perceptions, attitudes, and stigma about counseling services that are influenced by their community-held beliefs on mental health and the role of Black women (Austin et al., 1990).

Framing Mental Health in Black Female College Students

The impact of racism on the mental health of African Americans has been well-documented (Alexander & Poussaint, 2000; Broman, Jackson, Neighbors, &Thompson, 1996; Brown et al., 1996; Burke, 1984; Klonoff & Landrine, 1996; Klonoff et al., 1999; Outlaw, 1993; Pillay, 1984; Sillen & Thomas, 1972). Racism, in its intentional and unintentional forms, continues to have a negative effect on the mental health of African Americans (Burrow et al., 2010; Williams, Neighbors, Jackson, 2003). However, African Americans continue to underutilize mental health services at alarming rates. Barriers to the utilization of sufficient mental health services by the Black community include poor access to healthcare, stigma

regarding mental illness, and lack of awareness about what constitutes a mental illness (Clark et al., 2010). As a result, African Americans tend to use informal coping mechanisms such as church, friends, and family rather than seek medical assistance for their mental health concerns (Clark et al., 2010; Matthews & Hughes, 2001; Neighbors, Musick, & Williams, 1998).

Belle and Doucet (2003) found that discriminatory acts of racism and sexism toward Black women in college decrease their self-esteem and lead to the development of depression. Along with depression, anger and anxiety are also psychological symptoms that are often displayed by Black female college students whose experiences are impacted by racism and sexism (Butler, Henry, & West, 2011; Neville, 2000). The limited research "regarding Black women's mental illness likely represents the reality that it is harder for these women to have their suffering validated or to get help" (Metzl, 2009, p. 207). Black female college students at PWIs are simultaneously advantaged because of their positioning within a higher education institution and disadvantaged because of their isolated existence within an institution that pressures them to assimilate towards Eurocentric norms of intellectualism. As a result, their mental distress can, at times, remain unacknowledged and unaddressed.

Research on Black student populations in college has focused a great deal on the low enrollment and graduate rates of Black male students (Harper, 2006; Roach, 2001). When viewed within the context of this 'crisis of Black men,' the issues of Black women are minimized and downplayed (King, 1992). When one considers that Black women make up 65% of the Black student population in the United States, one might assume that they are not experiencing difficult barriers of their own (Butler et al., 2011; Chronicle of Higher Education, 2008; King, 1992). When Black women are viewed as advantaged in comparison to their male counterparts, the "myriad dimensions of oppression in their lives" are discounted (King, 1992, p.

42). In essence, Black women are made to feel that they have nothing to complain about and, as such, are silenced from portraying themselves as anything other than strong.

In the early 1900s, W.E.B. DuBois presented a concept known as double-consciousness which refers to "the perception that the collective psyche of people of African descent has been torn between competing cultural dictates as a result of its encounter with European culture" (Caldwell & Stewart, 2001, p. 225). Dubois (1897) referred to double-consciousness as a "sense of always looking at one's self through the eyes of others" while working to meet the expectations of "two warring ideals" (pp. 194-195). Building off of this concept, Jones and Shorter-Green (2003) coined the phrase 'shifting' which refers to the constant shift that Black women feel pressured to maintain between Black and White norms. Because of shifting, Black women "become susceptible to an array of psychological problems, including anxiety, low self-esteem, disordered eating, depression, and even outright self-hatred" (p. 8). Awareness of and adherence to these conflicting norms are often taught to Black women at a young age. This is accomplished through the "duality of socialization" in which Black children are raised to be aware of the majority culture as well as the importance of imitating it whether or not it is at odds with their own cultural norms (Greene, 1990, p. 214). For Black women, stoic strength is among the learned behaviors associated with the Black community and instilled at a young age. Research on the experiences of Black female college students often ignores the 'shifting' that such students feel compelled to endure (Winkle-Wagner, 2009). This study contributes research that speaks to the multi-layered performances of self that such students often feel led to display. Specifically, this study considered the psychological impact that the performance of strength as understood within the 'myth of the strong black woman' can have on the mental health of Black female college students at a PWI.

The Myth of the Strong Black Woman

In her book, *Black Macho and the Myth of the Superwoman*, Wallace (1978) explores, from a Black feminist standpoint, the idea of strength in Black women. The 'myth of the strong black woman' has been examined in Black feminist research for the past 30 years (Beauboeuf-LaFontant, 2009; Jones & Shorter-Gooden, 2003; Wallace, 1978). Beauboeuf-LaFontant (2007) argued that "the construct of strength is rooted in a set of problematic assumptions," some of which include the assumption that "strength is a natural quality of Black women" and "that being strong accurately characterizes Black women's motivations and behaviors" (p. 31). Black female college students internalize the myth of the strong Black woman to their detriment. In her study on identity in Black female college students at a PWI, Winkle-Wagner (2009) found that Black female college students were simultaneously pressured to portray themselves as strong while adhering to a campus culture that encouraged their silence. Black female college students are simultaneously pressured to be "'assertive and aggressive' as a means to be successful and to overturn racial stereotypes inside and outside of the classroom" as well as "passive and silent so as not be accused of having an 'attitude problem'" (Winkle-Wagner, 2009, p. 129). Much like the concept of double consciousness, adhering to two different forms of identity performance can incite anxiety, depression, and stress in Black female college students at a PWI. Furthermore, adherence to unrealistic ideas of strength in Black women can encourage such women to ignore mental health concerns resulting in their hidden disability becoming more hidden.

Attributes of the strong Black woman script include self-reliance, self-sacrifice, and self-silence (Black & Peacock, 2011). "Although multiple role fulfillment can increase feelings of purpose and self-worth and increase women's resources, gender socialization cultivates a process through which they are socialized to maintain roles that overburden them" (p. 145). For many

Black female college students, the script of strength in their lives has served them well and afforded them the ability to garner success in various aspects of their lives, including that of educational attainment. However, restricted race gender roles, such as that of the strong Black woman, prevent Black women from showing signs of vulnerability (Neville, 2000). Instead, they continue about their lives feeling as though they must be a shining example of success for their communities as well as a readily available source of support for all members of their families (Neville, 2000). "Managing stress in silence and providing self-sacrificial assistance to family and friends garnered respect and admiration from network members yet increased women's vulnerability to illness—in particular, psychological distress" (Neville, 2000, p. 148). Internalized ideas of strength incite depression in Black women while simultaneously encouraging them to hide, mask, or ignore it.

Within many Black communities, there is a historical expectation that Black women are the backbone of their communities (Black & Peacock, 2011). Informed largely by the anecdotal idea that ancestors of African descent weathered slavery with a stoic strength that has been passed down through generations, the myth of the strong Black woman "insists that struggle, selflessness, and silence are the hallmarks of Black womanhood" (Beauboeuf-LaFontant, 2008, p. 399). Danquah (1999) recognized the potential benefits of survival that the Black community has experienced from the strength that they seemingly acquired during their racially discriminatory and horrific history. As a result, strength is perceived as a legacy of slavery. However, continued reliance on this idea of strength "is not really strength at all. It is stoicism. It is denial. It is a complete negation of their pain" (Danquah, 1999, p. 277). For Black female college students with mental health concerns at a PWI, portraying the myth of the strong Black

woman can silence them from acknowledging their concerns or taking advantage of mental health services that may be available on their campuses.

Beauboeuf-Lafontant's (2007) research on strength in Black women suggested that the "discourse of being strong may normalize a distress-inducing level of selflessness and powerlessness among" Black women. (p. 28). As a result, mental health concerns in Black women are muted because they challenge "the tenets of strength, the bedrock of Black women's identity" (Beauboeuf-LaFontant, 2008, p. 401). Black female college students with mental health concerns who adhere to the myth of the strong Black woman often do not accept psychological distress such as depression as a legitimate diagnosis (Amankwaa, 2003). Instead, the idea of strength in Black women "is reinforced by community 'myths' that maintain that Black women do not get depressed and do not require assistance to manage their difficult lives" (Beauboeuf-LaFontant, 2007, p. 32). In essence, depression and fatigue are characteristics that are acceptable for White women but not for Black women; and certainly not for Black women who have the privilege and responsibility of acquiring post-secondary education.

In her research on strength in Black women, Beauboeuf-LaFontant (2007) likened strength "to a performance and a façade rather than an honest reflection of Black women's experiences" (p. 32). Strength as a performance encourages Black women to exhibit extreme caretaking responsibilities for their families and communities while negating, minimizing, or altogether ignoring any form of self-care, including recognition and treatment of mental health concerns. (Beauboeuf-LaFontant, 2007). For Black female college students with mental health concerns, being strong primarily focuses on the appearance of strength whether or not it is an accurate reflection of their emotional or physical states (Beauboeuf-LaFontant, 2007). "The strength discourse normalizes struggle, selflessness, and internalization strategies that

compromise the health of Black women" (Beauboeuf-LaFontant, 2007, p. 46). Lost in the normalization of their struggles, Black female college students with mental health concerns at PWIs suffer in silence while committing themselves to unrealistic ideas of strength that exacerbate their psychological distress.

Black feminist scholars have argued that the myth of the strong Black woman reflects racist and sexist images that inform how society views Black women (Beauboeuf-LaFontant, 2009; Jones & Shorter-Gooden, 2003; King, 1992; Wallace, 1978). Societal acceptance of the myth of the strong Black woman as an accurate representation of Black women encourages the continued disregard for the "cultural, historical, political and economic contexts of African Americans' lives" (King, 1992, p. 38). Uncritical adherence to the performance of strength traps many Black women in psychologically damaging roles of "caretakers, nurturers, healers of other people—any of the twelve dozen variations of Mammy" (Danquah, 1999, p. 19). As a result, admission of mental disorder or distress is deemed an intolerable weakness and inherently at odds with the innate strength of Black women. (Danquah, 1999)

> To assert the idea of strong Black women during slavery, segregation, or contemporary institutional racism and intra-racial sexism is to maintain a reassuring conviction: that personal actions and agency trump all manner of social abuses. Therefore, the presence of 'strong Black women' soothes many a conscience that could be troubled by the material conditions forced upon such persons and the toll of organized injustice on their humanity. (Beauboeuf-LaFontant, 2009, p. 3)

Black female college students with mental health concerns at PWIs who internalize the myth of the strong Black woman may question themselves and their capabilities before questioning their hostile or 'chilly' campus environments. Internalization of the myth of the strong Black woman also encourages the continued silence of Black women's suffering.

The Silencing Paradigm

Developed by feminist scholar and psychologist Crowley Jack (1991), the silencing paradigm is a concept that explores the normative expectations that require women to be "overly attuned to others' needs, often to great cost to their own goals, desires, and feelings" (Beauboeuf-Lafontant, 2007, p. 29). Within the silencing paradigm, women participate in self-silencing as they attempt to adhere to overwhelming social and cultural expectations (Attra, Bassett, & Grath, 1995; Crowley Jack, 1991). As a result of self-silencing, the mental health of women is compromised making them more susceptible to depression (Beauboeuf-Lafontant, 2007; Crowley Jack, 1991). Though the silencing paradigm has been critiqued for its focus on White female populations, it provides a model through which to consider the various social factors that contribute to self-silencing in Black female college students with mental health concerns at a PWI (Beauboeuf-Lafontant, 2007).

Black female college students with mental health concerns are inundated with conflicting messages of acceptable female behavior. The myth of the strong Black women encourages women to exhibit unrealistic 'superwoman' strength while traditional feminine norms encourage them to exhibit passive, docile characteristics in order to be viewed as a 'good woman' (Beauboeuf-Lafontant, 2007; Winkle-Wagner, 2009). In her study on identity in Black female colleges, Winkle-Wagner (2009) found that such students struggled with when to speak in class out of fear of being seen as overly aggressive or having an attitude problem, a stereotypical Black female characteristic that has been reinforced by media and communicated to peers and professors. As a result, many of the women in her study chose not to speak at all which resulted in silence that was perceived by faculty as a lack of interest (Winkle-Wagner, 2009). "The traits of silence and caring involved in being a good woman many inherently conflict with the

structure of formal higher education, which is highly individualistic and in which judgments are made based on one's ability to voice opinions" (Winkle-Wagner, 2009, p. 130). In addition, Black women who have a desire not to burden anyone with their problems or who desire not to negatively represent their community may silence themselves and not let anyone know that they are suffering from mental health concerns (Constantine & Wallace, 2005). In addition to depression, silence can lead to a heightened state of anxiety (Butler et al., 2011; Crowley Jack, 1991).

> The significance of the silencing paradigm to this study is that it
>
> refutes the conceptualization of depression as a unique and pathological state, as portrayed in the medical literature, and instead depicts it as a process and a continuum with deep roots in what are largely considered "normative" conditions of femininity and representations of feminine goodness. (Beauboeuf-LaFontant, 2008, p. 392)

The silence of Black female college students with mental health concerns at a PWI prevents them from being understood or from questioning and challenging potential power structures that contribute to their silencing (Reinharz, 1994). When viewed within the multi-layered context of the myth of the strong Black woman and the silencing paradigm, the mental health of the study participants depends on their realization of "that the discursive sociocultural representation of her womanhood fails to incorporate her reality" (Beauboeuf-LaFontant, 2007, p. 30).

Theoretical Framework

The theoretical frameworks that guided this study assist in the exploration of the experiences of Black female college students with mental health concerns at a PWI. Various pressures from their academic environments as well as their social environments influence the experiences of the study participants. In addition, the intersection of race, gender, and ability impact their experiences. The theoretical frameworks discussed in this section focus on

individual experiences and encompass a social justice component that does not speak for but with the study participants.

Disability Studies

Disability studies (DS) and critical race feminism were the two theoretical frameworks that guided this study. By making use of these theoretical frameworks, the study evaluated and potentially will shift conversations on the experiences of Black female college students with mental health concerns from a primarily medical emphasis to a liberatory emphasis. The traditionally held view of disabled individuals is largely informed by the medical model of disability and ultimately portrays such individuals as deficient (Beresford et al., 2010; Connor, 2008). Framing disability in terms of individual struggle against adversity deflects attention from the political realities of disability oppression (Mollow, 2006). Though DS has historically given greater attention to the study of observable disabilities, hidden disabilities such as mental illness or psychiatric disabilities are obtaining greater attention from DS scholars (Mollow, 2006; Price, 2011).

DS explores the many ways in which "people with disabilities are ostracized, medicalized, heroized, and otherwise pushed out of the societally defined space of 'normal'" (Price, 2011, p. 29). As a field of study, DS is, at its core, concerned with the social justice of individuals viewed as disabled (Connor, 2008). DS scholars recognize the oppression of individuals with disabilities as a reflection of societal barriers that trap such individuals in the role of disadvantaged, ill, and incapable patient (Connor, 2008). As such, disability scholars consider individuals labeled as being disabled to be whole individuals living with impairments who are only disabled when society fails to accommodate their differences and recognize them as a natural variation of humankind. "DS has been developed to disentangle the impairments

from the myth, ideology, and stigma that influence social interaction and social policy" (Linton, 1993, as cited in Nocella, 2009, p. 145). Many notable disability scholars come from academic disciplines such as sociology, political science, journalism, English, and psychology and include authors such as Simi Linton (1998), Irving Zola (1982), Tobin Siebers (2001), Nirmala Erevelles and Andrea Minear (2010), Tom Shakespeare (1994), Joseph Shapiro (1993), Harlan Hahn (1985) and Michael Oliver (1996).

Disability scholars challenged the predominantly held belief that disability is a medical issue that needs to be cured and argued instead that disability is a difference that is only considered a problem when viewed within a narrow, societal definition of normalcy (Price, 2011). This conceptualizes disability as a human impairment that is a natural and valuable aspect of the 'normal human variation' as articulated in the human variation model (Scotch & Schriner, 1997). "To the extent that society fully accommodates a condition, it ceases to be a disability as defined under the human variation model" (Schriner & Scotch, 2001, p. 105). Rather than view disability as a reflection of deficiency within an individual, DS shifts the focus from the individual towards damaging societal perceptions of disability and ultimately concludes that "people are not inherently disabled; it is society that disables them" (Connor, 2008, p. 36).

DS emerged over 30 years ago as a field of study that focuses on the experiences of individuals who have been labeled as disabled (Connor, 2008). "It is an interdisciplinary field based on a sociopolitical analysis of disability and informed both by the knowledge base and methodologies used in traditional liberal arts, and by conceptualizations and approaches developed in areas of the new scholarship" (Linton, 1998, p. 2). DS serves as a tool of empowerment for individuals labeled as disabled by considering the social, political, and cultural influences that socially construct disability as abnormal, deficient, and pathetic. Emerging

research cites the need for DS to theorize the intersectionality of race, gender, ability, and ethnicity in the lives of those living with a disability (Metzl, 2009; Mollow, 2006).

Critical Race Feminism

In order for a theory to understand and adequately address the experiences and needs of women of color, it should "be based on their cultural, personal, and social contexts, which clearly differs significantly from those of men and women who have not experienced racial and gender oppression" (Howard-Hamilton, 2003, p. 20). Critical race feminism (CRF) is such a theory. CRF is a theoretical framework that evolved in the 20th century as an addition to the critical race theory (CRT) movement. It is one of the most recently developed branches of critical analysis that was initiated by the emergence of CLS, a theory that provides "postmodern critiques of the inviolability of laws and hierarchy in Western society" (A.K. Wing, 1997, p. 946). Though CLS uses deconstruction as a method of analysis to problematize legal concepts that are allegedly neutral but construct inequitable power relationships, it has been criticized for failing to consider "the sexual and racial aspects of legal domination" (A.K. Wing, 1997, p. 947).

In response to the issues raised in the critique of CLS, CRT emerged as a theory that questioned traditionally held legal theories which reinforced discriminatory social power dynamics under the guise of objectivity and color-blindness (Wing, 1997). While prominent CRT scholars such as Derrick Bell (1992), Cheryl Harris (2002), Richard Delgado (1995), Richard Delgado and Jean Stefancic (2001), and Gloria Ladson-Billings and William Tate (1995), many women of color who used feminist frameworks to frame their legal analyses found themselves invisible and unacknowledged in the discussions taking place between CLS and CRT. "The social meaning of being a Black woman is not monolithic and static but contextual and dynamic" (Carbado & Gulati, 2003, p. 323). CRF emerged in response to the essentialist

portrayals of Black women in CLS and CRT. In so doing, CRF defined the multiple layers of experiences that impact women of color. Notable CRF scholars include bell hooks (1989), Angela Harris (1997) Adrien Wing (2003), Patricia Williams (1991), and Kimberle Crenshaw (1991).

CRF is by definition inherently anti-essentialist and challenges the ways in which CLS frames its analysis from a White, male, upper-class perspective, in much the same way that CRT frames its analysis from an essentialist Black and male perspective; neither of which focuses on gendered experience (Wing, 1997). In addition to these two perspectives, traditional feminist legal scholars also framed their analysis from a perspective of White, female, upper-class and assumed that gender was experienced by White women and women of color in the same ways (Esposito & Evans-Winters, 2010). CRF addressed this omission by incorporating a feminist lens that deconstructs the allegedly neutral concepts of CLS and CRT by focusing attention on the sexual and racial aspects of power relationships and the multi-dimensional experiences of women of color who are subjected to multiple forms of discrimination based on their race, class and gender (Wing, 1997).

Much like CRT, CRF operates from the standpoint that race is socially constructed and that such constructions inform inequitable laws promoted through a legal system that privileges some races over others (Wing, 2003). CRF broadens the scope of CRT by incorporating an analysis of how some genders benefit over others in inherently biased and unjust legal systems (Wing, 2003). CRF places women of color at the center of its analysis and denounces the existence of an essential womanhood that has been portrayed in Eurocentric terms within traditional feminism (Wing, 1997). In their study on the education of Black girls, Esposito and Evans-Winters (2010) found CRF to be beneficial in the following ways:

> Critical race feminism as a theoretical lens and movement purports that women of color's experiences, thus perspectives, are different from the experiences of men of color and those of White women;
>
> Critical race feminism focuses on the lives of women of color who face multiple forms of discrimination, due to the intersections of race, class, and gender within a system of White male patriarchy and racist oppression;
>
> Critical race feminism asserts the multiple identities and consciousness of women of color (i.e., anti-essentialist);
>
> Critical race feminism is multidisciplinary in scope and breadth; and
>
> Critical race feminism calls for theories and practices that simultaneously study and combat gender and racial oppression. (p. 20)

In effect, CRF celebrates the differences that exist among women of color while actively dismantling institutions that exist within society (Wing, 1997). "Although commonalities do exist among Black women, the diversity of class, religion, age, and sexual orientation of Black women as a group are multiple contexts from which their experiences can be revealed and understood" (Howard-Hamilton, 2003, p. 21). Utilizing theory as well as practical experiences, CRF focuses on articulating the problems that exist for women of color in society as well as leaving the door open to possible solutions (Wing, 1997). This study explored hidden disability and mental health as one of the contexts considered through CRF along with an investigation of how race, gender, and ability intersected in the lives of Black female college students with mental health concerns at a PWI.

Intersectionality

It is important to note that this study was not an attempt to consider the impact of race, gender, class, or ability in isolation from one another. In fact, by employing CRF and DS, this study seeks to explore the ways in which these various experiences intersect in different social, cultural, historical, and economic contexts. Committing to such an analysis encourages anti-essentialist and anti-dualistic thinking in regard to students who live in the margins of their intersecting identities. As mentioned earlier, DS has been criticized for failing to include the

voices of individuals of color. At the same time, CRF has been criticized for its "unconscious non-analysis of disability as it intersects with race, class, and gender oppression" (Erevelles & Minear, 2010, p. 128). Due to the challenges faced by DS and CRF scholars, intersectionality has become the analytical tool of choice for attempting to theorize the existence of multiple layers of oppression.

Kimberle Crenshaw has been credited for developing the concept of intersectionality as a means of conveying "the various ways in which race and gender interact to shape the multiple dimensions of Black women's" (Crenshaw, 1991, p. 1244) experiences. While disability was not initially included in Crenshaw's concept, authors such as Connor (2008), Stuart (1992), and Delgado and Stefancic (2001) have added disability, class, sexual orientation, and ethnicity to the experiential contexts considered within intersectionality. Intersectionality examines how "multiple systems of oppressions simultaneously corroborate and subjugate to conceal deliberate, marginalizing ideological maneuvers that define 'Otherness'" (Few, 2007, p. 454). While CRF and DS have been utilized primarily in the study of legal inequalities, they are both appropriate theoretical frameworks for a study that takes place within higher education institutions where marginalized student populations experience the intersection of multiple oppressions.

The use of intersectionality can be problematic if, for example, race is simply added to the analysis of disability oppression or vice versa. Connor (2007) found in his research on the intersection of learning disability, race, and class that "the understanding of intersectionality is contingent upon first knowing different forms of oppression can ironically lead to inadvertent reinforcement of their seeming separability" (p. 46). It is important not to separate systems of oppression so that they are not understood hierarchically. Such an analysis can be deleterious to the multiple forms of oppression that inform the experiences of individuals such as the

participants of this study. Women of color are disempowered when aspects of their experiences and identity are examined in isolation from each other (Lorde, 1984). As a result, the challenge exists to theorize how to utilize intersectionality in a way that discourages this separation.

McCall (2005) recognized the challenges and complexities of intersectionality. As a result, she distinguished three approaches for considering intersectionality. The three approaches include the anticategorical complexity, the intracategorical complexity, and the intercategorical complexity. The first approach is the anticategorical complexity. This approach has a deconstructionist basis in that it considers life to be "too irreducibly complex—overflowing with multiple and fluid determinations of both subjects and structures—to make fixed categories anything but simplifying social fictions that produce inequalities in the process of producing differences." (McCall, 2005, p. 1773). In essence, the anticategorical complexity refuses categories. The intercategorical complexity is the approach in which McCall situated her research. It is an approach that uses quantitative methods to study structural relationships rather than singular categories (McCall, 2005). The final approach, and the one best suited for this particular study, is the intracategorical complexity.

As an approach, the intracategorical complexity falls in between the anticategorical complexity and the intercategorical complexity. Similar to Crenshaw's articulation of intersectionality, the anticategorical complexity avoids generalizations and focuses instead on the often under-studied intersections of multiple social locations.

> The intracategorical framework is especially promising to CRF (critical race feminism) scholars because it validates the reality of racism as it intersects with sexism and other categories of difference (e.g. heterosexism; classism) in the everyday lives of women of color. (Erevelles & Minear, 2010, p. 130)

The intracategorical complexity can assist in exploring the experiences of Black female college students with mental health concerns at a PWI while, at the same time safeguarding against the

temptation to simply add race, gender, or disability to the analysis of the study or to study them in isolation.

Finally, the intracategorical complexity complements Crenshaw's (1991) three categories of intersectionality: structural, political, and representational. Each of these categories considers the ways in which multiple systems of oppression complicate and intensify one another (structural), political contexts marginalize the multi-dimensional experiences of women of color (political), and culturally constructed images that characterize women of color as damaging stereotypes that reflect stifling societal expectations (representational). Through the exploration of the experiences of Black female college students with mental health concerns at a PWI, this study provides revealing counter-stories that reflect the multi-dimensional experiences of the study participants in a way that allows us to consider both "the individual and the group without losing the uniqueness of either" (Taylor & Witherspoon, 2010, p. 137).

Counter-storytelling

Counter-storytelling is an instrumental technique often utilized by CRF and DS. Delgado and Stefancic (2001) define counter-storytelling as written works that aim "to cast doubt on the validity of accepted premises or myths, especially ones held by the majority" (p. 144). The analysis of counter-stories has the potential to cure an individual's silence by giving them the opportunity to name their own reality (Ladson-Billings & Tate, 1995). As stated by Delgado and Stefancic (2001),

> Many victims of racial discrimination suffer in silence, or blame themselves for their predicament. Stories can give them voice and reveal that others have similar experiences. Stories can name a type of discrimination; once named, it can be combated. (p. 43)

While this study did not focus solely on racial discrimination, it sought to use the words of the study participants to reveal that they were not alone in their experiences and to explore the layers

of influence that contribute to the experiences they have due to their race, gender, and mental health concerns.

Counter-storytelling challenges stories that reflect the privileged voices of dominant groups by combating them with the often-silenced stories of marginalized groups. Counter-stories consider the cultural and historical contexts of various policies and institutions that marginalize certain populations along the lines of socially constructed ideas of race, class, gender, and ability. As a result, dominant ideologies and the inequitable power relations they impose are exposed and unraveled. DS and CRF use counter-storytelling to bring the voices of marginalized groups to the forefront of poststructural emancipatory research. For example, definite diagnostic criteria for diagnosing such mental distress as depression remain elusive and, as such, are "most often recognized through the production of a narrative" (Mollow, 2006, p. 81). The counter-stories presented in this study speak to the potential reconstruction of how hidden disabilities and, specifically, mental health concerns are understood within the intersectional experiences of diverse student populations enrolled in higher education institutions.

Interrelating Theoretical Frameworks

Before exploring the lives of the study participants, it is important to understand the ways in which CRF and DS interrelate. Both theoretical frameworks have strengths and weaknesses. DS has been criticized for failing to consider multiple experiences and, instead, focusing on experiences that are White and middle-class (Connor, 2008). CRF has also been criticized for failing to view intersectionality in a way that includes "all members of subordinate groups" (Hutchinson, 2004, p. 1199). However, when combined, they provide a unique, multi-faceted lens through which to consider the experiences of Black female college students with mental health concerns at a PWI.

Despite their criticisms, DS and CRF are theoretical frameworks that complement each other and share interrelated similarities. Both theories are interested in the politics of identity and seek to represent the experiences of the researched by including them collaboratively in the research process. Both theories are interdisciplinary fields of study that have a social justice, activist-oriented interest in practice as well as research. Further, both theories use voice as a necessary tool for constructing powerful counter-stories that consider the cultural and historical contexts of various policies and institutions that marginalize certain populations along the lines of socially constructed ideas of race, class, gender, and ability.

Together, DS and CRF also share individual complexities that provide assumptions that guide the parameters of the study. One such assumption is that the voices and experiences of Black women, such as Black female college students with mental health concerns, are valuable and necessary tools for deconstructing ideas that perpetuate myths, stigmas, expectations, and stereotypes that simultaneously silence and marginalize. The second assumption is that "the degree and significance of an individual's impairment is often less of an issue than the degree to which someone identifies as disabled" (Linton, 1998, p. 12). While most of the participants in this study did not identify as having a disability, they all identified has having mental health concerns and many of them specified that they did not identify as having a disability out of fear of being trapped in a yet another misunderstood label.

The final assumption is that university policies and procedures regarding students with mental health concerns are largely informed by the DSM which, as stated previously, is founded in the medical model of disability. Since the DSM is administered as a neutral diagnostic system and does not consider the impact of social factors on an individual's mental health or the interlocking experiences of race, class, gender, and ability, counter-stories, such as the ones

shared in this study, are needed to consider the experiences of individuals marginalized by the lack of attention placed on social injustices (racism, sexism, classism, etc.) that may or may not contribute to mental health concerns. Ultimately, CRF and DS are effective theoretical frameworks to utilize in order to focus on the raciaddlized and gendered experiences of Black female college students with mental health concerns at PWIs.

Conclusion

This chapter provided a review of literature that allows for the articulation of the significance of societal factors that impact the experiences of Black female college students with mental health concerns at a PWI. Few studies explored the intersection of race and gender in an attempt to understand how such factors impact student experiences with mental health. Furthermore, little research considered the experiences of Black female college students with mental health needs. This study lessens the gap that currently exists in the literature with regards to the experiences of Black female college students with mental health concerns at a PWI.

CHAPTER III

METHODOLOGY

CRF and DS both utilize the voices of marginalized people to develop counter-stories that deconstruct race, gender, and disability (Higgins, 1992; Wing, 2003). As a method, counter-stories are the telling of stories that are about and by marginalized groups whose stories are often minimized, unnoticed, over-shadowed, or ignored by more dominant narratives or experiences (Delgado, 1995; Solorzano &Yosso, 2002). Counter-stories can be obtained by various methods and can take on many forms. This study collected and arranged counter-stories through the use of in-depth interviews (Patton, 1990; Stake, 1995, Yin, 1993).

This presents questions that are not answerable through quantitative or statistical means and acknowledges themes that arise in the experiences of the study participants not in hopes of developing generalizations but to consider the multiple layers of influence that race, gender, and mental health have on the experiences of the study participants. This chapter describes the research methods that were utilized in this study as well as the criteria for selection of participants, ethical considerations, data collection, researcher positionality, data analysis, and limitations of the study.

Research Questions

In order to explore the experiences of Black female college students with mental health concerns, the following research questions were utilized to guide the study:

Primary Qualitative Question

What are the experiences of Black female college students with mental health concerns at a predominantly White institution?

Qualitative Sub-questions

What impact do mental health concerns have on the academic experiences of Black female college students at a predominantly White institution?

What formal and informal methods of support do Black female college students with mental health concerns at a predominantly White institution access?

How do the intersections of race and gender affect the college experiences of Black female college students with mental health concerns at a predominantly White institution?

Context of the Study

For the purpose of this study, data were collected on the campus of Arden University (pseudonym) and Civitan University (pseudonym), two large, predominantly White public research intensive universities. Established in the late 1960s, Arden University is located in Arnoldtown (pseudonym), a major metropolitan city in the southeastern region of the United States. African American students at Arden University constitute 26% of the over 17,000 student population. Civitan University was founded in the early 1800s and currently boasts a student population of over 30,000 students; 13% of whom identify as African American. Civitan University is located in Smithville (pseudonym), an industrial city also located in the southeastern region of the United States. Both Arden University and Civitan University have student-focused resources available to their students such as a disability services office, counseling center, and student life office. Though the campus is predominantly White, the

population of Arnoldtown is 73% African American which is nearly twice that of Smithville (42%) (U.S. Census Bureau, 2010).

Participant Selection

The participants in this study are Black female college students with mental health concerns including those with diagnosed mental illnesses as well as those who self-report as suffering from symptoms commonly associated with mental illness such as anxiety, depression, mood swings, bipolar depression, and eating disorders. This specific population was selected in an effort to consider the intersection of multiple systems of marginalization based on race, gender, and disability. Upon the completion of all Institutional Review Board (IRB) requirements (see Appendix A), participants were recruited through the dissemination of flyers posted in student centers, residential halls, gymnasiums, libraries, and classroom buildings. In addition, flyers were emailed through student listservs affiliated with the counseling center, disability services office, and other student affairs offices of the study sites (see Appendix B). Finally, as the primary researcher, I recruited study participants by speaking at chapter meetings of campus sororities and campus student organizations with a large number of Black female student members. Students who chose to participate in the study disclosed themselves to me, the primary researcher. All participants were at least 19 years of age in order to meet the age of majority for the state where the data were collected. In total, 20 students were interviewed. Thirteen (65%) of the study participants were undergraduate students and the remaining 7 (35%) were graduate students. The mean age of the study participants was 23. A description of the study participants is provided in Tables 1 and 2 in Chapter IV.

Ethical Considerations

Informed Consent

For the purpose of this study, the primary goal of informed consent was to express the voluntary nature of participation. Participants were provided with two copies of an informed consent form (Appendix C): one to sign and return to the researcher and one of to keep for their own records. Informed consent forms stated the purpose of the study, the fact that participation in the study was voluntary, that participants freely agreed to participate, and that they were free to withdraw their participation at any time without penalty (Bieger & Gerlach, 1996). In addition, informed consent forms provided participants with steps taken by the researcher to protect confidentiality and informed participants that interviews were audio-taped as well as accompanied by field notes taken by the researcher (Heppner, Kivlighan, & Wampold, 1999). With the understanding that informed consent is a continuous process, the researcher reiterated the rights of participants before and after all interviews and provided opportunities for participants to ask questions regarding informed consent at any time during the study (Madison, 2005).

Confidentiality

Measures of confidentiality were taken to protect the privacy of the study participants and to ensure that the only persons with access to research records was the primary researcher, Institutional Review Board (IRB) professionals, and other persons or agencies required by law. A description of the study was formally submitted and approved by the Institutional Review Board (IRB) and included detailed steps taken to protect the identity of all study participants. While the race and gender of the study participants were recorded, their names and the name of their institution were not. Personally identifiable information that was expressed during

participant interviews was removed and participant transcripts were assigned a number as a way to separate them from other transcripts. Additional measures of confidentiality included using pseudonyms chosen by each participant in place of participant names and storing all research material in a locked safe at the residence of the primary researcher. Upon completion of the primary researcher's dissertation, all research material will remain in a locked safe for 12 months. At 12 months, all audio-recorded interviews will be deleted and transcribed interviews with pseudonyms will be kept on file by the primary researcher.

Risks and Benefits

The risks and benefits of the study were presented to the participants in the informed consent form. The researcher explained to participants the risks, as well as measures taken to minimize the risks, and procedures to follow should harm occur (Bieger & Gerlach, 1996). A possible risk to participants of the study was the risk of experiencing heightened anxiety when sharing a difficult experience with the interviewer. When this occurred, the participant was given time to collect her composure before continuing, if she desired to continue at all. In addition, a campus counselor affiliated with the participant's institution was available during the time of the interview should the participant desire to take advantage of one. Finally, a list of local and national material pertaining to mental illness services was provided to all study participants for their own reference. The risk associated with this study appeared to be minimal.

A possible benefit to participants of the study was the opportunity to help students, faculty, and campus staff better understand experiences had by Black female college students with mental health concerns on predominantly White campuses so that they could potentially move past any misinformed perceptions that they may hold about mental health concerns and mental illness. Members of oppressed groups, such as Black female college students at a PWI,

are more likely to experience mental health needs due to the prejudice, social inequalities, and discrimination that they experience (Nicki, 2001). Through their participation in the study, participants were provided the opportunity to share their experiences in a way that could potentially lead to policy and program changes for other students with mental health needs. The potential benefits of this study appeared to outweigh any potential risk involved.

Data Collection

Data from this study were collected from in-depth interviews. In-depth interviews are conversational in nature and can utilize both open-ended and semi-structured questions that allow for representation of participant feelings, attitudes, and experiences (Cottrell & McKenzie, 2005; Yin, 2003). The interview questions formulated for this study were guided by the literature reviewed in Chapter II of this study and borrowed heavily from the questions used in Beauboeuf-Lafontant's (2007) study on gender, race, and depression (Appendix D).

The interview protocol was designed to solicit a 45-60 minute conversation. In total, interviews ranged from approximately 20 minutes to 2-1/2 hours. During each interview, questions were adjusted to encourage participant dialogue and, thus, provide richer reflection and greater story detail from the study participant. In addition, information provided by the participants was used to ask probing and immediate follow-up questions for clarification and to encourage conversation. The interviews were conducted at a location of the participant's choosing. All interviews conducted by the primary researcher during this study were audio-taped and transcribed into text. Notes were also taken during each interview. Two transcriptionists were hired to assist with transcribing the interviews. Both transcriptionists completed a training course offered by the National Institutes of Health (NIH) Office of Extramural Research entitled "Protecting Human Research Participants," agreed to maintain participant confidentiality, and

were approved to assist with transcribing by the University of Alabama's Institutional Review Board. In an effort to obtain the most accurate representation of participant perspectives, copies of interview transcriptions were emailed to study participants in order to provide them with an opportunity to review their complete transcript for accuracy (Creswell, 1998). Of the 20 study participants, 6 responded and approved their transcripts with no changes.

My role as the researcher was to operate as the "primary instrument for data collection and analysis" (Merriam, 1998, p. 7). As the researcher, I was sensitive to the variables that potentially impacted the study including the location of the interviews, the information being shared by the study participants, and any bias that I may have that could have influenced my investigation (Merriam, 1998). I also understood that the data collected could be affected by the rapport I was able to establish with the study participants and, thus, proceeded with data collection using the study's methodology as a tool to listen to the silenced voices of the study participants (Hesse-Biber & Leckenby, 2004; Schram, 2006; Spradley, 1979).

Researcher Positionality

"I have attempted to search for theoretical grounding that acknowledges my standpoint and simultaneously forces me to problematize it" (Ladson-Billings, 1995, p. 471).

Before applying to graduate school at The University of Alabama, I worked with educational nonprofit organizations that focused on promoting international educational exchange programs and educational access for low-income, under-represented minority college students. As a doctoral student in Higher Education Administration, I spent a great deal of my graduate studies reading and researching topics related to diversity, social justice, and educational equality. I also took advantage of several opportunities to present at national and international conferences while focusing my research and teaching efforts on various issues related to the experiences of under-represented minority college students. Despite the knowledge

I have gained, it was a very humbling experience when a student in a class that I was teaching disclosed her mental health concerns to me. It was then that I realized that there was an entire community of disadvantaged students that I had ignored in my research efforts: those living with a disability.

Unfamiliar with the challenges of college students living with a disability, I began to review literature on the topic and found that a need existed for research on students with mental health needs that incorporates the first-hand experiences and narratives of students with mental health concerns. Eager to right this wrong, I began to conduct research on disabilities, particularly on college students with a hidden disability. Narrowing my research to college students with a psychiatric disability, I made another embarrassing, yet enlightening, generalization. By unconsciously tying my research on psychiatric disabilities to an investigation of campus shootings, I subscribed to the generally accepted negative stereotype that students with a psychiatric disability have a greater propensity towards acts of violence. Where had this idea come from? How many others have internalized this image? What impact has this image had on the experiences of college students with a psychiatric disability or other mental health needs and their ability to matriculate; including students in my very own classroom? Most importantly, how many professionals are currently working and teaching on college campuses across the country while making this same mistake in their everyday interactions with students? What do we, as current and future faculty and administrators, truly know about the mental health of the students we serve?

Through this study, I combined my new-found interest in mental health concerns with my established research interest in the experiences of Black female college students. Ultimately, through this study, I sought to listen to the voices of the study participants and make their voices

the focal component of the study. Perhaps, through their experiences, we can further consider the questions posed above.

One step toward self-reflection involved an exploration of myself as a researcher. What did I believe and what bias did those beliefs inform? Based on my professional background, it can be presumed that I have a bias toward the creation of equitable educational opportunities for under-represented minority students. This bias was informed by my personal experiences as an under-represented minority just as much as it was informed by my professional and academic knowledge of the institutional and societal racism that create and maintain inequitable educational access for under-represented minorities. It is my belief as an individual and a professional that these issues of inequality are unjust.

In order for me to explore myself as a researcher, I had to be transparent in my beliefs and understanding of the fact that who I am as an individual (race, gender, class, religion, etc.) impacts who I am as a researcher and, thus, what I research (Mehra, 2001; Scheurich, 1994). However, as a researcher, I also operate from the premise that there is no essential experience that all Black female college students share and, therefore, no "native perspective" (Ladson-Billings, 1995, p. 470) to avoid. In essence, I was an insider during the course this study because my race, gender, and positioning as a Black female college student at a PWI left me susceptible to some of the same experiences, and possibly same forms of discrimination, that may or may not have been experienced by the study participants.

In addition, I am sensitized to these experiences because of the awareness I have gained through my review of literature on Black female college students at a PWI and interactions with such students as classmates, colleagues, and students (during my time teaching courses). However, I am an outsider as well because the differences in my own personal experiences

inform a perspective that is uniquely my own. Thus, I am an expert in my own experiences just as the study participants are experts in their own experiences (Delpit, 1995). This is the core of Collins's (1991) "outsider within" concept which acknowledges the multiple layers to the social locations of Black women and the knowledge produced in everyday human experience. While some may question the objectivity and validity of my research, I situate my understanding of myself as a researcher on the writings of Dillard (2000), hooks (1994), and Ladson-Billings (1995) who are all Black female researchers, all actively engaged the challenges they faced while researching communities that they were members of, and all ultimately committed to being self-reflective researchers who explored power dynamics, question concepts of normality, and advocated the need for research conducted by people of color that focuses on the experiences of people of color.

Data Analysis

Data analysis and data collection occurred simultaneously in this study as is typical in qualitative research (Merriam, 1998). As a result, emergent themes that arose during initial data analysis guided the consecutive steps in data collection. Interview data were transcribed, read, coded, and re-read. Constant comparative analysis was used to interpret the data. Through this form of data analysis, previously collected data were constantly compared to recently collected data to produce codes, identify patterns, and construct themes. For this study, data were read and re-read until theoretical saturation was met resulting in the emergence of no new themes (Stauss & Corbin, 1998).

Open, axial, and selective coding were the three processes used to analysis the collected data. Each process assisted in the emergence and grouping of codes as well as the conceptualization of patterns of meaning which ultimately gave rise to the emergence of theory

(Boeije, 2002; Merriam, 1998; Strauss & Corbin, 1998). During the process of open coding, each sentence of each transcribed interview was read and codes ssigned to words, phrases, and/or sentences that conveyed participant meaning (Cottrell & McKenzie, 2005; Merriam, 1998). Open coding was repeated resulting in the grouping, elimination, and the renaming of codes. During the axial coding process, emerging categories that were shared amongst the transcribed data sets were considered and codes that relayed the casual relationships between data sets were used to better understand the experiences of the study participants (Cottrell & McKenzie, 2005; Strauss & Corbin, 1998). "The purpose of axial coding is to begin the process of reassembling data that were fractured during open coding" (Strauss & Corbin, 1998, p. 124). Through the use of constant comparative analysis, categories continued to emerge and were refined with each reading of the data sets.

Finally, the selective coding process was used to consider the theory that emerged from the data. During the selective coding process, codes were grouped and restructured while remaining relevant to the theory that emerges. "Selective coding allows the researcher to develop a single story line around which grouping of related data and themes follows" (Cottrell & McKenzie, 2005, p. 224). Through this process, categories were integrated and theory was refined (Strauss & Corbin, 1998). While counter-stories typically present research in the form of a story infused with themes that arise in collected data, this study took the established route of presenting its research findings whereby quotes are used to validate and provide illustration to the themes that take shape (Glaser, 1965).

Again, in an effort to encourage accuracy and, thus, trustworthiness, study participants were consulted at various points of the research; including analysis. This was accomplished by emailing each study participant a copy of their interview transcription to review for accuracy and

emailing each study participant a copy of Chapter IV to read and review. Of the 20 women that participated in the study, 6 emailed the primary researcher approving the interview transcript. These steps toward accuracy and trustworthiness encouraged a collaborative research environment in which the study participants were co-facilitators in the construction of their individual counter-story. In addition, such steps limited the potential of the researcher to speak for the study participants but rather permitted the researcher to speak with the study participants. Such collaborations between the researcher and researched are key components to the social justice mission of CRF and DS.

Limitations of the Study

In order to encourage trustworthiness and utilize the findings of this study effectively, it was first important to consider the limitations of the study. While 20 narratives are presented within this study, the life experiences of the study participants do not and should not be used to speak unilaterally for all Black female college students at PWIs. Instead, the number of study participants, while limited, did allow for in-depth analysis of the obtained experiences and, as such, provided a representative sample of the challenges experienced by Black female college students with mental health concerns at a PWI. Further, this study did not focus on whether participants were born with their mental health needs or whether these needs were the result of traumatic experiences or illnesses. As such, conclusions regarding a certain type of mental health concern cannot be drawn from the data provided in this study. Instead, the broadness of the mental health concerns represented within the experiences of the study participants allowed for a greater focus and consideration of the definition and societal understanding of disability, mental illness and normalcy.

Another limitation of the study was that I only interviewed each study participant once. While the interviews proved to be fruitful exchanges, I believe that the study would have been better served with additional interviews that provided additional data on the experiences of the study participants. In addition, by using the term Black to encompass and represent the entire African Diaspora, this study did not explore culture or ethnicity as a factor of influence. According to Chang et al. (2001), culture as well as ethnicity can influence a student's postsecondary education experience. At least one of the study participants identified as being a first-generation American citizen. However, this study largely focused on the culture of the Black community and some of its cultural symbols such as the idea of the "Black church."

Finally, both undergraduate and graduate student were participants of this study. As such, the design of study did not focus on the differences in study development level between undergraduate and graduate students. Further, the study interviewed students from PWIs. Future research may want to focus on the experiences of Black female college students within different educational settings such as private, liberal arts, or historically Black colleges and universities (HBCUs). In closing, this study was conducted in the southeastern region of the United States. While this study adds to the literature of Black female college students in this particular region, it is limited in its general contribution to the experiences of Black female college students within other regions. However, the discussion section of this study may provide implications for further considering the experiences of Black female college students with mental health concerns regardless of geographical region.

Conclusion

This chapter provided a description of the methods utilized for the study. This study examined and learned from the experiences of Black female college students with mental health

concerns at a PWI. Common themes that arose in the experiences of the study participants are discussed in detail in Chapters IV and V of the study as well as study implications and recommendations for future research.

CHAPTER IV

FINDINGS

> "One of the great, mostly untold, stories about Black women and men is how the centuries of oppression we have endured in this country have damaged our psyches" (Hull, Scott, & Smith, 1982, p.108).

The extent to which oppression has impacted the psyche of Black women may never be fully known because, as articulated by Hull et al. (1982), the stories and experiences of Black women are "mostly untold." One of the reasons that the stories of Black women remain hidden is because of the work of scholars who, in their attempts to consider experience, have portrayed Black women as one dimensional, without taking into consideration the layers of socialization and personal struggle that have shaped their identity. However, as found in this study and in much of the literature utilized to analyze the interview data provided by the study participants, Black women are multidimensional beings. Attempts to focus on one aspect of identity in isolation deny the interconnectedness of experiences that are simultaneously impacted such as race, class, gender, and ability. Chapter IV provides an introduction of the study participants and presents research findings in the form of themes that emerged from participant transcripts during the transcribing, coding, and analysis process. The five themes are Strength as a Necessity, Weakness as a Liability, the Luxury of Lunacy, Mentorship and Mental Wellness, and Spirit-Murdering Silence.

Theme one, Strength as a Necessity, refers to the participants' understanding and use of strength as a necessary attribute to combat racism and adhere to a cultural expectation of

impermeable strength. This cultural expectation of strength normalizes struggle in the lives of Black women, such as the study participants, and exacerbates mental illness by trapping them in distressing and disingenuous performances of self. Participants repeatedly referred to an ever-present awareness of their minority status within their university settings; a status that was largely informed by the visibility of their race and gender as well as the invisibility of their mental health concerns. In order to 'prove' themselves as capable intellectual academic counterparts, the study participants used an internalized image of strength to combat what they perceived as both covert and overt assumptions of their inferiority. For the study participants, strength was a necessity that was taught to them, imposed upon them, and internalized by them. As a result, the expectation of strength was rarely questioned, challenged, or deconstructed by the study participants.

Theme two, Weakness as a Liability, refers to participants' unwillingness to acknowledge any aspect of vulnerability that threatened their ability to adhere to their understanding of strength. In essence, acknowledging one's mental health concerns became a liability to their potential to combat racially discriminatory ideas of Black inferiority with a positive representation of the strength, perseverance, and ability of a Black person to achieve the same potential success as a White person. However, while an admission of mental illness situated Black women in the tenuous position of having their mental illness seen as further reason for discrimination from the dominant culture, it also signified weakness within the Black community; a weakness that placed them at odds with what was culturally expected. Unfortunately, as found in the experiences of the study participants, this traps Black women in performances of strength that increase susceptibility to mental distress.

Theme three, the Luxury of Lunacy, refers to the socioeconomic factors that make healthcare a luxury unavailable to some. It also refers to the racialized ways in which mental illness is understood and constructed as a luxury not available to Black women. Theme four, Mentorship and Mental Wellness, specifically refers to the challenge that many of the study participants faced in finding support systems or mentors within their institutions. It also refers to the impact that campus climate can have on mental wellness.

The final theme, Spirit-Murdering Silence, refers to participants' unwillingness to share their mental health concerns with others. While each of the study participants self-identified as suffering from a mental health concern, the majority of the study participants had not shared their concerns with anyone in their families or communities. Further, very few of the study participants shared their concerns with an on-campus professional such as a professor, or took advantage of on-campus services such as a counseling center because they did not want to be viewed as weak and incapable of completing their studies. As such, the participants utilized silence as a means of coping with their mental health concerns as well as a means of hiding their mental health concerns and adhering to the necessity of strength required to combat the oppression that they faced due to their race and gender. For many of the study participants, sharing their mental health concerns with others would simply mean that they were giving others yet another reason to discriminate against them or doubt their ability. The purpose of the themes presented was not intended to generalize but was submitted as a means of highlighting the multiple layers of influence that race, gender and mental health have on the experiences of the study participants. The chapter closes with a theoretical discussion that utilizes a DS and CRF framework to expound upon the research findings.

Snapshot of Participants

For the purpose of this study, 20 participants were interviewed between March 9, 2012 and April 30, 2012. Each participant self-identified as a Black female college student with mental health concerns. Eight (40%) of the participants were enrolled in pseudonymous Arden University and 12 (60%) were enrolled in pseudonymous Civitan University. The participants ranged in age from 19 to 39 years old with a median age of 23. Seven (35%) of the participants were graduate students while the remaining 13 (65%) identified as undergraduate students. Nine (45%) of the participants were first-generation college students. Eleven (55%) of the study participants had visited their campus's counseling center at least once. However, of those 11, 5 no longer took advantage of that resource. Nine (45%) of the study participants had never visited their campus's counseling center. Seven (35%) of the study participants had been diagnosed with a mental health concern such as an anxiety disorder, eating disorder, panic disorder, cutting, depression, or obsessive compulsive disorder. The remaining 13 (65%), though not diagnosed, identified as suffering from mental health concerns such as depression, anxiety, anger, mood swings, and low self-esteem. Thirteen (65%) of the study participants worked full-time or part-time jobs in addition to their studies. Three (15%) of the study participants took medication to manage their mental health concerns. Six (30%) of the study participants were taking or had taken advantage of off-campus mental health services such as psychiatrists and faith-based counselors to manage their mental health concerns. Four (20%) of the study participants had either considered or had been linked to suicidal ideations. Summaries of this information are presented in Tables 1 and 2.

Introduction of Participants

March 2, 2012

Today is the first day of interviewing. I have been overwhelmed by the number of women interested in participating in this study and anxious to see what they will share. I suppose that, since this is my first interview, I will get an idea of whether my research questions encourage the kinds of conversations that will yield valuable data and insight into the experiences of these ladies. As I sit in the lobby of my interviewee's on-campus office building, thoughts run through my mind. What if she doesn't want to talk to me? What if my research questions are confusing? What if the recorder doesn't work? Then she

Table 1

Participant Academic Overview

Name*	University	Age	Classification	Major	First Generation	Employed
Alesia	Arden University	21	Undergraduate	Communications	No	Part-time/ Off-Campus
Danielle	Civitan University	21	Graduate	Chemistry	No	Part-time/ On-Campus
Erica	Civitan University	19	Undergraduate	International Studies & French	No	Part-time/ On-Campus
Angela	Arden University	19	Undergraduate	Nursing	No	Part-time/ Off-Campus
Anne (Anxiety)	Civitan University	23	Graduate	Human Development & Family Studies	Yes	Part-time/On- and Off-Campus
Ashley	Civitan University	19	Undergraduate	Psychology	Yes	No
Audrey	Arden University	25	Graduate	Public Health	No	No
Kim	Civitan University	27	Graduate	Chemistry	Yes	No
Melissa	Civitan University	21	Undergraduate	Spanish	Yes	No
Christine	Arden University	24	Undergraduate	Respiratory Therapy	Yes	Part-time/ On-Campus
Katherine	Arden University	21	Undergraduate	Nursing	No	No
Lisa	Civitan University	25	Graduate	Human Performance	No	Part-time/ On-Campus
Susan	Civitan University	39	Graduate	Journalism	Yes	Part-time/ On-Campus
Rachel	Civitan University	23	Graduate	Social Psychology	Yes	Part-time/ On-Campus
Sarah	Civitan University	21	Undergraduate	Criminal Justice & Psychology	No	Full-time/ On-Campus
Michelle	Arden University	22	Undergraduate	Biology & Spanish	No	Part-time/ On-Campus
Kate	Arden University	22	Undergraduate	Respiratory Therapy	Yes	No
Nicole	Arden University	20	Undergraduate	Biology	No	Part-time/ On-Campus
Naomi	Civitan University	19	Undergraduate	Political Science	No	No
Jane	Civitan University	24	Undergraduate	Social Work	Yes	Part-time/ On-Campus

*pseudonym

Table 2

Participant Mental Health Overview

Name*	Mental Health Concern	Diagnosed	Taking Medication	Utilize Campus Counseling Center
Alesia	Depression, Obessesive Compulsive Disorder, Anger, Anxiety	No	No	No
Danielle	Panic Disorder	Yes	No	Yes
Erica	Depression	Yes	No	Yes
Angela	Depression	No	No	No
Anne (Anxiety)	Anxiety	No	No	Yes
Ashley	Depression and Anxiety	No	No	No
Audrey	Depression and Low Self-Esteem	Yes	Yes	Yes
Kim	Anger, Anxiety, Depression	No	No	No
Melissa	Anxiety	Yes	Yes	Yes
Christine	Depression and Anxiety	No	No	Yes
Katherine	Depression, Anxiety, and Cutting	Yes	Yes	Yes
Lisa	Depression and Stress	No	No	No
Susan	Anxiety Disorder	Yes	No	No
Rachel	Anxiety	No	No	No
Sarah	Anger, Anxiety, and Depression	No	No	Yes
Michelle	Depression	No	No	No
Kate	Depression and Anxiety	No	No	Yes
Nicole	Depression, Anxiety, and Stress	No	No	No
Naomi	Obsessive Compulsive Disorder	Yes	No	Yes
Jane	Depression	No	No	Yes

*pseudonym

> approaches. With a smile, she ushers me into an office that she has secured for our meeting. As I set up the recorder and provide her with a copy of the informed consent, I am taken aback by her level of comfort with me. She is relaxed and jokingly conversing with me as though we had known each other for years. Then, I ask her for a pseudonym. "Let me think of the Whitest name I can think of", she laughingly replied. "How about Anne . . . for anxiety". And so we begin. (Field notes, March 2, 2012)

As a novice researcher, I was both excited and nervous about beginning my dissertation interviews. While I have a great interest in the topic of mental health, Black women, and student development, I was worried about my skills as an interviewer as well as whether or not the study participants would be willing to truly share their experiences with me, a stranger. However, with each new interview, I became more confident in my ability to engage and maintain the conversations necessary for the study. More importantly, I began to recognize and utilize what I call the "You know what I mean?" expression of association.

The "You know what I mean?" expression of association refers to a phrase used to establish a presumed shared identity. It was a phrase frequently used by many of the study participants who presumed, because of my appearance as a Black female and my positioning as a fellow student, presumed that I could relate to them and their experiences on various different levels. In a sense, our presumed shared identity benefited the progress of the study. For example, many of the study participants expressed a recognizable level of comfort interacting with me in a very short amount of time as evidenced when Anne jokingly referred to selecting the "Whitest name" she could think of for her pseudonym. It is questionable whether or not she would have made such a joke if I was not a Black female. In addition, their comfort and seeming honesty with me set my own anxieties at ease and made the interview a fruitful interaction. This is not to say that interviews with a White researcher would not have been productive for this particular study. However, as shared by Winkle-Wanger (2009), it is beneficial for White female researchers, such as herself, to build authentic friendship networks that consist of Black females in order to garner the skills necessary to build and maintain the trust of Black female study participants.

While the "You know what I mean?" expression of association served to benefit the study, it also presented a particular challenge. How could I capture the richness of each participant's unique experiences as Black women if they interacted with me as though we all shared similar perspectives? In essence, my presence played a role in building trust amongst the study participants. I was described as relatable, nice, and caring. However, I did not want to pervert our valuable interaction by inferring meaning into their words. I did not want to speak for them. It was important to me and to the validity of the study that I understand what each participant was sharing about her unique experiences. As such, I made efforts to focus on the

information that each participant shared with me. For example, I took advantage of available opportunities to ask appropriate follow-up questions in an effort not to make assumptions about the meaning of their words. In addition, once the interviews were completed, I constructed participant introductions (Appendix E) to establish each study participant as unique individuals whose lives are impacted in distinctively different ways. The process of creating a participant introduction consisted of extracting life experiences from interview transcripts. While participant introductions are not included within the findings of this study, they were used to better contextualize the themes that arose in the study.

Presentation of Themes

> Kim: For me, there is a consistent kind of feeling of just being a little different. And there's always this, um, for me, there's this like, a fear that you're gonna sort of misrepresent for your race and gender. I have also a fear of stereotypes. I get very . . . I get . . . I experience a lot of anxiety when I feel like I am appearing, you know, sort of as a stereotype.

Kim is a graduate student at Civitan University. As a Black female college student in the chemistry department, some would consider her to be a strong individual for committing to a field of study in which few Black women find success. However, Kim does not consider herself to be strong. Instead, she feels overwhelmed by her academic environment and worries about misrepresenting her race and gender by coming across as an "angry Black woman." Kim, like many of the participants of this study, negotiated her experience as a Black female college student with mental health concerns at a PWI while adhering to an image of strength that sought to "prove" her worth as a student despite negative stereotypes that labelled her as intellectually inferior to her White counterparts. Kim could not acknowledge any kind of perceivable vulnerability, such a mental illness. For Black women like Kim, suffering from a mental illness is not merely seen as an individual experience. Instead, it is perceived as a negative representation of the Black community in a society fraught with discriminatory stereotypes of

Black people. Out of fear of being perceived as weak and or incapable of competing academically with her non-Black classmates, Kim chose not to share her mental health concerns with any professors in her department. Each of the five theses, Strength as a Necessity, Weakness as a Liability, the Luxury of Lunacy, Mentorship and Mental Wellness, and Spirit-Murdering Silence, were reoccurring themes throughout the participants' stories. The remainder of Chapter IV provides excerpts from participant transcriptions that illustrate each theme as well as a DS and CRF analysis of the themes.

Strength as a Necessity

Historical imagery that dates back to times of slavery has provided representations of Black women as innately hard-working, strong, and nurturing (Beauboeuf-Lafontant, 2009; Wallace, 1978). Such images justified the oppression of Black women by portraying them with "superhuman" strength that made it impossible for them to experience victimization; even in the midst of the most cruel and discriminatory circumstances (Beauboeuf-Lafontant, 2009). "As persons who cannot suffer, strong Black women are denied a vocabulary for examining their overwhelming obligations to others, their limited resources for meeting those demands, and their needs for comfort" (Beauboeuf-Lafontant, 2009, p. 54). Though this image and expectation of strength in Black women originated in their service to White communities, it is reinforced within their own communities by their gender-specific roles as caregivers and matriarchs; ones who use all their strength to take care of the needs of others while never complaining or taking the time to consider their own needs (Heath, 2006).

Black feminist scholars have suggested the image of impermeable strength in Black women to be "a prescriptive discourse embedded in both racist and sexist characterizations of Black women as laborers for others" (Beauboeuf-Lafontant, 2008, p. 395). It has also been

argued that the image of strength continues to inform societal images of Black women as evidenced in the persistence of stereotypes such as the "angry Black woman" and the "welfare queen" (Beauboeuf-Lafontant, 2007). As a result, strength has become a societal expectation that normalizes the frustrated toil and subordination of Black women while silencing them from their distressful exhaustion and detracting from the sociopolitical inequities that they negotiate daily (Beauboeuf-Lafontant, 2007; Collins, 1991).

Strength has become a burdensome expectation for Black women that is both informed and maintained by a matrix of interlocking oppressive categories such as, but not limited to, race, class, gender, and ability. Beauboeuf-Lafontant (2009) argued that this idea of strength in Black women seeks "to defend and maintain a stratified social order by obscuring Black women's experiences of suffering, acts of desperation, and anger" (p. 2). The mental, emotional, and physical health of Black women is compromised when they seek to portray an image of impermeable strength. However, this image of strength has been internalized by generations of Black women who have reinterpreted strength as a cultural imperative for distinguishing them from White women and combating the racist, classist, and sexist abuses that they experience both in and out of their own communities (Beauboeuf-Lafontant, 2009).

The first theme, Strength as a Necessity, arose in the experiences of the study participants and is evidenced through the manner in which they perceive strength as a necessary attribute for combating discrimination and demonstrating ability. Strength, as expressed by the study participants, is a characteristic born out of necessity. In many ways, it is viewed historically as the characteristic necessary to endure slavery and Jim Crow as well as the various forms of discrimination that continue to exist. However, this internalized image of strength is a distorted version of an image that "reduces Black women to the confines of a race and gender order

grounded in claims of their lesser humanity" (Beauboeuf-Lafontant, 2009, p. 42). For the study participants, strength served as a symbol of encouragement and a reassurance that they have, within themselves, the wherewithal to succeed and overcome any barriers that they might face (Harris-Lacewell, 2001). This interpretation of strength insists that they focus on their attitudes and hold themselves accountable for being representations of Black female competence in a society that discredits their faculties, doubts their potential, and devalues their worth.

Strength, as interpreted and expressed by the study participants, provided a powerful, communal characteristic that warranted them membership into a sisterhood of women who have triumphed over various forms of discrimination and oppression (Beauboeuf-Lafontant, 2009; Edge & Rogers, 2005). However, this understanding of strength did not consider the psychological harm that has been experienced by generations of Black women nor did it challenge the persistence of oppressive conditions that require overcoming. Specifically, as college students, strength is perceived as a necessary tool for success in "the individualistic structures of formal higher education" (Winkle-Wagner, 2009, p. 115). It is, all at once, a cultural rite passed as though genetically through generations, a necessity for combating all forms of discrimination, and a key to academic success within higher education institutions.

> ***Ashley***: Maybe . . . 'cause of all the adversity in our history. And it's just like you have to be strong to get over that kind of stuff. You have to be strong so you can keep moving forward and all that crap, but that's probably it. Just like, as a Black person in this country, you have to be strong or you won't make it or you won't be able to do certain things. You just won't be. You have to be strong basically. It's just like this whole you have to be strong mentality in order to be able to do anything to get by basically, you can't be weak.
>
> ***Katherine***: I think that it's because of our history and the fact that some things have changed and some things haven't. Like when it comes to segregation and things like that, there's always going to be people that are racist, there's always going to be people that are this . . .
>
> ***Audrey***: I think too knowing a little bit of like, our history as African Americans and what we what we've had to go through and certain stereotypes that, you

> know, that are out there and that exist about African American woman pushes you even more.

Strength is also viewed as a mechanism for bearing the torch of endurance that has been passed down through generations as well as a defense from discriminatory stereotypes that categorize minorities as less capable, competent or intelligent. According to Alexander and Poussaint (2000),

> the changing face of racism in America by the close of the twentieth century—from overt and unmistakable devaluation and even hostility to more subtle and nuanced but still racist attitudes and assumptions—has added a peculiar burden to the Black psyche, an element of elusiveness that may compound feelings of isolation and frustration. (p. 103)

As such, many of the study participants have internalized and use strength in an attempt to prove their intelligence in an environment that questions their intellectual value and, as a result, induces stress and anxiety. Melissa, when asked why the idea of superior strength persists among many Black women, responded by insisting that "we don't want to be put down like we were." To this extent, strength is seen as a tool for resisting oppression and combating stereotypes.

> ***Melissa***: Because we were put down for a reason (our race) but we don't want to give people a reason to put us down. Our ancestors were tortured and we had to stand up for ourselves. Now people have made a way for us; we like shouldn't back down from it. We should stand up and be stronger.
>
> ***Michelle***: And then, even though racism isn't as rampant as it was, it still exists. And when you do come into contact with it, whether it be so subtle or right in your face, that just reinforces oh, ok, this is what it is. So, I need to, you know, do things to counteract this or at least prove myself some kind of way. So, you wanna just always be stronger and always be…you don't want to let them see you sweat.
>
> ***Kim***: I guess like those (stereotypes) being associated with people from like my background. Which is like lazy or um not as smart as, you know, my White colleagues or even, you know, Asian or Indian colleagues, right. Also, you know, just being like not very, you know, like intelligent like as far as like social situations go. Like having the ability to speak well and, you know, present myself properly. And then I also don't want to appear to be. I don't know . . . you just feel like, just as a minority period, you have to kind of prove yourself. At least I do.

Danielle especially viewed strength as a way of proving her intelligence in an educational environment that she perceives as being unsupportive of Black female students. As a Black female student in a science, technology, engineering, or math (STEM) field of study, Danielle was aware that she is a part of an underrepresented student population. Further, research shows that women and minorities who intend to complete STEM-related degrees are less likely to persist toward completion (Price, 2010). However, Danielle viewed such statistics as motivation for her to succeed in her program: "I'm one of those people who, when the odds are against me, I want to prove my point. Uh, so that's motivation too." Though she had few examples of success to motivate her, she had internalized a drive that recognizes her obstacles and pushes her forward:

> . . . [T]here's not a lot of Black people in chemistry. There's even less [*sic*] women in chemistry. I can only think of two Black chemists that I know that are female so, just showing that it can be done. I know there's two other Black females in the department and they'll be the first two to ever graduate from uh from here. And one should graduate, hopefully, in December and the other one in August which will make me the third.

In addition to the legacy of slavery and discrimination to their understanding of strength, the study participants also perceived strength as a particular expectation of Black women. For women who also face oppressive and dehumanizing stereotypes of inferiority that are informed by racist, sexist, ableist, and classist ideologies, this independence and strength that, generationally, was used to combat racial discrimination then becomes something that is infused and exhibited in all relationships that attempt to marginalize and/or control them.

> ***Michelle***: I think it like dates back to slavery because well, Black people in general had to deal with a lot and so we're considered to be like, you know, strong people. And then the woman, she has to like deal with the kids and, you know, support, you know, all the other things that the man isn't doing when he's not home or when he's at work. So, even though now we're becoming more independent and we have our own, you know, we have jobs, we work outside the home, that stigma still persists. . . . I think we hold on to some of that just 'cause,

you know, I'm Black so I need to be, you know, I need to know how to be strong. I have to be better.

Alesia: . . . [M]aybe, when we got here . . ., as in America, maybe in Africa too but I only know, you know, what I've read and what I've perceived. But, when we got here to America, you know, we're being traded and we have to work and we have to bear children and we have to keep going. And I think we realized really quickly that sobbing was not gonna help. Talking was not going to help. We had work to do. We had kids to feed, kids to bear, you know. You don't really have time to go, 'hmm, am I feeling, you know, mentally exhausted today?' You don't have time for that. And I think that after maybe, maybe the first generation or whenever we weren't, we weren't, you know, slaves anymore, we still thought that, I mean even the men too, we thought crying is not going to help anything. We've gotta live. We've gotta survive. It doesn't matter whether, you know, I'm emotionally exhausted or whether I'm falling apart internally. I have to do this. I have to live so my kids can live. And then we tell the kids . . . you know, you have to be strong mentally and physically and, you know, we got we got shit to do. So, I think that's where it came from. I think it just came from not having the option to sit down and talk to somebody and be like 'I feel this way' 'cause you don't have the time; you just try and live. And I feel like that's where that came from and it just keep . . . it keeps manifesting itself; maybe not in the exact same way because now we have the option of actually talking but, since it's so ingrained in everyone that we feel that we have to be, you know, we have to be strong, it's how we get through it.

Sarah: I think it's [the idea that] you have to be strong because there are so many Black women that are single mothers and in school and trying to be homemakers and everything like that. So, I think it's just a, when you look at the Black woman, you automatically know oh, she's a strong Black woman because she has to be.

Jane: I mean even back in the slavery times, you're getting your baby snatched, your husband's gone, and you have to somehow live on. I mean, that happened a lot. And later on, all the guys are in prison. And I mean, those stereotypes that people have of you, I mean, not that they have of you, that you internalize it I guess and you teach your daughter the same thing. Like my mom, like she's really headstrong but she took a lot, like, from my dad, so she will tell me, "you need to be strong, you need to be independent, don't worry about what anybody else, you know, 'cause you have to, you have to survive on your own," because we rarely get married, we rarely have people who understand, you know, so it's like you have to be that way in order to survive almost. I feel like that's the message that I was sent. So it's like showing somebody that weakness gives them like power to use against you.

Jane's quote speaks of an internalized message of strength; one that is taught to view strength as a tool of necessity needed to manage familial life circumstances that result in

challenges faced by Black women that are reminiscent of *The Negro Family: The Case for National Action,* better known as the1965 Moynihan Report. The Moynihan Report, though praised by neoconservatives as an astute examination of the breakdown of the Black family structure, has long been criticized for providing a patriarchal analysis that results in a pathology in which social deviancy in the Black community is blamed on the absence of the Black male from the family unit rather than a result of social, political, or economic forms of institutional inequality that make it difficult for Black families to acquire wealth (Crenshaw, 1991; Few, 2007; Wanzo, 2011). When internalized, the message of the Moynihan Report can result in Black women portraying strength as a necessity to combat the challenges that allegedly result from the absence of Black men who, ultimately, "are not able to reap the material and social rewards for their participation in patriarchy" (Hooks, 1990, p. 63). Jane's mother taught her the strength she felt would be needed for Jane to acquire the ability to "survive" on her own. While socioeconomic realities often necessitate the need for combined household incomes, the lesson of strength passed to Jane from her mother does not take into account the discriminatory factors that perpetuate the perceived need for Black women to constantly exert greater effort in order to "survive."

Harris-Lacewell (2001) described the symbol of strength in Black women as a cultural myth that has been passed down through the generations by women whose "resiliency in the face of crisis are an important reinforcing mechanism for the belief that 'strong' is a well earned adjective for African American women" (p. 5). Many of the study participants talked about the message of strength being taught to them by a relative in the same way that strength was communicated to Jane by her mother. Even Melissa, whose mother passed when she was a

young child, sees strength as an attribute that is taught by a mother and, since her mother did not raise her, she sees this as a reason for her low self-esteem and perceived lack of strength.

Though the origin of the message of impermeable strength in Black women is rooted in their powerlessness and laborious exploitation, strength continues to be taught as a distinctive cultural symbol of Black womanhood. Strength, as envisioned and internalized in the Black community, is "a culturally generated measure for protecting Black women against a life structured against them" (Beauboeuf-LaFontant, 2009, p. 25). The lesson of strength is a central component of racial and gender socialization that aims to prepare young Black girls for hostile and discriminatory environments with the tools necessary to negate images that discredit their worth (Harris-Lacewell, 2001).

Strength was communicated to Michelle by her mother as well as her father as a means of preparing her for the inevitable discriminatory environment in which she would have to compete. According to Michelle, "I know I've been told (by my parents) before, when you grow up, you can be just as good as anybody else but since you're Black you gotta be two times better." Other study participants talked about the message of strength either being taught or simply understood through witnessing other women in their lives, such as mother, aunts, and grandmothers, live the example of strength.

> ***Anne***: . . . [M]y mom was like, you know, don't ever show like a moment of weakness, kind of. You know, you can always do this and if someone's telling you that you can't do this, then, just prove them wrong. So, I kind of grew up believing that, you know, there was nothing that I couldn't tackle . . .

> ***Audrey***: I guess, because growing up for me, I've always seen. . . . I've always seem Black women as very strong. . . . Black women are able to carry a lot. Carry the heavy burdens of different loads of issues. But, you know, part of being a Black woman is just being strong. You're able to handle the situations, you know, come what may, however they come at you, from whatever angles.

Audrey continued to share her perception of strength as something that was passed down to her. While she does not recall her mother sitting her down and telling her that Black women had to be strong, she saw her mother as a living example and, as a result, saw the need to exhibit strength as something that was "just kind of understood." Once strength is seen as simply understood, it is then imposed onto the lives of the study participants as an expectation. The expectation of strength for the study participants comes from family, the Black community, and society in general.

> ***Melissa***: . . . Black people want you to be more standupish. And if they don't see that in you, they don't think you're strong enough. And I think they want us to be . . . they want other Black people to be strong and if they don't see you being strong, they are just like "what's the point in you being in college when we've been through all we've been through," you know with racism and stuff.

> ***Rachel***: So, even when everyone else is complaining and I chime in it's like, you don't know what we're talking about. You're always happy. And, so, I mean. And I think a lot of people do experience that because you kind of have to always be something and people don't . . . I don't think a lot of people allow our identity to be flexible because when you have . . . when you're the minority, a lot of times you're so . . . um, they stick you into that mode and that's what you are.

> ***Alesia***: . . . [Y]ou grow up in the south and, you know, you are female and you are Black. There are things you see. There are things that happen to you and you are allowed to express yourself but, at the end of the day, even your family expects you to just suck it up 'cause you are a strong black woman and . . . if I had a dime for every time somebody told me that, you know, because if someone keeps telling you something you feel . . . you feel obligated to be that person.

In much the same way that Alesia shared, once strength is continuously insisted upon, it becomes an obligatory aspiration for many of the study participants. When strength is not seen as a genuine reflection of one's state of mind, it is likened to a performance meant to meet the expectations placed upon them. "As a performance, being strong encourages Black women to adopt an extensive and potentially self-negating caretaking role to others" (Beauboeuf-LaFontant, 2007, p. 32). This role of caretaker is reflective of the historical perception of Black

women as hard-working and selfless laborers; a perception that is both informed and perpetuated by racist and sexist ideologies (hooks, 2005; Lorde, 1984).

Strength that encourages the internalization of the role of caretaker asserts that Black women place themselves and, in some cases, their own well-being last while fulfilling the needs of others. This is a characteristic exhibited by many of the study participants. For example, Lisa, who does not have a strong relationship with her mother and suffers from depression but has never been to a counselor on or off-campus, is a graduate student who, within a year's time, placed her father in rehabilitation, ended a romantic relationship, and took guardianship of her niece. While she balanced her studies with taking care of others, she has not made the time to seriously manage her own mental health concerns. Instead, she felt as though, if she continued to make good grades and could continue about her daily life, it was not necessary for her to make time for herself in order to find out why there were days that she spent crying. Other study participants told similar stories of care-giving as a goal, reality, or expectation.

> ***Audrey***: You know, as I said earlier, we just don't take the time to take care of ourselves. And, I mean, not even just on a mental health aspect, that's in general when it comes to health. You know, statistics will say African Americans, you know, have the highest percentage from diabetes to other different types of illnesses. I just don't think, I think we're hard workers but we don't ever take the time to stop and do a self-check and say you know how am I doing today. . . . They just continue to just push, push whatever it is they're pushing toward, a career or just being that glue that, um, holds the family together or whatever role that they are taking on. Like they just, you know, they don't stop.
>
> ***Anne***: I . . . worked two jobs pretty much my whole college career, um, I would drive back and forth to help my mom with my grandmother while she was she lived in our home, and she was terminal so I was helping her take care of that. Afterwards, at one point in time, I was working three jobs and I was going to school. I never let my grades slip low enough that I never could keep a scholarship.
>
> ***Sarah***: . . . I would come home (from high school), I would cook a meal for my brothers and sisters, I would get them bathed, I would help them with homework, get them into bed and the only thing she (my mother) had to do when she came home was go to bed. There was like . . . the house was in order by the time she got

> home and I would still be up doing homework and I would go to bed, wake up the next day and do it all over again. And it became a routine so when I moved out into the dorm my freshman year (of college), it was just like oh my gosh, I have all this free time to do whatever I want to do but I don't know what to do with myself.

Sarah is a strong example of how an internalized message of strength can disconnect women from their own personal needs. Once she found herself in a place of not caring for others, she was so out of tune with herself that she felt lost. Black women "who have been socialized from childhood on to feel that Black women's 'personal power' only comes through serving others may have the most difficult time learning to see that personal power really begins with care of the self" (Hooks, 2005, p. 66). When Black women normalize their roles as caregivers, they oftentimes are unable to recognize or acknowledge their own vulnerability or transition from the role of caregiver to the role of being cared for. For example, neither Rachel nor Nicole, both students who identified as Black female students with mental health concerns, had ever visited their campus counseling center. However, they both described themselves as such strong support systems for their friends that they are unable to assume the role of being the one in need of support.

> ***Nicole***:. . . I'm a listener, I'm definitely . . . I'm a listener and all of my friends can probably agree to that and I do more . . . moreso of the listening and they do moreso the talking. And so, there are plenty of times where I just want to call up one of my friends and just kind of like, you know, just vent and just let some things out but I never do or I never get the opportunity to because I'm always the one listening and so I try to vent with my mom 'cause, you know, she lets me vent sometimes but, you know, she's busy with her job and everything.

> ***Rachel***: . . . I'm always the counselor friend, but never the counseled friend. (Laughs) And I think a lot of times my friends have gotten so used to that, so even when they call me and ask me how I'm doing and I start talk about something, some turn in the conversation will bring it back to their problems. And I'm a middle child, too, so I'm so used to being that strength or that pillar for everyone else that I don't really know how other people can be there for me. And I get that from my mom because she is the same way.

Rachel's comments reintroduce the idea of strength being taught. Her example for exhibiting strength and being a care-giver was her mother. However, as expressed by Alesia, there is a false idea that one will find personal fulfillment in exhibiting strength and unselfishly meeting the needs of others.

> Alesia: . . . [W]e just kind of feel responsible for, for other people. so that's, that's why I think, you know, outside of the media, just within ourselves and what people tell us, we just feel like portraying this image (of strength) will help us feel better by helping them make us, you know, them feel better. Which is not really the case, not really the case at all.

When this personal fulfillment is not experienced by Black women, exhaustive caregiving can result in fatigue, distress, and confusion about one's worth or purpose; this jeopardizes mental wellness. hooks (2005) recognized the tendency of internalizing the role of caregiver in herself and asserts that it allows Black women "to become over-extended—working, meeting the needs of others—we often do not take the time for care of the self" (p. 66). By internalizing an imposed message of strength, Black women are encouraged to turn a blind eye to their own personal needs or, in the case of this study, their own mental health concerns.

> ***Kim***: I wouldn't say I am a strong Black woman. But that is definitely my aspiration for some reason. I still see that as the option or the only option really. Just kind of taking care of others. Others being your family. You know. And just kind of taking care of yourself when you can, when you get an opportunity. I come last, like I really do. Like, in general. Like, I mean I do my work, research and stuff, but that's why we . . . like some of the questions you're asking, I have never considered. Like, is there something wrong with me? Like, I don't have time to. If it's not about to fall off, I don't even notice it. (Laughter) Like really. But I might be. . . . I might have all kinds of issues.
>
> ***Audrey***: I just don't think we really take the time to take care of ourselves. 'Cause you know especially as an educated women, um you know you're always pushing toward your career and where you want to go in life and you just don't take the time to like check out of your world and say let me relax, let me get myself together.
>
> ***Sarah***: And I think a lot of us feel like we have to uphold that image so, um, I guess they don't really have time to take care of the self because they have other

> things that they have to, you know, present forward. I'm this way whether you know it or not behind closed doors I'm another woman.

This interpretation of strength encourages women to suppress anything that can be perceived as vulnerability. "When seeking help means showing unacceptable weakness, actual Black women, unlike their mythical counterpart, face the ravages of depression, anxiety and loneliness" (Harris-Lacewell, 2001, p. 24). Most of the participants of the study did not take advantage of on or off-campus services for their mental health concerns. For example, Kim, who felt as though she suffered from depression, anxiety, and anger, shared that she would only consider visiting her campus counseling center if she was "on the brink of a breakdown." Likewise, Jane and Kate, who both visited their campus counseling center at least once, admitted that they only utilized campus services when they felt as though they were having a "nervous breakdown" or that they could not get control of their emotions. "Having well learned to suppress those voices in conflict with strength . . . many Black women cling to the very identity that is burdening their minds and bodies" (Beauboeuf-LaFontant, 2009, p. 56). As a result, a consequence of the image of strength in Black women is a reluctance of women to take advantage of resources of support; even if they acknowledge to themselves that they are in need of assistance.

> ***Anne***: . . . I've always had that support system but it's just not what I was taught to, you know . . . you only go in times of crisis to that support system.
>
> ***Michelle***: You know how like some people, they don't like to go to the doctor unless they . . . they're like about to die. Like, I don't do that. If I feel sick, I'll like . . . if I have the medicine to take care of it, I'll do it. . . . But when it comes to like mental things, I don't . . . I don't know. I wait until I'm about to like have some sort of conniption and then I'm like, "oh my gosh, I need to talk to somebody." But it's been building for a while. I don't know why I do that.
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> ***Rachel***: . . . I think that, a lot of times in the African American community in general, and more specifically African American women, we feel like we can't talk about things that are bothering us, and that's not even just going as so far as to seek help, but it's also just talking to friends about it. Like, we feel like we

> have to be strong in all of our roles, as a friend, as sisters, as daughters, we always feel like we have to be so strong. And it's not even giving up strength to say that you feel a certain way or you feel incapable or you feel sad or lonely, but I think we interpret it as giving up a significant amount of strength and being vulnerable, it's always seen as a bad thing, but other people are allowed to do it, other races are allowed to do it.
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> ***Erica***: . . . I feel like, in the Black community, they don't really talk about mental health stuff as much and here (at a predominantly White institution) they actually do.
>
> ***Jane***: I think it's perceived as more ok, in their (White people) community to seek help. Does that make sense? I mean, even in my own family. Like, my mom has bipolar disorder and she didn't find out about it until she was like, late like middle age because it's not . . . it's . . . I don't want to say it's frowned upon but it's like we're less likely to seek help than a White female might have because they might . . . in their culture, it seems to me, and I don't want to say it is but, it seems to me like they probably are more like, it's probably more culturally acceptable to accept that you have mental health concerns for yourself.
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> ***Anne***: . . . [B]eing African American being in the South, you know, there's just so many things that you are taught to, you know basically, just hide. Whereas, you know, if you're Caucasian then therapy is okay, and, you know, depression is okay, anxiety is okay, but when you look at the African American community, mental health is so stigmatized . . ..
>
> ***Katherine***: I don't want to say shoved under the table but it's not really like welcome maybe because, you know life, if you look at stats and stuff, like Black people don't get eating disorders and things like that. So, I think that it is kind of looked down upon and just shoved under the table.

Much like strength, Anne expressed that silence is a message that is taught. Due to the stigma of mental health in the Black community, mental health concerns are hidden. As such, statistics ('stats'), such as the ones referred to by Katherine, give the impression that Black people do not have mental health concerns. When such impressions are left unchallenged, stereotypes persist and influence this societal perception of mental health in the Black community as well as normalization of impermeable strength in Black women.

Once the idea of strength is imposed and internalized, it can become subsequently enforced by media images. "Contemporary Black entertainment and media are replete with

references to and admiration of strong Black women" (Harris-Lacewell, 2001, p. 5). It is an image that has been used to counteract distorted representations of Black womanhood that dominated media for many years (Harris-Lacewell, 2001; hooks, 2005). Study participants shared that media images often left them feeling as though their only acceptable option was to exhibit strength at all times. Once internalized, the image of strength is concurrently affirming and yet can become damaging to one's mental health when it does not reflect an accurate representation of self. Ashley expressed frustration for not living up to the "sassy" Black girl attitude that she saw portrayed on television. Other participants observed a call to strength and lack of vulnerability in media portrayals of Black women.

> ***Kim***: I don't think I have ever seen any other image positively. You know, there was either that strong Black woman who's reserved and very regal and kind of, you know, handling business or there was like the other kind that was just like ignorant. You know. And kind of . . . like there was never just a vulnerable yet strong successful Black woman like portrayed to me. You know what I mean. Like there just never was. I mean, Oprah would cry every now and then so maybe that (Laughs) but they were always so put together, the images. My mom was never . . . she's never cracked. You know what I'm saying. Period.

> ***Audrey***: To fit what society or what the African American community has said is this image of a strong Black woman. You get it through movies; you see it a lot in predominantly Black movies. That one woman that's just super woman . . . give her her cape. Um, you don't really see Black woman in a vulnerable position and, if you do, you like, that's a little weird.

Media portrayals of Black women are reflective of racist and patriarchal representations of strength that have been reinterpreted and internalized by Black women as a means of distinguishing themselves from White women (Harris-Lacewell, 2001; hooks, 2005). "Internalized racism seems to have a greater hold on the psyches of Black people now than at any other moment in history" (hooks, 2005, p. 61). This is due in part to the metamorphosis and acceptability of the message of Black women's strength; a strength that ultimately dehumanizes Black women, induces mental distress, and encourages inaccurate representations of self.

The image of strength in Black women stands in stark opposition to the historically dominant image of White, docile femininity; an image depicted as one of comfort and privilege (Harris-Lacewell, 2001). "Foregrounding Black women's survival of enslavement and continued socioeconomic marginalization, the strength discourse gathers its authority not from empirical investigation but from contrasting Black women to normatively feminine, White, middle-class women" (Beauboeuf-Lafontant, 2007, p. 31). This comparison of the socially constructed dichotomous categorizations of women as Black/White, strong/weak, and feminine/non-feminine is an example of what hooks (1990) referred to as the dualistic thinking that serves as "the philosophical underpinning of systems of domination" (p. 62). It ultimately serves to justify the continued exploitation of Black women by referring to them as strong enough to over-extend themselves for others with no consideration for their own needs.

For the study participants, media images reinforced the image of strength in Black women and portrayed them as impervious to any form of mental distress or illness. Such images are particularly problematic for Black female college students at PWIs who interact with White classmates who rely on media images "as their primary exposure to people of color" and, as a result, are socialized to view Black women as strong (Winkle-Gagner, 2009, p. 71). The media message that is ultimately communicated to the participants is that mental health concerns are rarely, if ever, experienced by Black women who are strong and, instead, are more likely experienced, accepted, diagnosed, and treated by White women who have the luxury of being weak.

> ***Danielle***: You know, in any, really in any novel that you can think about, you always see the Black woman being the strong person who's holding stuff together and, when she's upset, you never see her go off and tell anybody. And like, in the movies, it's always just the strength that's associated with them. . . . You know, you don't normally see that and it's not, I guess, the norm. 'Cause I'm like, even on TV, when you see people going to counselors, it's always like the White

families and they're talking to the shrink and it's normally stuff that doesn't matter. And it's like, you really don't see Black people really doing that I guess. It's almost taboo.

Ashley: Like, you know, every time like you see somebody who's depressed, it's always some White lady or some White guy and they never really consider too much, like every, in my classes, when we talk about stuff like that, they never really consider like us . . .. Like, if you see any kind of television commercial, like antidepressants just, they're all White. . . . they're all White like and they're like walking around in their kitchen like that (puts hand up to head in gesture of exhaustion). And in books, they always show White people. They show like nice Black happy families sometimes but never any like Black women with mental concerns.

Michelle: Actually, I hear of more mental health stigmas in the White community. Like, you know, all the little teenage rich White kids are on Prozac. They have all this money but they're not happy so on and on and on. And then they have the money to pay for medication. And I'm like I don't know if that's true but I haven't heard of it in the Black community.

Christine: Like, I didn't know that depression was like a clinical condition; like a real serious condition and that they had medications for it until I got like maybe in college and they really talked about it. Because, that's how society and TV portray Caucasian women as opposed to African American women. I think they portray them in the worst ways. Like, every time you hear about a statistic, like low-income, no insurance, Medicaid, anything like that, it's always Black women, Black culture of, you know. And food stamps stuff like that. Like welfare. So, I don't. They always . . . I think it's society and how the media portrays us.

Kim: So, I recently started watching Desperate Housewives. And I noticed every time they had these problems, the first thing they wanted to do was go to a therapist. These White characters, all they want to do is go to therapist like immediately. Any problem they have. And it's like, if I grew up seeing people doing things like that, I wouldn't have a problem right now going over to the counseling center or whatever. But I just, I've never heard of people going to therapy for like regular problems.

Audrey: . . . I feel like, when it comes to other ethnic groups, because you don't hear about like as many negative stereotypes, I think it's much easier than for them. Um, I think with Caucasians, like, I'm trying . . . I wanna make sure I'm not sounding racist but, with like Caucasians being the predominate like party, like I feel like they have no worries, you know. They can have, you know, mental health issues and they can maybe take lexapro or xanax or something like that and that's just acceptable, it's cool.

Katherine: I think that it is just because if you look at people that do get counseling and do get help and do get eating disorders and do cut. Like, no one

> ever really sees any type minority having those issues. I think that it is just kind of ingrained that these are things that happen to White people. They don't happen to minorities . . . I think, I remember like learning in high school like health class and things like that. Or things you see on TV about eating disorders and magazine ads. It's always about White girls. It's always about White advertisements. It's always about just them in general. . . . I remember a video we watch in high school health class about eating disorders and all, there were like 30 girls that they followed and all of them were White. . . . . I feel like, I don't want to say that it is tailor-made for them but, it seems more like it is kind of more acceptable for them to go and do these things than anyone else.

While portraying Black women as strong, media images also encouraged the racialization of mental distress as a White concern. Such images socialize a societal comfort with and expectation of laborious strength and wherewithal. Katherine shared that she saw the message of strength evidenced in the media coverage of musical artists Britney Spears (a White woman) and Whitney Houston (a Black woman) who both had what appeared to be public battles with drug abuse and possible mental health concerns. Coverage of the artists' struggles appeared to reveal an acceptance and support of Britney's display of distress and an accusatory condemnation of Whitney's distress.

In her opinion, Katherine felt as though the public was urged to come to Britney Spears's rescue by encouraging her to commit to rehabilitation and counseling while Whitney Houston was portrayed as a selfish disgrace to the Black community and fodder for the paparazzi. Katherine also viewed the Black community's response to Whitney Houston's unorthodox behavior as unsupportive. Rather than question what she could be dealing with mentally or why she resorted to unhealthy life choices, Katherine felt as though the Black community looked down on Whitney Houston and condemned her for being weak and not strong enough to overcome her struggles. This is an example of the imposed message of strength that has been enforced by media images and community expectations. As a result, the message of strength has been internalized by Katherine who, though she has been diagnosed with depression and an

eating disorder for which she takes medication, has not shared her mental health concerns with any family members. This is the type of silencing of experience that is presented during the explanation of theme five; Spirit-Murdering Silence.

In addition to media images, participation in culturally traditional religious practices and beliefs can also reinforce the message and expectation of strength in Black women. According to research produced by scholars in womanist, psychological, and religious studies, Black women's belief in a divine power has often sustained them in the midst of generations of oppression (Comas-Diaz & Greene, 1994; Heath, 2006; Paris, 1995). This belief is largely evidenced through membership and devotional participation in "the Black church." "While there is no single body of doctrine that defines the religious identity of Black people in the USA, there is a common religious experience that stems from the formation of the Black church" (Taylor & Witherspoon, 2010, p. 137). As such, "the Black church" stands as a cultural symbol of the collective religiosity that has been a historical component of endurance of and resistance to discrimination and oppression in the Black community (Taylor & Witherspoon, 2010).

In order to consider the sociocultural factors that influence the experiences of the study participants, it is first important to consider the various contexts "in which the realities of Black women's mental health is shaped" (Heath, 2006, p. 162). Culturally synonymous with the Black community, "the Black church" has historically been the focal point for community activity, self-preservation, and political resistance in the face of oppression (Taylor & Witherspoon, 2010). Through their participation with "the Black church," generations of Black women found value, support, comfort, and a sense of community (Heath, 2006). As such, "the Black church" remains a source of support for many Black women today. Reliance on faith for coping with mental

health concerns is a message that several study participants learned through family expectations and media images such as the ones described below.

> ***Jane***: You can't hear, you can't watch stories about slavery . . . and they're using like negro spirituals to get through being slaves and like Tyler Perry movies and stuff like that. It's just, it's another cultural thing. I mean that's all you hear about, when you hear like about back in the days with the mammies and they just like singing, you know, this feel good music 'cause it's like, you know, it's just another cultural thing that's been around for a long time I mean it's worked, it's got us through . . ..
>
> ***Melissa***: People are really strong when it comes to God and when it comes to going to church. The members, I mean, when you can go to church you just see that you have a future and that you have a future with God and that you have someone and that God does care about every one of us. I think that they use that to keep them up.
>
> ***Audrey***: The church, for my experience growing up, has just been like the glue that holds like the family together, at least my mom's side of the family. Um, it's always been the solution for everything. It's, I mean, it's been the way to get involved in your community, it's been the way to network, like the church is like the hallmark of my family, so naturally of course they're gonna tell me this is where you need to go (for mental health concerns).
>
> ***Christine***: Like, if you come from a background where your aunties, everybody, the whole family just stayed in the church. And they're just like . . . you have to pray for everything, if you want something, you know, you seek the Lord. If you're going through something, you pray about it and don't worry about it because he has everything handled. He knows what your expectations and your goals. So, I just think that's why religion plays . . . Religion plays a big part on the mental health status.

In order to apply a CRF and DS theoretical lens to this study, it is important not to essentialize all Black women as religious. As a matter of fact, towards the end of the 20th century, the Black community "experienced a disconnection from several of the traditional social supports and protective aspects of the Black culture, including the church" (Alexander & Poussaint, 2000, p. 106). While many of the study participants described themselves as Christian or spiritual, many of them also described themselves as not regularly engaging in religious practices such as prayer, meditation, scriptural study, or regular church attendance. Regardless of

their level of participation, religion, and the strong sociocultural influence of "the Black church" on many of the families and communities of the study participants proved to be another way in which the message of strength was imposed.

Black women's historical reliance on "the Black church" for support is problematic; specifically when it comes to coping with mental health concerns. This is due in part to the way in which "the Black church" "has historically upheld the philosophy of 'bearing up' at any cost under the pain of slavery and the long-lasting effects of discrimination" (Alexander & Poussaint, 2000, p. 101). In essence, "the Black church" proselytizes a message of strength that can "overcome" any obstacle and encourages selfless service. For generations, participation in "the Black church" often encouraged and provided opportunities for women to exhibit this strength through their participation in the various caregiving activities often delegated to female members of the congregation. Such roles normalized selflessness while reinforcing the expectation of strength in Black women.

The message of strength as interpreted through "the Black church" echoes the societal expectation of strength in Black women and blames Black women with perceivable vulnerabilities for not being a "strong" representative of Black womanhood while simultaneously criticizing them for not measuring up to a faith-based standard that has sustained the Black community for generations. Naomi, who was raised in a conservative Christian home, expressed that, while she relied on her faith to cope with her mental health concerns, she also used that same faith to judge people in her life; people like her own sister whom she called a whore for not being strong enough to resist sexual pressure from her boyfriend. Audrey shared that she felt judged by the church for her mental health concerns. She felt as though her concerns would be interpreted as having weak faith.

> . . . [A]nd sometimes, in that environment . . . the place you'd think that would be the most supportive can be the most critical because you're . . . the first thought is she's not tapped into this. She's not tapped into religion. She hasn't tapped into her relationship with God.

The message of strength as expressed in "the Black church" encourages a fierce reliance on spiritual faith for coping with all forms of oppression or distress. Unfortunately, it also discourages Black women with mental health concerns from deconstructing the source of their distress or exploring other options of coping that may be available to them. "The influence of religion—predominantly but not exclusively the Christian faith—has added to the widespread notion that nonmedical resources provided the surest way to assuage emotional or psychological stress" (Alexander & Poussaint, 2000, p. 104). This is an idea that manifested itself in the narratives of the study participants. For example, when Jane tried to talk to her grandmother about her depression, her grandmother encouraged her to read her Bible.

> . . . [S]o it was just kind of like . . . I felt almost a little bit discouraged almost because I was like, I don't know. I just felt like I. . . . I was asking for this but because we have this kind of belief system that was ingrained I couldn't do it. Like, I couldn't get the help I wanted.

Other study participants were taught to rely on religion for their mental health concerns. However, very few were taught to see the utilization of such services as the campus counseling center as a viable option.

> ***Lisa***: . . . [A] lot of women weren't . . . they weren't brought up to say you can go get counseling. It was more. I mean, I know me and my friends, it was like "oh baby just pray about it." Go to church. Read your Bible. You know. Talk to God and it will get better. And I do agree but to a certain extent you need to go see a professional. But it's just, it's not something that is . . . I can't say accepted. But it's just not taught and it's not talked about. So, if you never know to do it and you never think it's acceptable, then why would you or how would you know to seek help.
>
> ***Kim***: I think it's kind of just what's taught in a lot of, you know, religious situations. It's either what's taught or maybe the way it's interpreted. I don't know if really that's the message that the pastors mean to send when they say

certain things. But I think that's definitely the way it's interpreted. You know, just go to him for everything. And that's it.

Ashley: I distinctly remember like our preacher, he was like, if you don't go to church then you will have those kind of issues because you don't have God. If you have God, you have everything and like nothing . . . and like you are going to have your trials and tribulations but if you have God then you won't have like those mental stuff. And I'm pretty sure he said like the reason a lot of people go to counselors like is because they don't have God and like if they just went to church they would be fine . . . But I've never like . . . before recently, I've never really felt that close to God and so I really couldn't relate to that and I think that's why like we think that since most of us at least in that particular community, people who actually go to church, they think that since you're in this community, in church, you shouldn't feel certain ways, because you should just be able to pray and it will better.

Audrey: . . . [F]amily will tend to say well, you know, when you're having these issues, you just need to pray about it . . . but I don't have the strength to do that. I don't even have the strength to get out of bed. . . . But, you know, like not getting out of the bed, not eating, just getting up to go to the restroom, you know, thinking about, you know, ways of like killing myself . . . getting on my knees and praying is the last thing I'm thinking of right now, 'cause you don't have the strength.

Since religion reinforced the imposed message of strength for many of the study participants, church became a place where they could go to plug into and enhance the strength that is required of them. Church became a support system that enabled them to go about their lives as strong Black women. Additionally, church also provided a place of communion that supplied a support system that they felt as though they could not find on their campuses or in a counselor's office. For example, Nicole, who felt as though she managed anxiety and depression, had never been to her campus counseling center but took advantage of events that she found supportive, such as workshops geared toward women in her church.

Nicole: . . . [T]his event basically was an event to encourage young women to remain positive, you know, remain strong in their relationships with God and ways to build your relationship and ways to stay positive as women in society. I would attend something like that to help me one, to build my relationship, continue to build my relationship with God and two, so that I can go and network with other women and kind of see, you know, there may be something that they may have that can help me, and there's something that I may have that can help

> them and just being around those type of people, we can kind of work together in a sense.

Nicole viewed her church events as a positive way of managing her mental health concerns. She also found a certain level of support in the relationships that she was able to develop with other women with whom she can receive as well as share advice. Alesia perceived the use of church and faith in a similar manner. She saw the communion and community of church to be a more appealing means by which to manage mental health concern than utilizing the services of a campus counselor or off-campus psychiatrist.

> ***Alesia***: . . . [T]here's more unity in the faith I think because, when you go out and seek professional help, you're alone. I'm going into this, this session on Friday by myself, completely by myself. And if I were to go to my mom and be like I want you to pray for me and I want us to pray together, that feels so different than going to a doctor's office.

This value placed on the communal quality of "the Black church" may be a lesson learned and internalized out of necessity. For those study participants who decided to combine their faith with the utilization of mental health services, they did so with the understanding that members of their community did not agree with their decision to seek help.

> ***Audrey***: The first time, um, I didn't go for it (counseling services) because family was encouraging me to um become stronger in my faith, seek God more than medicine, um so I didn't do it. But the second go around, I'm like, you know what, these people don't have to wake up and look in the mirror and deal with what I'm dealing with right now. I've gotta do whatever is going to get me through the day.

> ***Jane***: . . . I'm a pretty spiritual person. I do think it helps. I do think it helps but I think a lot of things that are around us are gifts from God, like medicine, . . . I do think that prayer and spirituality is a good way to deal with any kind of depression but you have to use other ways.

> ***Danielle***: I have one friend, she doesn't agree with me going to counseling. She's on her super religious kick at the moment and so she's on her "Well, no, you just need to pray and Jesus will help you through it and da da da." Which, yeah, I agree with that but I feel like he put people in place so we can get help when we need it.

> ***Naomi***: . . . [I]n the beginning I was like you know prayer is the answer to everything and it does help but I think that some people can take it a little too literally and you know one way that God does help us is providing the people with that have the skills to help us through certain things.

When mental health services were not available to the Black community, "the church traditionally assumed the role of mental health counselor" (Alexander & Poussaint, 2000, p. 105). Further, using the church as a support system eliminates the burden of paying for a counselor; an expense that several of the study participants saw as a financial burden that they were admittedly not willing to assume.

> ***Ashley***: I guess, it's because like for a while that's (the church) all we had. Like, all we really had was each other and going to church and praying. And I guess people think that should make things better or help and it really doesn't all the time.

> ***Alesia***: . . . God is free, point blank, God is free. So I mean . . . Think about it. God is free. When you feel tired, like you can't go on, you say Lord, Lord, help me. Lord, help me. Then you get up and you go do it and whether or not that's placebo and it comes from your brain, it's free. It's free.

When one considers the various ways in which the study participants were taught this message of strength, it would appear that the display of any form of perceivable weakness is a liability to one's ability to adhere to the imposed, expected, and internalized message of strength. In order for strength to be utilized as a strategy for combating the various forms of oppression that Black women face, study participants were encouraged to construct their mental health concerns in language that portrayed them as a personal shortcoming to overcome. As such, the second theme that emerged in the interview data was Weakness as a Liability.

Weakness as a Liability

The second theme discussed, Weakness as a Liability, arose in the experiences of the study participants and was evidenced through the manner in which they were blamed for their mental health concerns and criticized for not being strong enough to overcome them. The idea of mental health as a weakness is an imposed message that encouraged the study participants to

view their mental health concerns as character flaws, weaknesses, and, ultimately, liabilities to the perceived necessity for the image of strength to be portrayed at all times in the Black community. The perception of mental health as a weakness and, thus, a liability to the perceived necessity of strength is problematic because the perception of strength as necessary to combat oppression is expressed with language that is rooted in three claims of inferiority; that of Black inferiority, female inferiority, and cognitive inferiority.

Claims of Black inferiority, female inferiority, and cognitive inferiority are informed by racist, sexist, and ableist ideologies that construct Black people, women, and individuals deemed mentally disabled as deviant, subhuman, subservient, and imbecilic. Individually, each of these claims of inferiority oppresses marginalized groups by denigrating their worth and privileging dominant standards of normalcy. Generally, individuals with mental disabilities are perceived as incompetent and dangerous (Price, 2011). This perception has historically justified the vilification and incarceration of individuals with mental disabilities (Price, 2011). However, when claims of cognitive inferiority intersect claims of Black inferiority that once deemed Black people as biologically unfit for freedom from slavery, language is used to construct Black people with mental health concerns as lazy, feeble-minded, or crazy (Beauboeuf-Lafontant, 2008; Erevelles & Minear, 2010; hooks, 1993; Metzl, 2009; Nicki, 2001).

For individuals with mental health concerns, referring to someone as crazy "reinforces the belief that 'crazy' or mentally ill people are less than fully human and not deserving of respect" (Nicki, 2001, p. 87). The construction of laziness and feeblemindedness in Black people with mental health concerns are polar opposites of the racialized ways in which mental illness is interpreted as genius in some White men or acceptable feminine docility in some White women (Danquah, 1998; Beauboeuf-Lafontant, 2007). Instead, Black men with mental health concerns

are constructed as defiantly hostile (Metzl, 2009). For Black women with mental health concerns, their experiences are triply jeopardized by the intersecting claims of inferiority. As such, Black women with mental health concerns are constructed as weak (Beauboeuf-Lafontant, 2007; Danquah, 1998).

Study participants were encouraged to prove their ability and worth by tapping into their strength rather than challenging racist, sexist, and ableist claims of their inferiority. "The influence of racism in American culture has resulted in a topsy-turvy social construct in which some Blacks perpetuate the damning images that fuel a limited and counterproductive lexicon of stereotypes about authentic 'Blackness'" (Alexander & Poussaint, 2000, p. 104). When claims of inferiority are internalized, they give rise to cultural signifiers of "Blackness," such as strength, that aim to counteract oppressive claims of inferiority. However, when cultural signifiers of "Blackness" result in destructive behaviors such as self-silencing or exhaustive exertions of caregiving, oppressive claims of inferiority are ultimately reinforced. By being made to feel as though they were weak and somehow not "Black" enough, the study participants were encouraged to view their mental health concerns as imagined or as a personal weakness to overcome by tapping into their strength.

> ***Katherine***: I feel like when it comes to mental disorders, that's a topic or mental health, that's always a topic that, "oh, it's your fault." Whether it is alcoholism or depression or something bad. It's always like it's your fault. You are weak. . . . Like, I remember one experience when I was telling one of my friends because I had scars and she asked how and I told her I was a cutter and she was like 'Why? You're Black'. And she's Black too. . . . I feel like that stigma looking down on this health issue is 10 times worse like in my family. Like, it's "you're weak if you do this or you do that or you should be able to get through this or get through that." So no, my family doesn't know.

Katherine's comment suggested the racialized interpretation of mental illness that exists within the Black community. She continued:

> It's not just White people that make themselves throw up. It's not just White people that cut. It's not just White people who have this or that.

Again, Katherine expressed frustration with the deleterious ways in which mental illness is perceived in the Black community. When viewed as an "infliction" that is only experienced in the White community, mental illness becomes a divisive experience that separates Black women with mental health concerns from the normative culture and feminine expectation of the Black community. In addition to the false societal perception of Black women's indomitable strength, women such as Katherine shoulder the burden of either explaining to their family, friends, and community that Black women do struggle with mental health concerns or hiding their concerns and suffering in silence. Other study participants expressed similar experiences.

> ***Jane***: The mental health, like it has a lot of negative like stereotypes, like if you go to the therapist, you're crazy or something like that. People think you're crazy 'cause, if you weren't crazy, you wouldn't have to. I feel like that's definitely something a lot of Black people feel. I mean, if you can't handle it with your general strength that you have as a Black person then you've got to be like crazy.

> ***Susan***: I remember when I was seeing a therapist and uh taking medication, this would have been the late nineties. And it was almost like I was telling people that I was smoking crack. And Black people would have been more comfortable with me had I told them that I was smoking crack.

The racialized discourse employed in the quotes provided above suggests the overwhelming challenges faced by Black women with mental health concerns. Clearly, mental illness is constructed as a White person's illness or disease as illustrated in Katherine's friend's disbelief when Katherine disclosed herself, a Black female, as a cutter. Further, Susan's statement illustrates how normative discourses about acceptable Black behavior or experiences become constructed and internalized by individuals and communities. In her community, the image of a Black person with mental health concerns is a foreign idea; primarily understood as a concern only in White community. However, the image of a person smoking crack, though not acceptable, has become a normal and somewhat expected image in the Black community. Thus,

the existence of drug addiction becomes more normal than the existence of mental health concerns and ultimately stigmatizes mental illness in the Black community.

Once mental health concerns were internalized as a weakness to overcome and/or a White issue that is not experienced by Black individuals, the study participants were encouraged to not identify themselves as an individual suffering from a mental health concern or disability. Linton (1998) expressed the importance of naming one's disability in order to draw attention to the ways in which those living with a disability are "devalued and discriminated against" (p. 13). None of the study participants, however, fully identified as suffering from a disability and, thus, diminished the potential for drawing attention to other Black women who may suffer discrimination, ostracism, and stigmatization for experiencing similar concerns.

> ***Melissa***: I don't see it as a disability because a lot of people don't see it as a disability. But I would say it was a disability if it wasn't for other people because it does affect, you know, me. If I don't feel like getting out of bed, I don't get out of bed. So, it does affect you just like if you couldn't walk or talk or eat or see.
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> ***Kim***: . . . [M]aybe if I redefine disability but, I don't know. I just look at it as what? The inability to do something. I guess technically I might (have a disability) but I never considered that. I guess if we were to discuss it, I wouldn't disagree with it. But I wouldn't like classify myself with at person with a disability.

For many of the study participants, disability was still thought of only as a physical impairment that dramatically limits an individual from making a contribution to society. This is reflective of the general societal understanding of mental illness which is primarily articulated in terms informed by the medical model of disability.

Language has the power to influence, impact, and place mental illness in spaces that are either humane or inhumane. It has the power to construct mental illness in such a way that it is understood as deviant (unacceptable) or as a naturally occurring human difference (acceptable). However, when the medical language used to construct an understanding of mental illness is not

engaged or problematized, it traps societal understandings of mental illness in patient-oriented, subhuman terms such as ill, lacking, or deficient. Unfortunately, higher education institutions greatly rely on the medical terminology of the diagnostic and statistical manual of mental disorders (DSM) to inform their policies regarding members (faculty, staff, and students) of the campus population that identify as living with a mental illness. Based on the words of the study participants, it would appear that this understanding of mental illness has been internalized by many Black women.

> ***Alesia***: . . . I don't like to think of it like that. I don't think it's a disability because I'm breathing, I'm walking, I'm talking, I'm, I'm functioning like I'm not, you know. When I think disabled, I think I can't work, which I'm working; I can't do academic, which I'm doing. I don't think of it as a disability at all. I don't. It can be dis . . . you know . . . it can make me feel helpless but I wouldn't . . . I wouldn't say that I was.
>
> ***Christine***: I define disability, I always think of something physical. I never actually put any thought into mental . . . well, yeah mental is like, as far depression . . . 'cause I don't think of my depression. I get little spouts [*sic*] of depression. I don't think it is that serious. That doesn't define me as having a disability.
>
> ***Audrey***: . . . [Y]es, I see myself as, you know, having something that I need to work through but when you say disability, it almost sounds like there's a possibility that it may never go away. Um, or almost like a physical handicap sort of and I don't look at it that way.
>
> ***Anne***: . . . I think, when we think disability, we think okay, you know, physical handicap and . . . Is it a disability? Yes, it is. Do I feel like I have a disability? That's a yes . . . it's a grey area. Because it's like I've learned to deal with it but, in the grand scheme of things, if I'm really true and honest with myself, I'm like yes, I do have a disability. Yes, it would help me if I could have more time on my test. Or yes, it would help me if, you know, the person that's tapping their pencil to the side of me just quit because I really need quiet because I'm already so anxious about the test you know. So, I mean, there's definitely, when I look at it, yes, it is a disability because if I had certain accommodations then it would make my college experience a lot easier.

Though she struggled with truly acknowledging herself as having a disability, Anne, like many of the other study participants, claimed that she had "learned to deal" with her mental

health concerns and had not taken advantage of any on or off-campus services. According to Reynolds (as cited in Price, 2011), the increasing number of individuals who identify as living with a mental illness will be impacted by their vulnerability to the rhetoric of the medical heath care profession. Experiences such as Anne's illustrate the internalization of blame for one's mental health concerns, an idea that is heavily influenced by deficit understandings of disability. However, Price (2011) stated that, "mental disabilities are best understood in terms of variety and difference rather than 'yes/no' diagnoses" (p. 6) or "the deeply problematic nature of modern psychiatric discourse" (p. 15). Unfortunately, in the same way that strength is used to combat discrimination, the study participants utilize language to disassociate themselves from mental illness so as to not be discriminated against or aligned with the stigma that exists specifically in the Black community as well as within the general society. This is evident in the way that study participants spoke of "dealing" or "coping" with mental health concerns that they recognized only as hindrances to overcome.

> ***Michelle***: . . . I don't . . . it's not so bad that I need medication or a therapist or anything like that. It's just like every now and then, when it does hit me, it's like not normal "oh I just don't feel good today" but since it's not like every day, all the time, I feel like it's . . . I'm coping with it.
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> ***Nicole***: Although I do have moments where I'm stressed out, I don't struggle with depression, I never did. I was always a happy-go-lucky child. I do have moments though where like the nervous breakdown incident where I do tend to get to depressed. Where I do tend to get depressed but I don't use it as a clutch [*sic*] and I don't think it's an issue that I have to worry about.
>
> ***Danielle***: I don't think it's really inhibiting anything. It will take me longer to do it but I know it's something I can work through. And normally like even when I have like the anxiety attacks, they only last like for a minute or so and so I don't think it's really inhibiting me in any way.
>
> ***Ashley***: I mean I don't think, I don't know, I mean it can be debilitating when I just can't convince myself to get up in the morning but I don't consider it a disability. . . . I mean when you think of disabilities I think of people who can't do stuff like who can't walk or who can't like speak well but like this it's more like ah well I guess it could be. 'Cause I have a really hard time like staying happy,

> like I'll be happy like one day and then like for a month I'm just like I can't really stay happy very, very long and I guess it could be a disabled to be a happy person but I don't know if would still call it a disability. Maybe a hindrance not something as severe as . . . there's disability and there's hindrance.
>
> ***Rachel***: I don't think that it's anything that needs to be treated with medication, or anything that would be even a lifelong handicap. I think it's just something that I will always have to work through, since like I said I have always had some level of anxiety, but depending on the, you know, environment and the things that I was surrounding myself with, it would be more or less apparent to me or to other people. I think at this point, really, it's just about getting those feelings out and working through them and figuring out why or how to live with them. But I don't think that it is anything that would hinder me from any type of things that I would want to do.
>
> ***Alesia***: . . . I mean it's life, you're gonna have to deal with more than just yourself and so that's, that's probably why I'm gonna start pushing myself because that's when it'll become a disability, when I cannot do, you know when I can't organize a group of people to do this or I can't get feedback from this amount of people, you know when I can't do things like that then that's when it will become a disability and that's what I'm afraid of . . ..

By approaching their mental health concerns as a weakness or obstacle to be overcome, the study participants internalized the blame that comes from not exhibiting the strength that is expected of them by their communities. In her comments, Nicole talked about not using her disability or mental health concerns as a "clutch" [*sic*]. Her choice of words portray an attempt to disassociate herself from the general understanding of individuals living with hidden disabilities such as mental illness as unjustly entitled to unwarranted accommodations. Her disassociation is similar to the performance of strength as a means of combating racial stereotypes of laziness.

Ashley shared that she struggles to stay "happy." "The pressure on the disabled to be cheerful is particularly intense for people afflicted with mental illnesses to which depression is central, since for them the pressure to be cheerful requires a full-fledged denial of their disorders" (Nicki, 2001, p. 94). For Ashley, who had never been to a counselor but believed that she suffers from depression and anxiety, her desire to exude happiness was rooted in an ableist

understanding of depression; an understanding that fosters hostility toward those who are unable to move past their "bad moods."

Finally, though Rachel recognized that her environment contributed to her anxiety, she still insisted that it was up to her to overcome her mental health concerns. "Social structures based on able-mindedness, which marginalizes people with mental illnesses, and assume that they can simply 'snap out' of their conditions" are disabling (Nicki, 2001, p. 81). Repeatedly, study participants used language to disassociate themselves from disability which illustrates the pervasiveness of the internalized deficient understanding of mental illness that is informed by the medical model of disability. When combined with the message of strength, the stigma of mental health, perceived liability of weakness, and damaging language of disability, the study participants interacted in discriminatory educational settings with a mindset of proving that they were in fact capable, despite the multi-layered differences for which they were discriminated against. Within the confines of this understanding and performance of strength, any variation of human experience that contradicts strength and expresses vulnerability is construed as a weakness and a personal shortcoming to be conquered.

Committing to the mission of overcoming the perceivable obstacle of one's mental health concerns is the equivalent of striving for exceptionality in order to counteract racist, sexist, and ableist stereotypes of inability, incompetence and inferiority (Linton, 1998). Rather than being viewed as a naturally occurring human variation, mental disability, much like race and gender, is socially constructed in deficient terms that, once internalized, insists that individuals commit to self-defeating efforts of proving their worth while simultaneously being told that they have no worth.

> ***Anne***: And when you come to college, usually the people that come to college are the people that were in the top 30% of their class, you know, so you kind of

always had these expectations for yourself and then it's like okay well, I realize you have this disease or disability and this isn't going to stop me because you want to prove it to yourself. You wanna be like ok well, like I said, I'm not broken. I mean, I might have this disability, or this disease, or this disorder but, you know, I'm gonna show everybody else I can still perform, you know, there is nothing wrong with me.

Rachel: I think it's easier for them (non-Black Female students) to wear their concerns or speak about them, because uh, I know like the "strong Black Woman Syndrome." Like you don't want to appear weak in an environment where you are already always being told that you have to be 10 times better, and you have to prove yourself. Or it's all of these statistical numbers against you, and it's like you can't be like "I'm depressed today" or "I feel sad today".

Lisa: . . . [J]ust because I have issues doesn't mean that I'm not going to finish. I'm not gonna quit. Like, by any means necessary. I'm not gonna quit. So, whether I have to cry my whole way through or whatever it takes, I'm gonna finish. And, if I have anything to do with it, finish on time. So it's just . . . I've just always been a person to persevere.

Katherine: You know, they kind of see it as oh you have ADD, ADHD, you have this issue, you have that issue so you can't, I don't want to say you're weak but you can't perform on the same level as everyone else. And I don't think, I don't know if I am stubborn or I don't see myself as being like that and I am going to fight to the end of it whenever it comes.

Danielle: Uh, just because I have them doesn't mean I don't wanna be here because I think a lot of people have associated with 'Well, you know, if you're getting that stressed out and that worked up over it then you really don't want this or you don't want to be here or you probably shouldn't do this.' And that's not the truth. I mean, I feel like if you're working through it that shows that you really want to stay and you want to succeed.

As shown, a concerted effort is required from the study participants to counteract the stereotypes that are attached to vulnerability so that strength can be exhibited at all cost. The result is a vicious cycle of the performance of strength that results in greater levels of stress, anxiety, and psychological distress. For example, Kim, who was in a science-related graduate program, appeared to have internalized the message of proving herself as capable to the point that she struggled to ask for help or guidance from her professors.

. . . I feel like I'm saying that, I don't know. I just feel like I am saying like I'm, you know, like not smart enough to get this. I lack the ability. I sort of lack the

> ability to kind of, I don't know. It hurts my self-esteem to like ask for help. Even though really, in principle, my boss actually, he says this to me all the time, you know, you're not expected to know everything right now. But I . . . you know, I think I have created this kind of standard that I cannot get rid of for some reason. Like, I just can't. Like, it eats me up. I hate it.

For the study participants, mental health concerns were not acceptable within many of their communities and were considered frivolous complaints often associated with predominantly White communities. However, as seen in theme three, the Luxury of Lunacy, the ability to access mental health services was also largely impacted by socioeconomic status.

The Luxury of Lunacy

The third theme was the Luxury of Lunacy. When the image of impermeable strength is imposed, expected, and internalized, Black women become trapped within performances of strength that deny their true human subjectivity. This denial constructs the expression of any perceived vulnerability as a luxury not afforded to Black women. Trudier Harris (as cited in Beauboeuf-Lafontant, 2009) found that Black women who commit to superhuman performances of strength "have been denied the 'luxuries' of failure, nervous breakdowns, leisured existences or anything else that would suggest that they are complex, feeling human beings" (p. 45). As a result, mental health is compromised as Black women struggle to be all things to all people. In addition to this perception of mental health concerns as a luxury of expression, socioeconomic status constructs mental health concerns as a luxury available to those who have the financial means to explore treatment options.

According to Davis (1990), "poverty increases vulnerability to mental illness" (p. 21). Further, in their research on the politics of Black women's health, Hull et al. (1982) found that, in addition to racism and sexism, the effects of class oppression deprives Black women of decent health care and, as a result, makes them less healthy. Several of the study participants shared that cost hindered their access to services both on and off campus. For example, Danielle simply

stated that, since her on-campus counselor was more affordable, she had not explored the possibility of any off-campus services. Anne expressed that her status as a student allowed her to remain insured. However, in Anne's case, since her insurance covered the cost of her fibromyalgia medication, she did not believe that it would cover the additional expense of a psychiatrist so she did not utilize mental health services.

> ***Ashley***: . . . [T]hen there's also the issue of I don't know how you're supposed to pay for that (counseling). And then I don't wanna go in and then be like oh I can't afford this and leave so I just don't do it.
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> ***Katherine***: And then also like with money, I didn't want to be paying out of pocket for something.
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> ***Erica***: I just stopped (going to the campus counseling center) and I don't really have the money to go do that.

According to the study participants, mental health services were considered luxuries that only the wealthy can afford. As such, only the wealthy are able to truly acknowledge their mental health concerns. In addition to hindering access to services, financial concerns also contributed to a lack of academic focus and an increased predisposition toward depression. Lisa shared that it was difficult to care about making good grades "when you have to figure out how are you going to pay for a baby sitter so that you can go to work or how you're going to pay rent." Christine shared that most of her worries were financial and that she felt as though she will be judged in her new educational environment because of her socioeconomic background.

> Another thing that made me like kind of feel like depressed and things like that was like finances because I come from a background like my mom, she only completed high school and I don't remember what education level my dad completed. But, you know, I don't come from a wealthy background. Like, you know, I notice that a lot of my classmates or people I go to school with they come from a wealthy background or things like that. But I just worry about . . . I used to worry about am I gonna fit in. What would they think of me if they met my parents? Or how would they think?

Collins (1989) stated that "removing any one piece of the triad of race, gender or class from analysis seriously jeopardizes a full understanding of the experiences of any group of people" (p. 884). Class was an undeniable component of participant understanding of mental illness and utilization of on and off-campus mental health services. While some of the study participants recognized that, if not for the discounted services offered on their campus through offices like the counseling center, they would not have been able to afford treatment for their mental health concerns, other participants recognized that it was a combination of limited resources and community stigma that hindered them from taking advantage of mental health services. This included students who were covered by their parent's insurance because they did not want to admit to their parents or themselves that they had mental health concerns. Though she has never been to the campus counseling center, Alesia shared that she would not go off-campus to access mental health services because of cost and the need for parental permission. For example, Erica felt that, if someone doesn't have the means to go to a doctor, it didn't really make sense to talk about any issues that they may be facing.

> ***Katherine***: I feel like, I know my parents wouldn't pay for anything. So, I feel like that all has something to do with it too. Like, if you have a stigma in a community, in a racial community, you're not going to be willing to get help. You're not going to be willing to pay for it or to admit that you have a problem.
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> ***Naomi***: I think that actually being here helped because I was away from my family, I didn't have to be like hey mom, dad like I want to go see a shrink or something you know I could just on my own free will go to the counseling center who referred me to a therapist.
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> ***Susan***: I think that they don't seek mental health, especially minorities, because you grow up going to the doctor or the eye doctor or the dentist. The mental health part is not factored in there. And many times, even if you're having a little problem sleeping or some anxiety, that regular doctor is still just giving you something. But the counseling part of that is not in there. So, I don't really think that it's all about I'm a strong Black woman. I just think that that's another step. Another step beyond the normal steps that I'm taking. And I don't think that people, you know, that's a little bit different. Like, when I go to my regular doctor or to my OBGYN, they don't know that I'm going because I have an STD. They

> know that I'm just going there because, you know, it could be a pap-smear or I could be pregnant. I mean, it could be anything. But, you know, they don't know why I'm there. But when you go see a mental health practitioner, they know that you're there because you're dealing with a mental health issue. And I think that people are just sort of private about that kind of stuff.
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> ***Kim***: I think that mental health issues are looked down upon because I think it's more of a socioeconomic thing. I think it's because, you know, we've . . . at least where I come from, like, we were kind of too poor to look into or afford to be helped for like . . . it would have to be coming off. You know? It would have to really be a problem. So, the only time you saw someone getting psychiatric help was when they had fell off the deep end. I mean, deep deep end. We didn't really have the resources to get help for depression, you know what I am saying. Not unless you were like suicidal but not for depression. You know so, I think in order to cope with a . . . as a way of coping with that reality, you know, people just started to just assume you know, the only way you would be getting help from a psychiatrist or a counselor is if you are nuts. 'Cause that's what we saw, you didn't get help from . . . you didn't get that kind of help unless you were just crazy or you had a real real big problem.

Though the participants of this study were arguably privileged based on their access to and positioning within higher education institutions, study participants shared that, in addition to the pressure of their financial difficulties as students, they also faced additional pressures based on their family expectations, race, and gender. Some of the study participants expressed that, because of their status as first-generation college students, they felt pressure not to fail in any way. For example, Anne shared that the desire to acquire her graduate education was so that she could make a difference in her family as well as her community because many of them did not get the opportunity to go to college. Rachel also shared that, while she never thought of herself as a role model, she considered it to be "imperative" for her to finish her degree so that she could encourage family members to set similar goals. Alesia shared that she felt additional pressure because many of the relatives in her age range were unable to finish college because they either became pregnant or got involved with drugs and, as a result, she felt that her family had placed her on a pedestal and invested a great deal of hope in her future.

> I don't want to let them down, 'cause I feel like they're like I'm their only hope like I really do and it . . . I feel like I have to do all these things just to prove to them like, you, know hey you guys I'm doing this, this is . . . you know . . . the right thing to do and, you know, I'm just I just wanna show them which is, I'm such like a like a family pleaser, like I really just want them to be proud of me and I don't want to make mistakes which, which is weird cause it's gonna happen but I don't want to, 'cause I don't wanna have to like . . . God forbid that I make a mistake and they see it and they're just like thinking that I'm gonna became somebody that I'm not.

Alesia's commitment to her performance of ability and strength silenced her from sharing concerns about her academic experiences. In the process, she contributed to her own psychological distress. She did not have the luxury of her own thoughts or emotions. "It is healthy to give expression to a wide range of emotions. This is a form of positive thinking and action that can dramatically reduce stress" (hooks, 2005, p. 46). Self-expression has the potential to contribute to mental wellness but also present an accurate representation of Black womanhood that can be used to combat oppressive representations that insist on the portrayal of disingenuous performances of identity.

Mentorship and Mental Wellness

The fourth theme was Mentorship and Mental Wellness. Within the PWIs featured in this study, the faculty population was predominantly White and male. Such racial dynamics make it a challenge for Black female college students to find mentors who can relate to their experiences of racism and sexism. For the participants of this study, their experiences of isolation were exacerbated in many of their classes where they were the only person of color present.

> ***Rachel***: . . . I'm always the one African-American everywhere I go, but it's always like a running joke, and everyone feels like it always has to be mentioned. And being present in class, like with a room full of European-American students, I already know that I am the only African American student. And we study a lot of, you know, race relations and all of the stereotypes and things of that nature and just whenever anything comes up, it's always like "well, what do you think?" Or like, everyone like, the spotlight comes on me, and I'm like "I'm not the spokesperson for the AA community" because my experience is different.

Rachel's voice quivered and her hands shook anxiously as she shared her experiences. She continued; "What they (non-Black students) say is for them but what we (Black students) say is for every Black person in the United States." Feelings of isolation and frustration within predominantly White higher education institutions can exacerbate feelings of being singled-out or spotlighted; especially for Black women (Winkle-Wagner, 2009). Several study participants acknowledged the additional pressure that they felt because of their underrepresented status on campus. For example, Kim shared, "I don't think they (non-Black students) feel that kind of extra pressure to sort of represent their race." Similarly, Lisa shared that her feelings of constantly being reminded of her race and underrepresented status caused her additional stress as a student. The additional pressure of being underrepresented at a PWI institution repeatedly presented itself in the experiences of the study participants.

> ***Nicole***: I naturally feel that it's a must among myself, you know, it's expected of me as an African American female, you know, because people look at us as, you know, some people say that we are considered the lowest, you know, race and as far as being female, and so here at a predominately White institute, I feel that the pressure . . . there's more pressure on me to exceed higher than any other female of another race or any other male of another race or try to at least do my very best too. So, it's a lot of pressure and a lot of stress.
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> ***Audrey***: . . . [A]s a Black woman, like I said going back to those negative stereotypes, you know, or um, I sometimes, walking in a building even on campus, you know, all eyes on me. I'm natural, not straight, like I automatically think about, you know, what are they thinking? Like, what's going through their head, you know. Are people judging me before I even open my mouth? So, I think that just increases like especially with my issues in terms of like low self-esteem so . . . constantly thinking about what other people are thinking . . ..
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> ***Jane***: I mean like feel like our school particularly is segregated. I mean, it's kind of obviously when you look around so when you do interact . . . 'cause, I'm really active on campus and I do meet a lot of student leaders who might be White or might be something else and you do . . . I mean, I do immediately wonder what they think already before I open my mouth. Before I sound educated or before I even like, I don't know, like they might be some stereotype about my personality or the way I might present myself before I even do so that kind of causes me to be cautious even more so towards the other person because I might think that they . . . I might be stereotyping them and thinking they think that they feel a certain

way about me. I think that's a kind of internalization that a lot of Black women feel on our campus.

Rachel: It's so much attention like being an African American student here. It's like, it's so much attention on the fact that you are African American. And it's just like, that's your first point of entry in every conversation. And I know, you know, you can't take it off, and you can't. I mean, I'm proud to be a Black woman and all of those things, but it's just like everything doesn't have to be that, and every interaction doesn't have to be about that. . . . like my research focuses on marginalized groups, but that's not just race. (Laughs) And I think everyone thinks I just do race. And I think a lot of times the conversations that are had about specific things are only, like I'm only thought of being valuable when it comes to that. So, um, it's just being aware that you don't have to mention it for it to be there, and you don't have to . . . like it's either, it doesn't have to be completely ignored or completely included. And I think people seem to think that you have to do one or the other. And I don't think that is the case, because, you know, it's a part of my identity, and a very big part, so yes it is to be acknowledged, but it isn't to be focused on or be fixated on. And I think a lot of people either ignore it or fixate on it. And I think that either one of those makes it worse.

Anne: I think just being a Black female at a predominantly White institution is just, in itself, kind of, I don't know like, I feel like you're in a box because everything around you does not look like you. And you don't . . . you don't really see, you know, the university tries to say, okay they are trying to diversify but if you look on campus, you know, do you really see that many African American people here?

While the enrollment of diverse student populations continues to rise within higher education institutions, the development of inclusive academic environments are hindered by campus climate (Dahlvig, 2010). Anne's comment above speaks specifically to how inconsistencies between an espoused institutional mission and an actual intentional campus commitment to inclusivity damage campus climate for underrepresented student populations and increase anxiety and stress (Winkle-Wagner, 2009). "A sense of belonging can never exist because there is no personal or cultural fit between the experience of African American women and the dominant group" (Howard-Hamilton, 2003, p. 21). Micro-aggressions and perceivably mild or insufficient administrative management of discriminatory campus occurrences, such as the ones listed below, also contribute unwelcoming campus climates for Black women.

> ***Anne***: Well, when you have a university like the Civitan University where every semester or every year there's going to be a racial slur written on the side of the building and then you don't hear of any action that has been taken to rectify the situation, you know, it's almost like a joke, you know? I feel like we brush over the surface of the issues. We put a band aid on it and we really just don't know that underneath is some stuff bubbling and boiling over, you know. So, you can't . . . in a way you're guarded and you can't let your guard down cause you really don't know some of the people that you're talking to cause they might be closeted racists.
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> ***Kim***: And then like, I remember, you know, just little things happen. I remember walking into the mailroom and hearing two professors discuss . . . basically, it was "we don't have to allow any minorities in this year" or something. It was like relief. Like I forgot what the subject matter was but they were talking about the fact that in their new roster of grad students, they didn't have any minorities, like they didn't have to 'cause they had enough. You know . . . It was little stuff like that. And then, also a stressful factor is the fact that the other two (Black) girls that I came in with, it wasn't for them. So, they ended up doing very badly and then leaving. Which also, kind of, put me in an awkward position. It's like just made me feel like, ok, I have to perform now.

Psychological and emotional support was one of the four areas identified by Nora and Crisp (2007) that comprise a concept of mentoring. "Due to the disproportionately low number of African American faculty at PWIs, African American students have few same race-role models or mentors available to them" (Dahlvig, 2010, p. 372). This is especially challenging for Black female college students who, according to Jackson, Kite, and Branscombe (as cited in Dahlvig, 2010), place importance on race and gender when deciding on and selecting mentors. Study participants expressed difficulty in finding diverse faculty mentors that could potentially relate to their experiences on campus.

> ***Anne***: I've been in classes where I'm the only African American person period. And when you see faculty, most of my, the faculty aren't African American so when you're trying to cultivate those relationships and if you think that you're, you know, having mental issue or a concern . . . a mental health concern, who do you talk to?
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> ***Rachel***: I guess you can say that it is rather difficult, because you don't really know who to talk you, and if your concerns are race specific concerns, or if you are feeling a certain way about the interactions you are having on campus or with other people. Like, there is no one in your department to really talk to or about,

> because no one has that experience, especially if you have a major or in a department where you are one of the only ones, or the only one. I guess you can say that it is added stress. . . . Like my advisor, she's a sweetheart, but it's so many degrees of separation between us. So it's like, as an older White woman, and me being a young Black woman, and us coming from two very different spaces, like if I, you know, I'm sure she would listen and she would be understanding, but it's not, the conversation would be mostly me explaining why and when and how, more so than talking through it. It's more leaning toward me explaining what it is I'm talking about. Instead of just being like "it's hard being a Black woman on campus" and the other person be like "I know." (Laughs)
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> ***Danielle***: . . . [S]ometimes I wish I could go like to my professors or really good friends and try to explain it but when it comes to being like a Black female, um, sometimes I feel like it's an outside and you don't have that person that you can really go talk to. I don't think we have one Black professor in the department. And then like, when the professors try to sympathize, it's amusing at some points. 'Cause you like know that they don't understand what you're going through but seeing them try I guess is a positive.

Kim, who had never been to an on or off-campus counselor but who believed that she suffered from depression, anxiety, and anger, was especially vocal about the potential amelioration effects of mentorship on mental wellness. Before beginning graduate school, she shared that her undergraduate professors were mostly White and, as a result, she felt ill-equipped for the race-related stress she experienced within her new academic department. She shared; "Nobody addressed the possibility that I might get stressed out, that it might be different for me being an African American woman in an all-White department because they were White." However, within her new graduate institution, she describes a Black female scientist who, though a mentor because of her presence alone, maintains such an impenetrable sense of professionalism that Kim feels compelled to portray a similar act of professionalism. This performance of professionalism is similar to the performance of strength described by many of the study participants because it does not allow for the expression of vulnerability.

According to Price (2011), "ableism contributes to the construction of a rigid, elitist, hierarchical, and inhumane academic system" (p. 8). By treating mental distress or disability as a

marker of defectiveness rather than a normal human variation worthy of inclusiveness, higher education institutions encourage performances of professionalism that coincide with the performances of strength in Black women and intensify feelings such as stress, anxiety, and depression. Kim, like many other study participants, struggled to find mentors who felt comfortable fully expressing themselves and their experiences. She did, however, find this kind of exchange with a former student. She became acquainted with a Black female who graduated from Civitan University with a science-related graduate degree. As Kim shared her experiences with this newfound mentor, she expressed her admiration of the candor and encouragement that her new mentor expressed.

> ***Kim***: I look up to her and she was actually able to put aside her professional sort of. I was able to catch her outside of this place, and she showed herself to me. And she showed me that, you know, we were just alike. She was going through it just like me. But you catch her here, she's like a brick. She got it all together. But, um, if you catch her outside, you know, she may cry or anything. She got all kind of stuff going on. . . . She just talked; she started talking and started talking about everything, you know. Things she was experiencing with her advisor, things she was experiencing with her committee members or fellow colleagues in the professional stuff. And then she started talking about her personal life, you know. And I was like, you know, wow. She started talking about, honestly, her mental health issues, you know. She's depressed, or she's sad or she's afraid that, you know, this may not happen or, you know, she feels like. She just started talking a lot about her feelings and the things she was going through. And that was like one of the first times I felt like somebody I actually looked up to and has actually gotten to where I want to be on some level. Wow, she actually is like me, you know. She actually is like I am inside.

While Kim benefited from her exchange with this former student, it was evident that this student felt compelled to portray a performance of professionalism within the academic setting of her alma mater (Civitan University) that required a suppression of her human subjectivity. Again, this mirrors the performance of strength in occurrence and consequence.

In her research on mentoring African American women at PWI, Dahlvig (2010) shared that "race can be a confounding factor in developing trust and establishing a mentoring

relationship" (p. 371). For Black students who have little or no access to mentors of color, participation in minority-focused student organizations or programs can serve as social counterspaces that are both hospitable and supportive (Howard-Hamilton, 2003). While Kim benefited from her relationship with a Black female alumna, she also found support in her participation in student organizations. She explained, "It keeps your mind in the academic setting but it kind of takes you out of this stifling, kind of all White male dominant environment". Rachel did not speak specifically about participation in a student organization. However, she did speak about the benefits of having other minority students to confide in.

> ***Rachel***: . . . [O]ther minority students . . . of course, most of them are in other departments, but you experience the same things, some of the same things. And even though, I mean, I don't know if they have feelings of anxiety or depressing feelings or sadness or anything like that, but just talking to them about just experiences and swapping stories and knowing that you are not the only one going through it, like, of course, the world, but in the very university that you're in. So, it's not like you're alone in whatever is going on.

Rachel, when unable to find an appropriate faculty mentor, relied on her interactions with fellow minority students to vent her frustrations and find solace. "The primary emphasis of the counterspace is on finding shelter from the daily torrent of microaggressions and to be in a place that is validating and supportive" (Howard-Hamilton, 2003, p. 23). However, these interactions, though supportive, do little to challenge the structural inequalities that exist in their academic environments or society at large. Instead, Black women continue to garner the strength they are socialized to have in order to combat oppression in their academic and non-academic communities. As a result, socio-political conditions of racism, sexism, and ableism persist unchallenged and continue to damage the psyches, weaken the body, and murder the spirit of Black women.

Spirit-Murdering Silence

According to Williams (1997), the spirits of Black women can gradually be slaughtered through subtle psychological assaults or micro-aggressions that are informed by racist and sexist ideologies (Alexander-Floyd, 2010). Described as no less detrimental than physical murder, "spirit-murder" produces "a system of formalized distortions of thought" as well as "social structures centered around fear and hate" (Williams, 1997, p. 234). The narratives of the study participants revealed that strength is taught as a necessity for combating dehumanizing claims of their inferiority. However, Williams (1997) shared that "Blacks are conditioned from infancy to see in themselves only what others who despise them see" (p. 233). As such, the study participants have been socialized to see in themselves the same inferiority that they are being taught to combat with strength. Further, their commitment to the performance of strength suppresses questions about their self-worth and hinders their ability to engage and challenge their oppressive environments. In so doing, they inadvertently perpetuate the cycle of structural inequalities that disadvantage Black women, normalize struggle, and obstruct the expression of accurate representations of Black womanhood. Ultimately, such silences do not protect Black women nor do they dispel ignorance (Gilmore, 2003; Lorde, 1984). In order for Black women to challenge the oppressive stereotypes that they navigate daily, they must first define themselves for themselves.

As demonstrated in the previously presented themes, most of the study participants had chosen not to disclose their mental health concerns and, instead, to remain silent about their concerns both within their communities as well as the PWIs where they study. This strategy of silence has a long history in the Black community; particularly in the ways in which Black mothers socialize their daughters. The role of Black mothers is central to the socialization of

ensuing generations of Black men and women (Collins, 1986). "African American parents socialize their children based on cultural and political interpretations and assumptions derived from their lived experience of being Black in White America" (Ward, 1996, p. 86). However, it has been found that Black youth, and especially Black girls, are mothered as well as other-mothered (Ward, 1996).

James (as cited in O'Reilly, 2004) defined other-mothering "as acceptance of responsibility for a child not one's own, in an arrangement that may or may not be formal" (p. 5). In essence, other-mother figures in the community serve as extended networks of support and assist in the socialization of girls toward communal and societal expectations. "Historically, Black daughters have been socialized toward both traditional (care and nurturing wife and mother) and nontraditional roles (worker and employee)" (Ward, 1996, p. 89). However, when Black girls are socialized to exhibit impermeable strength in response to various claims of inferiority, they are "socialized to respect fear more than (their) own needs for language and definition" (Lorde, 1984, p. 44). This results in immobilizing, spirit-murdering silence of truthful representations of Black womanhood. Nonetheless, study participants shared stories of socialization that resulted in this type of silence. For example, Angela was taught by her mother not to discuss personal business. Her mother went as far as to punish her and her siblings if they were seen as discussing household occurrences outside of the home, even if it was shared with other relatives.

> . . . [W]ell when I was growing up I was taught, you know, you keep your family business private. You know, what you're going through, you keep it private . . . in the house. You keep it private, so you don't talk to other people about it; you don't put your business out like that.

Angela, who had never seen an on or off-campus counselor for her mental health concerns, apparently took her mother's advice to heart. She spoke candidly about hiding her mental health

concerns. One of the ways that Angela hid her mental health concerns was by staying busy with school work. She described taking online classes during the summer while she was not on campus because it took her mind off of her mental health concerns. In this sense, staying busy is a strategy that is characteristic of Black women who have internalized a commitment to the portrayal of strength that silences them away from their concerns.

> If you're trying to identify depression in Black women, one of the first things to look for is a woman who is working very hard and seems disconnected from her own needs. She may be busy around the clock, constantly on the go, unable to relax, and often compromising her sleep for household, child-care, and job tasks that she feels impelled to take care of. Not taking the time to tend to herself makes her more vulnerable to depression. Or her busyness may be a way to keep her mind off of the feelings of sadness that have already arisen. (Shorter-Green as cited in Beauboeuf-Lafontant, 2008, p. 394)

Despite the counter-productiveness of silence to mental wellness, other study participants shared similar experiences of being taught the strategy of silence. For example, Ashley perceived that she has a harder time managing her mental health concerns because "not many people in our community really talk about stuff like this." When she attempted to express her concerns to her parents, Ashley was silenced with the insistence that she would "get over it." Christine shared how she learned a similar lesson by watching her mother.

> ***Christine***: She always tries to keep a smile on her face when she's out in public. And you just can't . . . If you show that you're like, not inferior, that's a bad choice of words but like, if you're vulnerable or something like that, people will prey on that. They will take advantage of you. But if you put that smile, they're not gonna know what's going on; what's wrong with you.

It is both interesting and revealing that Christine would inadvertently use the word inferior in an attempt to describe vulnerability. In a sense, it is as though she perceived her performance of strength as a necessary tool for combating discriminatory assumptions of her as being inferior. However, such a performance also kept her from expressing her mental health concerns. The result of her action was silence. Danielle was taught a similar lesson. However, unlike many of

the other study participants, she decided to visit her on-campus counseling center and found their services beneficial.

> . . . I realize that one of the things that you're taught I guess um that you're supposed to be strong and that you can make it through anything and that you're not supposed to go to people unless it's like for help. You keep your private business your private business. Um, but after I went (to the counseling center), I'm really happy I did.

Silence is also the result of the perceivably internalized message of strength in the communities of the study participants. As previously explained, mental health concerns are perceived in many Black communities as a problem that only White people experience, specifically frivolous White women (Beauboeuf-Lafontant, 2008; hooks, 1993). Within the parameters of this perception of mental health in the Black community, accessing mental health services places the study participants at odds with what is expected and culturally acceptable for strong Black women. As a result, study participants found limited, if any at all, safe spaces in which to express their own mental health concern. Once again, silence was encouraged.

Black women are encouraged to hide their mental health concerns to their own detriment. Katherine, for example, shared, "I have hidden it (mental health concerns) for so long or have just been fighting through it and then it just feels normal now." In essence, Katherine, who at the time of the study utilized the services of mental health professionals for depression and suicidal ideations, normalized her mental health concerns; concerns that she still had not disclosed to her family.

The use of silence was also encouraged in the families of the study participants by ignoring the possible existence of mental health concerns altogether. Twelve (60%) of the study participants expressed concern about unspoken family histories with mental health concerns. Though these unspoken family histories shared the characteristic of silence, they were all expressed in different ways. For example, Alesia, Sarah, Michelle, Naomi, and Melissa all had

relatives who exhibited characteristics of depression and obsessive compulsive disorder (OCD). Naomi's sister even attempted suicide. However, despite the apparent severity of some of these characteristics, the possible existence of a treatable mental health concern was never discussed among the participant's families nor was the possible need to take advantage of the services of a mental health professional. Instead, such characteristics were dismissively attributed to personality quirks that merited no serious consideration. According to Alesia, who had a grandfather and aunt whom she believed exhibit characteristics of OCD, once a relative becomes good at hiding their mental differences, other relatives begin to believe that it truly is not a problem to address.

> They are just so good at hiding it. They're so good at it. Like I said, the only reason why I know my granddad is (hoarding) cause I'm close to him and I, I do the same things so I would be able to pick it out. And my aunt, she's just the hummingbird. She's the one who, you know, cleans up when she comes to my grandma's house, she has the cleanest house, you know.

Alesia, who was among the five (25%) study participants who specifically expressed concern that their mental health concerns could unknowingly be the result of hereditary traits, felt as though she was silenced and encouraged to not acknowledge her own mental health concerns, because she did not want to be seen as weak for not managing her concerns in silence in the same way her relatives had for their entire lives. Anne shared that she and her mother basically had to force her father to seek treatment for his concerns and it was not until she was in college that she learned that her own grandfather had been taking antidepressants for years. When her father finally agreed to be seen by a mental health professional, he was diagnosed but still refused to take his medication consistently.

> . . . [W]hen you have generations of it and no one talked about it, so I just kind of felt like, okay, I'm the over-anxious one, even though I could see it in my family, I was like well, everybody else is dealing so, you know, I should be dealing, too. But, not knowing that everyone else was having issues and I was in college before

> I found out ok, they were just doing something about it but they weren't speaking to other family members about it, it was just hush-hush, it was untold.

Anne and Alesia both found themselves encouraged by their family's actions to cope with their mental health concerns in silence. While the purpose of this tactic of silence was not articulated in the communities of the study participants, based on excerpts from previous interviews, it can nonetheless be interpreted as a technique for displaying impermeable strength. Only Jane, who converted to a new religion in college, linked her family's unwillingness to accept mental health concerns as a treatable condition to a mistrust of White mental health professionals; a mistrust fueled by their religious views. As a result, she chose not to share her concerns with her family.

> My family is like Nation of Islam Black people. Like, they have, like really, like, I don't know, like separatist views a little bit. And that's why a lot of the stuff I feel, I think now is not really consistent with how I grew up. But, like it's this concept of, "how would a White person know how to help you when they don't even know understand what it's like to be Black." So, it's like, most therapists are viewed as going to be this White person, sitting there, scrutinizing your situation.

In order to maintain the application of a CRF and DS lens to the findings of this study, it is important to note that the mistrust that Jane's family had toward mental health professionals may well be culturally informed by historically discriminatory medical instances such as the Tuskegee experiment, the 1960s' pathologization of Black male civil rights activists as mentally ill, or the sterilization of Black women thought to be mentally retarded (Goodwin, 2003; Metzl, 2009; Ward, Clark, & Heidrich, 2009). "Furthermore, a lack of cultural awareness plagues the mental health field and most mental health professionals make no efforts to allow racial bias in their practice" (Heath, 2006, p. 164). Such occurrences continue to inform the cultural mistrust of institutional forms of healthcare services that exists in some areas of the Black community.

The utilization of silence as a strategy to adhere to the communal and societal expectation of strength in Black women encourages a commitment to the performance of strength that

portrays them as mere racists and patriarchal "caricatures of their true selves" (Harris-Lacewell, 2001, p. 2).

> ***Alesia***: . . . I've recently, probably about in about the past year or so, become obsessed with elephants. Because I think, it's gonna sound weird, but they're a lot like, they're a lot like Black people. Like, you see an elephant and you're like "oh my God. That's a big ass elephant." (Laughter) Ain't nobody about to mess with that elephant. That elephant's the shit. It can do what it wants. But, if you get an elephant by itself, it's helpless. Like, they don't like being alone. They're social. They're sensitive. They're . . . they're really, really intelligent. And I just feel like that's how, that's how I am. Like, if were to walk down the street with my hair like it normally is, which is like this big curly ass afro, some bright ass clothes, some wedges, and I don't even have to open my mouth and everyone's like clearly, people have told me this, they've seen me and they're clearly, ain't nobody messing with her. (Laughter) Clearly. You got it all together, she is A ok. But on the inside I'm like, oh my God, I'm so stressed out. Oh God, somebody help me . . ..

> ***Audrey***: . . . I find myself kind of becoming that . . . I can be that angry Black woman when I feel disrespected. And a lot of people say well, you know, that's, when you get angry, you're so out of character. You shouldn't behave that way or you shouldn't do this or you shouldn't do that. And I think because I have been hurt so many times, um, the only way to get people to back off of me is to be angry. But on the inside I would just love to just ball up and just cry and just be like you really hurt my feelings, or like you really disrespected me. But people don't respond well to tears. They see that as a sign of weakness. . . . And even dealing with my Black peers, you know, crying is just kind of like, what? Like, you're a wuss.

Alesia and Audrey both portrayed a performance of strength that hid their true self-expression and masked their mental distress. Silence isolates Black women from expressing their true selves to others and ultimately serves to sustain racist, sexist, and ableist interlocking systems of domination (hooks, 1990). The limited availability of accurate representations of Black women's multifaceted experiences is deleterious to the experiences of the study participants who identify as being Black women who suffer from mental health concerns.

Once the insistence of using the strategy of silence to adhere to the message of strength is internalized, strength becomes a performance that hinders the study participants from taking advantage of mental health services, or even fully acknowledging their mental health concerns.

> ***Christine***: I don't want you to know I am struggling with something. Or, if I'm depressed, I don't want you to know that I'm depressed. I always try to go with a smile on my face everywhere I go.
>
> ***Katherine***: Like, I have never been the one to show any weakness. If I am upset about something, that's just who I've been. It's always; I just put on a character. So, I think that, in some sense, it is, I don't want to say I try my hardest to but it's kind of just how it is, that I just kind of hide it.

This desire to hide one's struggles is also a strategy for resisting negative stereotyping that is often the result of the stigma that is associated with mental health concerns. For example, Melissa, who was prescribed anxiety medication to cope with her suicidal ideations, had not shared her mental health concerns with others specifically because she did not want to be judged or feared. Instead, she used silence because "I didn't want them (others) to be afraid so I just kept it hidden." Other study participants took similar measures to avoid association with the stigma of mental health. However, unfortunately, this avoidance also led some of the study participants to not access services such as their campus counseling centers or to confide in professionals such as professors who could have potentially served as a support system.

> ***Susan***: That . . . that's a really private thing that people don't want to talk about. And seeking help just makes you talk about it. It makes you deal with it. And I think that maybe emotionally, you're not ready to deal with it. I mean, no Black woman wants to be painted with the crazy brush.
>
> ***Anne***: I think it's just like it's really personal. It's like it stigmatizes you and I guess that's another sense why I haven't told most . . . 'cause I do have faculty that I'm close to, maybe not as close to as I am with my research mentor, but I never want people to feel like I cannot do something because they are worried about my mental capabilities or my faculties. And I feel like that is why I haven't, you know, told most of the faculty that I'm around because I don't want anybody to give me any kind of concessions as far as they think I can't handle it. . . . And I don't want people to approach me like I'm broken, you know. I want them to know I'm a whole person but, you know, I do have these anxiety issues and yes, it does come up from time to time but that doesn't change the person that I am. I'm still capable of a grueling research, you know, career. And I think that's a lot of the problem with it, because there's so much misinformation and just not a lot of education about it that, you know, I don't want to confide in the wrong person and then I'm stigmatized.

> ***Katherine***: I think it's the stigma with like mental health issues and I think it is also like since I have hidden it for so long and no one else knows so coming out now would be kind of like blind side people. And I don't want to do that.

The five themes presented (Strength as a Necessity, Weakness as a Liability, the Luxury of Lunacy, Mentorship and Mental Wellness, and Spirit-Murdering Silence) relate to the experiences of the study participants who self-identified as Black female college students with mental health concerns at a PWI. The presented themes speak to the multiple factors that impacted the identities of the study participants through sociocultural messages that were communicated and implemented in their lives.

CHAPTER V

DISCUSSION

The purpose of this study was to describe, examine, and learn from the experiences of Black female college students with mental health concerns at a PWI. In so doing, I sought to consider how race, class, gender, and ability intersected in the lives of the study participants. Interview transcripts from 20 Black female college students enrolled in two PWIs were used to explore the research questions articulated in Chapter III. Data were collected through in-person interviews that utilized open-ended and semi-structured questions. CRF and DS proved to be appropriate theoretical frameworks to guide the parameters of this study because of their recognition of the centrality of racism, sexism, classism, and ableism within institutions such as PWIs. In addition, CRF and DS assisted in the development of counter-stories that constructed representations of Black womanhood that blur mental illness and encourage a consideration of the complexity of how mental illness is understood within society and how that understanding ultimately impacts policy such as the diagnostic and statistical manual of mental disorders (DSM).

The following research questions guided the study:

1. What are the experiences of Black female college students with mental health concerns at a predominantly White institution? (Primary Question)

2. What impact do mental health concerns have on the academic experiences of Black female college students at a predominantly White institution? (Sub-question #1)

3. What formal and informal methods of support do Black female college students with mental health concerns at a predominantly White institution access? (Sub-question #2)

4. How do the intersections of race and gender affect the college experiences of Black female college students with mental health concerns at a predominantly White institution? (Sub-question #3)

In this chapter, I will discuss how the findings of my study answered each of these questions. I will focus particularly the experience of Black female college students living with mental health concerns, the academic experiences of Black female college students with mental health concerns, and formal and informal methods of support utilized by Black female college students with mental health concerns. I will also examine how the medical model of disability contributed to rhetoric that traps the study participants in a discourse of weakness and deficiency in the lives of Black female college students with mental health concerns.

Each of the study participants had different and varying life experiences; thus any attempts to generalize about the influence of race, class, gender, or ability on the lives of each participant would be fruitless. However, at some point, they all found themselves immobilized by the realization of the expectations placed on them, both within their communities and the larger dominant community, by the intersection of racism, sexism, classism, and ableism. The themes presented (Strength as a Necessity, Weakness as a Liability, the Luxury of Lunacy, Mentorship and Mental Wellness, and Spirit-Murdering Silence) each, in its own way, was therefore the result of a life lived always on guard, which in turn perpetuated a cycle of oppression and marginalization.

Living at the Intersection of Race, Gender and Mental Illness

In order to explore the experiences of the study participants, the primary research question was combined with sub-question number three. This allowed for a thorough consideration of the intersection of race, gender, and mental illness in the lives of the study participants. Race, gender, and disability are all socially constructed. When viewed through CRF and DS, race, gender, and disability are viewed as human variations that have been constructed in deficient and inferior ways by the dominant society. Having internalized various claims of inferiority, many of the participants of this study committed to performances that compromised their mental wellness. However, as understood by CRF and DS, the danger came when these various aspects of an individual's human variation was viewed in opposition to one another.

For most of the study participants, they did not identify as being a part of a disability community despite the fact that they identified as having mental health concerns. It would appear that this is the case due to the rejection of any additional claims of inferiority that may be linked to mental illness. For example, Melissa stated that, after historically being discriminated against because of race, "we don't want to give people a reason to put us down." When race, gender, and ability intersected in the lives of the study participants, it trapped them within three different claims of inferiority: Black inferiority, female inferiority, and cognitive inferiority.

Racist, sexist, and ableist ideologies informed claims of Black, female, and cognitive inferiority that limited the ability of the study participants to freely express their intersecting and unique identities. Such ideologies construct Black people, women, and those deemed mentally disabled in deviant, subhuman, and subservient ways and privileged dominant standards of normalcy. However, unlike race and gender, mental health concerns are not visible and thus can be hidden from those who would use mental health concerns as justification for intentional and

unintentional discrimination. When claims of cognitive inferiority intersect claims of Black inferiority that once deemed Black people as biologically unfit for freedom from slavery, language is used to construct Black people with mental health concerns as lazy, feeble-minded, or crazy (Beauboeuf-Lafontant, 2008; Erevelles & Minear, 2010; hooks, 1993; Metzl, 2009; Nicki, 2001). Black women with mental health concerns are further jeopardized by claims of female inferiority and, as such, are constructed as weak (Beauboeuf-Lafontant, 2007; Danquah, 1998).

Identity is a perfect synthesis of individual characteristics that fluctuates, moves, and morphs depending on one's environment. In her essay, "Age, Race, Class and Sex: Women Redefining Difference," Audre Lorde (1984) clearly stated that her positioning as a Black woman, lesbian, and feminist equally informed and constructed her identity.

> I find that I am constantly being encouraged to pluck out some one aspect of myself and present this as the meaningful whole, eclipsing or denying the other parts of self. But this is a destructive and fragmenting way to live. My fullest concentration of energy is available to me only when I integrate all the parts of who I am, openly, allowing power from particular sources of my living to flow back and forth freely through all my different selves, without the restrictions of externally imposed definition. (Lorde, 1984, pp. 120-121)

Taunya Lovell Banks (1997) expressed a comparable sentiment when she shared, "My life stories influence my perspective, a perspective unable to function within a single paradigm because I am too many things at one time" (p. 99). Similarly, the experiences of the study participants cannot be understood by isolating the various aspects of their personalities. Instead, race, gender, and disability must be understood in relation to each other. This can only be accomplished when accurate representations of Black womanhood are presented.

When negative self-images are internalized, damaging strategies are implemented to defeat one's perceived shortcomings. For the participants of this study, strength was a strategy for combating the various forms of oppression that Black women face and presenting a representation of Black female competence in a society that discredits their faculties, doubts their potential, and devalues their worth. However, for the Black women who participated in this study, strength was not a true representation of their personhood. Ashley viewed the idea and expectation of impermeable strength in Black women as "unfair" and "unrealistic," insisting instead that "that's just not who I am. Like, I try to be strong but it just doesn't work." Similarly, Kim shared that, while she did not see herself as a strong Black woman, she aspired to be one and believed that it was "the only option" for her. "Surviving oppression can leave a legacy of distress and difficulty, and those who appear most strident and strong in the political arena can carry a burden of self-hatred and internalized oppression which makes psycho-social fulfillment precarious and problematic" (Shakespeare, 1996, p. 103). In essence, a false portrayal of strength in the study participants served as an indicator of the internalization of various claims of inferiority.

In addition to the strategy of strength, many participants also spoke of "dealing with," "coping" or "handling" their mental health concerns. For example, Michelle dismissively shared that she was coping with her mental health concerns and that they were "not so bad." Nicole shared that she did not think her depression was an issue and did not want to use it as a clutch [*sic*] while Danielle insisted that her mental health concerns were "something I can work through." Shakespeare (1996) described this strategy as a form of denial that ultimately seeks to overcome one's perceived shortcomings. "When disabled people internalize the demand to 'overcome' rather than demand social change, they shoulder the same kind of exhausting and

self-defeating ‘Super Mom’ burden that feminists have analyzed” (Linton, 1998, p. 18). The strategy to “overcome” is problematic for a number of reasons.

Rather than challenge the rhetoric that articulates individuals with mental health concerns as subhuman, the strategy to “overcome” urges them to prove their worth by exerting efforts to adhere to an imagined idea of normalcy. Many of the study participants spoke of proving themselves. During her interview, Kim shared “as a minority, period, you have to kind of prove yourself.” Alesia admitted that her mental health concerns could be difficult at times but, according to her, “I try to get over it.” Anne shared that her mother taught her to prove people wrong when they doubted her ability. While she committed to proving her doubters wrong, Anne also admitted that, because of her mental health concerns, she felt as though she had to prove to herself that her concerns would not stop her from achieving her goals. However, Linton (1998) expressed the distress that individuals are trapped in when they seek to prove themselves.

> The expression (to overcome) is similar in tone to the phrase that was once more commonly used to describe an African American who was considered exceptional in some way: “He/she is a credit to his/her race.” The implication of this phrase is that the “race” is somehow discredited and needs people with extraordinary talent to give the group the credibility that it otherwise lacks. In either case, talking about the person who is African American or talking about the person with a disability, these phrases are often said with the intention of complimenting someone. The compliment has a double edge. To accept it, one must accept the implication that the group is inferior and that the individual is unlike others in that group. (p. 18)

Strength and the strategy to “overcome” are postures for coping that Black women are socialized to portray but that ultimately “involve psychological processes that allow one to deflect the effects of negative external estimations of worth” (Banks & Kohn-Wood, 2002, p. 179). In order for Black women with mental health concerns to shift their understanding of disability away from the generally accepted medical understanding to one that fosters a health self-identity, they must undergo what Shakespeare (1998) describes as a “coming out” process. “This ‘coming out’

is the process of positive self-identification, rejecting the cateorgization of subjection, and affirming subjectivity and collective power" (Shakespeare, 1998, p. 100). For Black women with mental health concerns, the process of self-definition replaces negative images of self and recognizes multiple identities such as race, gender, and ability as interlocking components of Black women's multi-faceted identity (Howard-Hamilton, 2003). With this in mind, self-identification is greatly supported by the ideas espoused by CRF.

From a CRF standpoint, "defining and valuing one's consciousness of one's own self-defined standpoint in the face of images that foster a self-definition as the objectified 'other' is an important way of resisting the dehumanization essential to systems of domination" (Collins, 1986, p. 179). For Black women, self-definition is a source of strength and survival that encompasses emancipatory possibilities (Howard-Hamilton, 2003; Hull et al., 1982). According to Collins (1986), "self-definition involves challenging the political knowledge-validation process that has resulted in externally-defined, stereotypical images of Afro-American womanhood" and "self-valuation stresses the content of Black women's self-definitions—namely, replacing externally-derived images with authentic Black female images" (pp. 177-178). In order for Black female college students with mental health concerns to define themselves, they must first develop what hooks described as a "counter-system of valuation" (hooks, 2005). This referred to knowing one's value and speaking against images and ideas that endanger well-being. It is when people know their value that they are able to transform their silence into self-revelatory action (Lorde, 1984). Self-definition and self-valuation are also key concepts that tie into the development of a disability culture that challenges stereotypes and builds solidarity (Shakespeare, 1986).

Navigations of Academia

While each of the presented themes impacted the lives of the study participants, three themes in particular (Strength as a Necessity, Weakness as a Liability, and Spirit-Murdering Silence) worked together to communicate damaging messages of strength and weakness; messages that can negatively impact a Black female's ability to navigate PWIs. As shared in Chapter IV, when these themes manifest in the lives of the participants, unhealthy messages of strength are normalized, mental wellness is compromised, stigmatizing myths and cultural and structural inequalities persist unchallenged, and candid representations of Black womanhood are unobtainable (see Figure 1).

The successful retention and persistence of Black college students has been linked to a number of factors such as, but not limited to, self-confidence, positive faculty interaction, family income, and substantive institutional commitments to diversity (Elling & Furr, 2002; Levin & Levin, 1991; Mayo, Murguia, & Padilla, 1995; Zamani, 2003). Few of the study participants, nine (45%) of which identified as first-generation college students, expressed concerns about their academic success. As a matter of fact, most participants expressed that they made above average grades in their classes. However, they did express that they experienced difficulty concentrating in class and that, at times, their grades were high because they used their studies as a way of keeping busy and keeping their minds off of their mental health concerns. For example, Angela found herself slipping deeper into her depression during a trip home over the summer so she decided to take an online class to occupy her mind. She made an A in the class and felt as though it helped her take her mind off of her depression. Shorter-Green (as cited in Beauboeuf-Lafontant, 2008) described busyness as an identifying factor of depression in Black women. Other participants shared that, while their grades were good, their mental health concerns made

acquiring those grades a challenge. For example, Alesia shared that, while it may sound masochistic, she somewhat enjoyed the sense of relief that she experienced from her extreme anxiety when she procrastinated on her studies. Despite her perceivably unhealthy study habits, Alesia shared that she had been making the best grades of her life. Similarly, Anne shared that, in the midst family challenges and financial concerns, she also made good grades that did not necessarily reflect the psychological challenges that she believed she was facing.

While successful completion of academic courses did not prove to be an indicator of mental distress in the study participants, anxiety and depression appeared to limit their ability to concentrate on their studies. Naomi, who had test anxiety, shared that she performed better when there was white noise in the classroom such as the sound of a projector. However, when she did not have white noise, her anxiety became so extreme that she had had to excuse herself from the room during test; a strategy that she feared will give the impression that she was cheating. Danielle, who had been diagnosed with a panic disorder, shared that her panic attacks took away from her ability to focus in class and resulted in her missing material presented by the professor. Similarly, Ashley shared that, while she was involved in academic organizations on campus such as honor societies, she had to force herself to get out of the bed in order to complete her school work.

Despite their concerns, none of the study participants requested accommodations for their concerns. Further, most of the study participants chose not to share their mental health concerns with a professor. Angela did not share her concerns with a professor because she did not want anyone to feel sorry for her. Anne and Ashley did not feel close enough to any of their professors to disclose their concerns. Jane did not share her concerns because she did not want to be judged, especially by an authority figure. Interestingly, two study participants shared their concerns in

the form of journal entries that they wrote for high school classes. However, while they received passing grades for their journal entry assignments, they never had conversations about their mental health concerns with their teachers and chose not to tell a professor once they entered college. Price (2011) characterized the avoidance of professors to engage students who express distress, whether in their assignments or classroom interactions, as a reflection of faculty encouragement not to become emotionally engaged with students; a practice that she argued supports ideologies such as the "adherence to medical discourse as the ultimate authority on disability in the classroom" (p. 50).

Danielle and Alesia did share their concerns with college professors. Danielle shared her concerns with two professors and received two different responses. One professor implemented a clicker system in class for answering questions which helped Danielle avoid panic attacks. However, the other professor insisted that Danielle answer questions out loud despite the fact that it increased her anxiety level and potential for a panic attack. Alesia confided in a professor who, though he was a White male, she felt that she had a lot in common with because they had similar childhood backgrounds, both enjoyed nature and being outdoors, and both enjoyed artistic expression such as creative writing. Alesia felt supported by her conversation with this professor because he shared his own mental health concerns with her as well as his experience temporarily taking medication before learning different ways to channel his energy such as meditation.

Within the narratives provided by study participants, normalized messages of strength were found to insist upon performances of strength and commitments to portraying a role of caregiver. Alesia shared that "we just kind of feel responsible for . . . for other people." For Black female college students with mental health concerns at PWIs, such performances of

strength increase mental distress by turning a blind eye to their own personal needs; specifically, their mental health needs. The retention and persistence of Black female college students is strongly influenced by their ability to portray accurate representations of self.

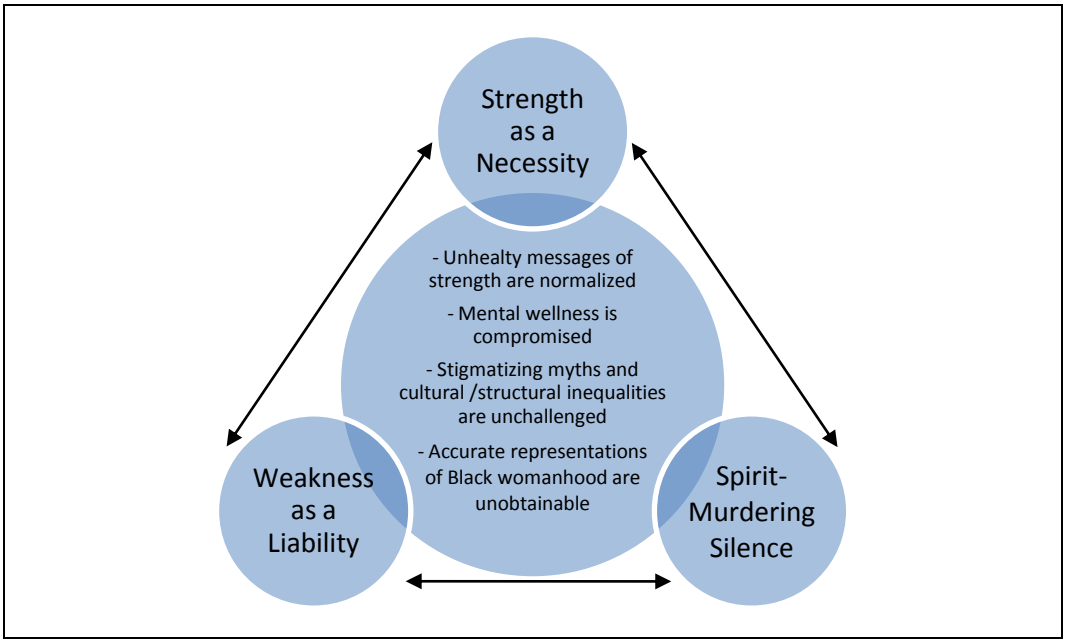

Figure 1. Consequences of intersecting themes

> "Our possibilities are constricted by the system's severely limited notions of what we should be" (Hull et al., 1982, p. 108).

Rhetoric proved to be a strong influence in the lives of the study participants; specifically the rhetoric of strength and disability. One-dimensional rhetorical descriptions of strength and ability lock Black women with mental health concerns into performances that isolate and hinder them from fully expressing their unique multifaceted selves. Unexamined definitions of strength and ability mask the historical, socio-political benefactors of these performances. As a result, interlocking systems of domination such as racism, sexism, classism, and ableism continue to uphold and sustain one another (hooks, 1990). Within the context of higher education, Black female college students negotiate their intersecting identities with the notion of that, as

individuals living with mental health concerns, they are incompetent and incapable of academic rigor or rhetorical or intellectual exchange (Price, 2011).

Accurate representations of Black womanhood are representations of self that recognize the imposed claims of inferiority that are informed by intersecting systems of domination yet actively reject those claims by living one's intersecting identities; identities such as race, gender, and disability. Such representations, as expressed by Lorde (1984), make it possible for a woman to utilize her fullest concentration of energy. As such, it can be argued that, by deconstructing the socio-political factors that encourage inaccurate representations of self, Black female college students with mental health concerns can access the personal energy and encouragement necessary for academic persistence within PWIs.

Formal and Informal Methods of Support

Study participants utilized various formal and informal methods of support as they navigated their experiences within their institutions. They casually shared methods such as campus counseling centers, sleep, exercise, prayer, and television. However, the most prominent method of support was not campus counseling centers but mentoring relationships. Whether it was a formal mentoring relationship with a professor or a peer relationship with a classmate, study participants spoke of the importance of having someone understand their various concerns.

Rachel, for example, completed her undergraduate studies at a historically Black institution. She shared that her undergraduate professors continued to serve as mentors and, because they were primarily Black women who were also first-generation college students who at some point attended PWIs, she felt as though they could relate to her and advise her. Also, since she had fewer opportunities to connect to Black female faculty on her current campus, Rachel spoke of forming relationships with other Black graduate students. Kim also spoke

glowingly of the positive impact her relationship with a Black female alumna made to her; especially when her mentor shared her own mental health challenges that she experienced while still a student. While many of the mentoring relationships were formed through similarities in race and gender, once relationships were formed and comfort was developed, a few participants also shared their mental health concerns within their relationships. This proved to be a source of support to them.

The response to the call for participants of this study was overwhelming; especially considering the sensitive disclosure that was necessary in order to fully engage in the conversation. However, what I found was that many of the participants welcomed the opportunity to speak with me. Several of the participants of this study shared that talking to me was a great help to them and thanked me for the opportunity to get some stuff of their chests. They spoke of feeling empowered and encouraged after our conversation; mainly because they were taking time out for themselves to discuss themselves. Their experience as participants in this study proved to be a liberatory exchange which is one of the goals of CRF. "Once reflection is awakened, it is not easy to restrain it. When it has taken hold, it develops sponstaneously beyond the limits assigned to it" (Habermas as cited in Winkle-Wagner, 2009, p. 47). Having learned that some of the study participants later decided to visit their campus counseling centers after participating in this study, it would appear that their self-reflection was awakened and that the first steps toward self-definition began. However, there remains a great deal of work to be done in order for disability to be understood as an identity and for truthful, holistic images of Black womanhood to become commonplace.

The Medical Model of Disability and the Rhetoric of Strength

In order to deconstruct race, gender, and ability and reconstruct in healthy ways for Black women with mental health concerns, it is first important to re-envision disability in terms that are not informed by the medical model of disability and harness the potential power of self-definition to transform damaging representations of Black womanhood. The fifth presented theme, Spirit-Murdering Silence, provided a criticism of the psychologically damaging ways in which weakness is constructed in Black women. Such an understanding of weakness is largely informed by the language of the medical model of disability. However, this understanding also encourages the development of a myth of normalcy that articulates strength and weakness in dualistic ways rather than in ways that foster an understanding of the interconnectedness of strength and weakness. Those who live within a dualistic understanding of strength and weakness pay a heavy psychological price for committing to performances of strength that require them to silence themselves from their natural variations of mental health. For many Black female college students in PWIs, navigations of academia often entail a negotiation of institutional expectations of individualistic academic success that devalue diversity of thought, experience, ability, and identity. As such, any deviation from what is traditionally deemed normal within the context of an institution of higher education as well as what is expected of Black women generally within society is demonized, criminalized, and inferiorized.

It was found that participants' general understanding of disability was largely informed by the rhetoric associated with the medical model of disability. For example, Susan shared that she did not see herself as having a disability because her mental health concerns do not handicap her. The word "handicap" served to pathologize disability solely as a medical condition that hinders, victimizes and burdens individuals. Similarly, Alesia shared that she did not consider

herself as having a disability because "I'm breathing, I'm walking, I'm talking, I'm functioning." Such understandings of disability severely limit the construction of disability as an identity as a naturally occurring human variation that can be experienced positively within environments that do not demonize or discriminate against it. However, as explained in Chapter II, a lack of consensus on how to define disability contributes to a societal lack of understanding when it comes to various forms of disability. As a result, the numerous misunderstood and misused definitions of mental illness default to a medical model of disability and contribute to the marginalization of individuals who live with mental health needs.

The biopsychosocial model of disability has the potential to contribute to how mental health is perceived in society by bridging the divide between the medical and social models of disability. However, until it is valued, taught, organized, and implemented to the same extent as the medical model, it will remain limited in its potential. As such, the medical model of disability continues to inform societal understandings of mental illness and encourage personal narratives within individuals with mental health concerns that emphasize pathology and victimization (Ridgway, 2001). In order to support Black females with mental health concerns, it is first important to dismantle the rhetoric of strength that is informed by the medical model of disability.

For many of the study participants, presenting accurate representations of Black womanhood would require a redefinition of disability; one that moves away from the medical model of disability to a biopsychosocial model. Though disability is generally understood in society as a medical issue, the biopsychosocial model of disability recognizes the biological factors related to mental illness while also focusing on the sociocultural factors that disable individuals through discriminatory medical classifications and stigmatizing myths that inform

cultural and structural inequalities. According to Metzl (2009), the ways in which mental health is understood and perceived reflects characteristics about society. Based on the experiences of the study participants, it would appear that individuals living with mental health concerns face attitudinal barriers to societal inclusivity which reflects a strongly ingrained societal understanding of disability that is informed by the medical model of disability; a model that blames, demonizes, and belittles individuals for their perceived deviation from an idea of normalcy and able-mindedness that is imagined and unreachable.

In her book, *Claiming Disability*, Simi Linton (1998) stated that, according to DS, disability is "best understood as a marker of identity" (p. 12). However, many people, including those within marginalized groups, do not view disability as an identity (Nocella, 2009). This certainly proved true for the participants of this study and, again, can be deemed a result of an internalized view of mental illness as articulated by the medical model of disability. The medical model of disability articulates disability with rhetoric of impairment and loss which results in negative self-identity (Shakespeare, 1996). This negative self-identity is exacerbated by capitalism which contributes to the marginalization of anyone who portrays differences that are perceived as weakness and used to justify their devaluation as contributors to the development of the economy (Nocella, 2009). "Social approaches view negative self-identity as a result of the experience of oppressive social relations, and focus attention on the possibilities for changing society, empowering disabled people, and promoting a different self-understanding" (Shakespeare, 1996, p. 98). In order to combat the rhetoric of strength, it is necessary to deconstruct the negative images of disability.

Implications for Practice

The aim of this study was to explore the experiences of the study participants in order to provide empirical research on the Black female college students with mental health concerns at a PWI. Based on the information provided, there are a number of implications for higher education institutions to consider; specifically PWIs. PWIs, like all higher education institutions, are in a unique position to encourage conversations that can potentially deconstruct intersecting identities such as race, gender, and ability.

> College and university teachers shape the communal knowledge base that is disseminated from kindergarten through the university. Activist academic practices include exploring the workings of oppression, constructing a tradition of disability culture, historical and textual retrieval, canon reformation, finding and being role models, mentoring, curriculum reform, course and program development, and integrating disability into existing syllabi. (Garland-Thomson, 2001, p. 18)

Higher education institutions can encourage steps toward the de-stigmatization of mental illness by fostering conversations that deconstruct other differences such as gender and race and lead to a normalization of human variation.

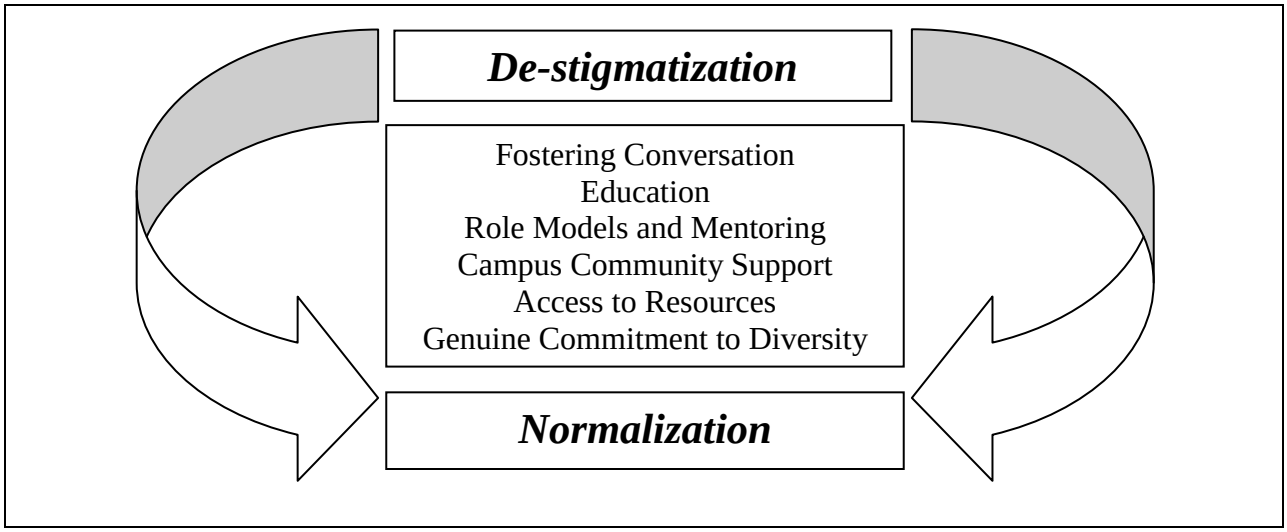

Figure 2. Contributing factors of de-stigmatization

The mental health concerns commonly experienced by college students are often not socially understood or perceived as a disability by the campus community and, as was the case with most of the participants of this study, by the individual with the concerns. As such, the governmental regulations that prohibit discrimination based on ability often do not assist such students. Therefore, the role of higher education institutions is multifaceted. For example, universities can develop campus training (for faculty, staff, and students) programs and services that speak directly to the mental wellness of students of diverse student populations. Few (2007) suggested applying CRF to contextualize the impact of policy on Black females. Based on the findings of this study, I would take Few's suggestion a step further and suggest that DS together with CRF be applied to contextualize the impact of university policies on Black female college students with mental health concerns. This would include a re-conceptualization of the Diagnostic and Statistical Manual of Mental Disorders; especially as it relates to its virtual racial blindness.

Higher education institutions are, at times, caught in the complicated position of committing to campus safety while, at the same time, respecting the rights and privacy of all individuals. This conundrum is especially problematic for individuals with mental health concerns. In essence, higher education institutions can be blamed for both over-responding and under-responding to the concerns of campus community members such as students who may be perceived as being in psychological distress. In order for institutions to ethically balance campus safety with the protection of the rights and humanity of all students regardless of the mental status, specific campus training on variations in human conditions can be utilized in a way that moves conversations about disability, and specifically mental disability, away from a narrative of

blame and deviancy to a narrative of that challenges supposed connections between mental illness and violence.

In addition to a theoretical consideration of the impact of policy, higher education institutions can create a campus environment that is more conducive to inclusivity by making genuine commitments to diversity. An inclusive academic environment and community is encouraged when diversity statements are more than words and a commitment to diversity takes the form of inclusive course curriculum, lived institutional mission statements, and diverse representation of faculty, staff, and students. Such commitments can benefit the retention and persistence of Black female college students while also fostering mental wellness. Faculty and staff training about mental health in college students can also assist in creating an inclusive campus by providing resources for culturally sensitive intervention and support approaches. Such training can provide information about on- and off-campus resources, encourage creative forms of campus collaborations for student support, and also demystify damaging ideas about mental illness that may result in discriminatory student interactions.

Perhaps the most significant source of support for Black women with mental health concerns was the presence of role models and mentors. As shared in Chapter IV, mentoring contributed to mental wellness in the study participants. Mentoring is a powerful tool of support that can diminish the vulnerabilities caused by race, gender and disability while destroying existing power structures (Smith, 2003). “Black women may be better able to take themselves seriously as intellectuals knowing that others like them are concerned professors, deans, provosts, and university presidents” (Allen, 1997, p. 83). Black female role models in particular have the potential to enhance power in others, give voice to the concerns of Black female college students, and encourage the development of healthy self-concepts in Black female college

students; all of which promote self-definition and self-valuation (Allen, 1997; Hull et al., 1982). However, hiring Black female faculty for the primary reason of serving as mentors to Black female college students hints at their intellectual inferiority as researchers, encourages their scholarly undervaluation, and allows non-Black professors to justifiably negate their responsibility for teaching and mentoring Black female college students in a culturally competent manner (Allen, 1997). True campus commitments to diversity and inclusivity would communicate the importance of diverse student populations being engaged and supported by all faculty.

Despite the importance of Black female role models, the fact remains that, on the campuses of PWIs, the vast majority of professors have historically been White men (Hull et al., 1982). Generally, faculty of color embody a small fraction of full-time faculty (Stanley, 2006). This is especially true for women of color who, at the turn of the 21st century, represented 2% of the 176,485 tenured full professors at the nation's public and private research universities (Evans, 2007). Tenure and promotion continue to be a subjective process that exploits minority faculty by disproportionately hiring them into lower adjunct and clinical positions with heavy teaching loads and limited office hours or administrative responsibilities to students outside of the classroom interaction (Evans, 2007; Tierney & Bensimon, 1996).

> Rarely do they (Black female college students) see Black women in responsible academic or administrative positions; and so students must look to each other for support and role models. As a result, they often form peer groups similar to extended family structures. (Hull et al., 1982, p. 119)

Such peer groups have the potential to serve as counterspaces where students can support themselves, resists destructive impositions on their identity, and facilitate agency that insists on healthy self-definition within their campuses (Winkle-Wagner, 2009).

> . . . [T]he university community should be prepared to support African American women when they seek a safe haven within predominantly Black student associations, Black sororities, and Black female support groups. Faculty and administrators must be comfortable with Black women establishing these spaces, or a vicious oppressive cycle in which the dominant group maintains the status quo on campus and all other remains outsiders within will persist. (Howard-Hamilton, 2003, p. 25)

Mentoring relationships have the potential to shift conversations toward an acceptance of self and an insistence on being valued, respected, and included. For Black female college students with mental health concerns, such relationships can promote a holistic acceptance of themselves as members of various communities; all of which inform a unique perspective, experience, and identity that they can call their own but that represents the fullness and complexity of Black womanhood.

Recommendations for Future Research

The findings of this study suggest that there exists a great potential for the dissemination of activist-oriented research when CRF and DS are used together; especially for Black women with mental health concerns. In addition, whether it is in research or administrative programming, there appears to be a "frequent absence of awareness that Black women's health is affected by sexism, racism and class position" (Hull et al., 1982, p. 104). As such, research is needed to explore the experiences of individuals with multiple intersecting identities so that damaging messages articulated through systems of domination can be uncovered and deconstructed, leading to the alleviation of oppressive conditions and encouraging social change.

In order to conduct research that speaks to experiences similar to the ones presented in this study, it is important to commit to self-reflexivity. "Self-reflexivity uncovers and unveils theoretical blind spots—internalized and subconscious racism, sexism, homophobia, classism, ethnocentrism, ableism, and xenophobism" (Few, 2007, p. 462). Self-reflexivity is utilized by both CRF and DS and hinders the perpetuation of Black women as one-dimensional beings. In

addition, both theoretical frameworks focus on failed help-seeking within institutions rather than coping strategies alone.

The findings of this study also indicate a need for inclusive models of female student socialization and away from linear models of student identity development. Inclusive models of student identity development would allow Black female students to communicate their personal experiences, acknowledge their oppression, embrace their multiple intersecting identities, and gain confidence in their value and worth. Winkle-Wagner (2009) suggested that a revised model of identity development for Black female students would be more sociological in nature and would allow for "a more fluid, continuous notion of identity" (p. 157). Voice-centered research can assist in the development of a revised model of identity development for Black female college students by revealing identity as a collection of voices that are fluid and changing (Beauboeuf-Lafontant, 2008). Future research that utilizes these techniques can assists in the development of research that present accurate representations of Black women.

Conclusion

Black female college students with mental health concerns at PWIs often find themselves trapped in silence-inducing performances of strength and ability. As they seek to prove their worth, they fail to challenge the claims of inferiority placed on them because of their race, gender, and ability. In addition, they navigate various forms of oppression as well as a societal lack of acceptance and understanding of their difference; all of which contribute to their psychological distress. The information provided in this study shows the importance of considering the sociocultural factors that inform institutional understandings of this student population. Further, the findings of this study have the potential to transform the ways in which

mental disability is understood in various student populations as well as how intersecting identities such as race and gender contribute to the fluidity of the identities of such students.

Challenges remain for Black female college students with mental health concerns at PWIs. They continue to under-utilize campus services, have limited access to mentors, and adhere to sociocultural expectations that contribute to their psychological distress. This study encourages future explorations of this important student population in order to assist in the retention and persistence of Black female college students within higher education institutions while fostering their commitment to healthy, accurate performances of self. In order for new understandings of disability to be developed and truthful representations of Black womanhood that supersede damaging, oppressive representations, it is crucially important that the rhetoric espoused through systems of domination is challenged, dismantled, and replaced with language that encourages a discourse of humanizing value and equality. Higher education institutions can contribute to this change by committing to diversity throughout their campus communities. Breaking the legacy of psychologically damaging oppression begins by breaking the silence of discrimination and redefining strength in a way that respects and values human variation.

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Appendix A

IRB Requirement

Nadia Monique Caesar-Richardson

Sections of the IRB Application

Purpose, Objectives, Design

1. The purpose of this study is to describe and increase the understanding of the experiences of Black female college students with mental health concerns at a predominantly White institution (PWI). To increase understanding of the experiences of Black female college students with mental health concerns at a PWI, this study will examine in-depth participant interviews in order to identify the common themes that may arise in their experiences. In addition, participant interviews will be examined in order to identify factors that influence the experiences of Black female college students with mental health concerns at a PWI. A purposeful sampling technique will be utilized in order to select study participants.

2. With this dissertation, the following questions will be explored: What are the experiences of Black female college students with mental health concerns at a predominantly White institution? What impact does mental health concerns have on the academic experiences of Black female college students at a predominantly White institution? What formal and informal methods of support do Black female college students with mental health concerns at a predominantly White institution access? How do the intersections of race and gender affect the college experiences of Black female college students with mental health concerns at a predominantly White institution?

3. The design of the study will consist of the following:
   - Interviewing Black female college students with mental health concerns at a predominantly White institution of higher education located in the southeastern region of the United States
   - Transcribe, code, analyze, and discuss responses received from interviews with study participants

4. This study is significant because it provides a lens through which to explore an under-researched topic and contribute to the existing body of research on mental health in college students by focusing on and providing a greater understanding of the experiences of Black female college students with mental health concerns at a predominantly White institution. Little research focuses on this particular topic as it relates to this particular population of students. Through informational conversations with college professionals from various campuses and informational interviews with counseling center staff, I have found that few Black female college students utilize campus counseling or wellness services. This study explores what the experiences of these students may be and possibly why they prefer not to take advantage of available services. The study will utilize disability studies and critical race feminism to investigate the experiences of Black female college students with mental health concerns. With the use of these theoretical frameworks, this study will seek to examine how race, gender, and ability intersect in the lives of Black female college students with mental health concerns. An analysis of in-

depth interviews will be used to find themes in participant experiences. Themes that emerge will be analyzed in order to illustrate the influence that intersections of race, gender, and ability may or may not have on the experiences of the study participants. Studies such as this have the potential to initiate conversations on the development of policy that create safe spaces of support for students with mental health needs to thrive academically and socially.

Study Procedures

1. The procedures for this study are listed below. The study will begin in the early Spring of 2012 semester.

    a. In the Spring semester of 2012, I will recruit 15-30 Black female college students with mental health concerns from 2 predominantly White institutions in the southeastern region of the United States (Arden University and Civitan University (pseudonyms)). Recruitment will consists of flyers posted around campus (student centers, libraries, residential life dorms, recreation centers, cafeterias, etc.), flyers emailed through campus department list servs, and active recruitment conducted by the primary interviewer during student organization meetings. (A recruitment flyer is attached). The recruitment email will be sent out immediately upon receiving IRB approval, and recipients will be asked to respond to the email promptly to express interest in participating.
    b. Following IRB approval from The University of Alabama (UA), an IRB application will be submitted for review to Arden University and Civitan University (pseudonyms) if required. No participants will be recruited for this study from Arden University and Civitan University until permission is obtained.
    c. Once study participants express interest in participating in the study, I will schedule a time to meet with them and conduct their interview. Each interview will be 45-60 minutes in length and will take place at a location of the study participant's choosing. The location chosen by the study participant will be a private room that is conducive for a confidential one-on-one interview with the primary investigator. All interview locations will provide a Before all interviews are conducted, I will brief the students on the study, review the informed consent form with them, give them an opportunity to ask questions, and collect the signed informed consent forms from those who agree to participate in the study. All interviews will be audio-recorded with a digital recorder unless the participant requests to not be recorded, upon which handwritten notes will be taken. All participant names will be changed in order to maintain participant confidentiality. Gift cards (value of $10.00 each) will be provided to each study participant at the conclusion of each interview. (Interview Protocol is attached).
    d. Each interview will be transcribed, coded, and analyzed. Study participants will only be re-contacted by the primary researcher during the IRB approved periods should clarification be needed. Open, axial, and selective coding will be three processes used to analysis the collected data. Each process will assist in the emergence and grouping of codes as well as the conceptualization of patterns of meaning which will ultimately give rise to the emergence of theory (Strauss &

Corbin, 1998; Boeije, 2002; Merriam, 1998). During the process of open coding, each sentence of each transcribed interview will be read and codes assigned to words, phrases, and/or sentences that convey participant meaning (Cottrell & McKenzie, 2005; Merriam, 1998). Open coding will be repeated resulting in the grouping, elimination, and the renaming of codes. During the axial coding process, emerging categories that are shared amongst the transcribed data sets will be considered and codes that relayed the casual relationships between data sets will be used to better understand the experiences of the study participants (Strauss & Corbin, 1998; Cottrell & McKenzie, 2005). Through the use of constant comparative analysis, categories will continue to emerge and refine with each reading of the data sets. Finally, the selective coding process will be used to consider the theory that may emerge from the data. During the selective coding process, codes will be grouped and restructured while remaining relevant to the theory that emerges. Quotes will be used to validate and provide illustration to the themes that shaped the emerging theory (Glaser, 1965).

e. The personnel involved in this study will consist of two individuals – myself (Nadia Caesar-Richardson) and my dissertation chair, Dr. Natalie Adams. I am a doctoral candidate in Higher Education Administration. I have experiences in various student-centered professional positions on and off college campuses. During my graduate studies, I completed qualitative research courses as well as courses that foster explorations of diverse issues such as race, gender, and class. In addition, I participated in the University of Alabama's workhop on IRB (Title: "How to Submit an IRB Human Subjects Protocol") and completed the human subjects online training certification. Dr. Natalie Adams is a Professor of Instructional Leadership and Social Foundations of Education in the Department of Educational Leadership, Policy, and Technology Studies. She is also Assistant Dean of the Graduate School, has taught for several years, chaired and served on several dissertation committees, and has completed the human subjects training certification.

f. The primary investigator (myself) and the second investigator (Dr. Natalie Adams, the dissertation chairperson) will not need any special training outside of the human subjects online training certification. Dr. Adams will supervise this study. As the primary investigator, I will pay close attention to any signs of resistance or distress in to answering interview questions. If the student expresses any distress during the interview, I will review the details of the study with the student and confirm if the student is willing to participate or would like to be removed from the study. The supervising professor, Dr. Adams, will be available to the participants via email and her office phone. The integrity of the study will be monitored and assured by the supervising professor, Dr. Adams. As the primary investigator, I will explain the details of the study and that participants should report any questions, concerns, complaints, deviations, unanticipated events, and scientific misconduct to the supervising professor via email. The supervising professor will periodically check in via email with the primary investigator to see that the study is progressing as initially presented. Any reports that cannot be handled by the primary investigator and second investigator will be referred to the UA Office of Research Compliance.

g. Deception will not be used in this study.

Study Background

1. Statement of the Problem: Despite the availability of research pertaining to student and faculty perceptions of college students with a mental illness, at present, there is a limited body of research that incorporates the experiences of Black female college students with mental health concerns or reflect the multi-layered reasons why African American women are less likely to utilize mental health services than their White counterparts (U.S. Department of Health and Human Services, 2001). As a result, a need exists to study the experiences of Black female college students with mental health concerns. In addition, previous research on college students with a mental illness has failed to extensively capture the experiences of students who also navigate a myriad of other social issues, such as oppression and discrimination based on their race, class, gender and/or sexual orientation. Due to the limited amount of research specifically targeting the experiences of diverse college students with mental health concerns, this study is needed to obtain a better understanding of the experiences of Black female college students with mental health concerns at a predominantly White institution (PWI).

2. Purpose of the Study: Data for this study will be gathered from Black female college students with mental health concerns including but not limited to students with diagnosed mental health needs or Black female college students who self-report as suffering from symptoms commonly associated with mental health needs such as anxiety, depression, bipolar depression, mood swings, and eating disorders. In addition, the data for this proposed study will be collected at a predominantly White institution (PWI). The purpose of this study is to describe and increase the understanding of the experiences of Black female college students with mental health concerns. To increase understanding of the experiences of Black female college students with mental health concerns, this study will examine in-depth participant interviews in order to identify the common themes that may arise in their experiences. In addition, participant interviews will be examined in order to identify factors that influence the experiences of Black female college students with mental health concerns.

   Participants will be selected from 2 predominantly White higher education institutions located in the southeastern of the United States (Arden University and Civitan University (pseudonyms)). The study will utilize disability studies and critical race feminism to investigate the experiences of Black female college students with mental health needs. With the use of these theoretical frameworks, this study will seek to examine how race, gender, and ability intersect in the lives of Black female college students with mental health needs. An analysis of in-depth interviews will be used to find themes in participant experiences. Themes that emerge will be analyzed in order to illustrate the influence that intersections of race, gender, and ability may or may not have on the experiences of the study participants. A purposeful sampling technique will be utilized in order to select study participants.

3. This is the primary investigator's doctoral dissertation.

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Subject Population

1. The participants for this study will consist of female college students who identify as Black and who are currently enrolled at one of the following universities: Arden University and Civitan University (pseudonyms). While no cap will be placed on the number of students that may be recruited as the initial sample to participate in the study, 15-30 participants that meet the participant criteria will be selected as the study sample and interviewed for the study. The participant criteria are as follows: self-identify as Black, female college student at one of the study sites, self-identify as experiences mental health concerns, and at least 19 years of age in order to meet the age of majority for the state where the data will be collected. Though participants may vary in age and classification, they will be at least 19 years of age. Of the 15-30 students chosen, if any student is unable to participate or needs to discontinue participation, I will return to the initial sample and randomly choose a student to replace the participant(s).

2. The participants in this study will be female college students who self identify as Black and self-identify as having mental health concerns including but not limited to students with diagnosed mental health needs or Black female college students who self-report as suffering from symptoms commonly associated with mental health needs such as anxiety, depression, bipolar depression, mood swings, and eating disorders. While this study does not aim to exclusively target or recruit students with a diagnosed mental health need or

disability, the primary researcher is cognizant that such students may potentially be recruited as participants. As a result, specific steps to safeguard participants from the minimal risk of heightened anxiety, stress or sadness that may arise during the interview, participants can, at any time, decide not to be in the study, refuse to answer a particular question, or not tell the interviewer things that they find to be sad or stressful. In addition, a list of local and national material pertaining to mental health services will be provided to all study participants for their own reference. Finally, all interviews will take place during regular campus office hours (8:00am – 5:00pm) so that campus counselors will be available during interviews should a student desire to take advantage of them. The following campus counselors have been contacted and have provided resources that are available on their campuses for students who choose to participate in this study:

a. Civitan University (pseudonym): Omitted for Confidentiality Purposes
b. Arden University (pseudonym): Omitted for Confidentiality Purposes

Subject Recruitment Methods

1. I will recruit Black female college students with mental health concerns at the 2 research sites (Civitan University and Arden University (pseudonym)) to participate in this study. Recruitment will be done via email using a recruitment email and campus flyer (the recruitment email and flyer are attached). Upon the completion of all Institutional Review Board (IRB) requirements, participants will be recruited through the dissemination of flyers posted in student centers, residential halls, gymnasiums, libraries, and classroom buildings. In addition, flyers will be emailed through student listservs affiliated with the counseling center, disability services office, and student affairs office of each study site. Finally, as the primary researcher, I will recruit study participants by speaking at chapter meetings of campus sororities and campus student organizations with a large number of Black female student members.

2. For each interview, I will briefly explain the purpose of the study (using the informed consent form as the script) and distribute the informed consent form. The study participants will be identified based on who self-identify as: being Black and having mental health concerns. Of those who identify themselves and agree to participate in the study, I will randomly choose 15-30 student interviews to use for the study. If any student later withdraws from the study for any reason, I will randomly select another student who consented to the study to replace that participant.

3. HIPAA, PHI, FERPA, and PPRA will not be involved in identifying and recruiting subjects. This is a non-medical study, which excludes the need for HIPPA and PHI. FERPA will not be involved because there will be no need to access students' educational records. PPRA will not be involved because no school children will be a part of the study.

4. Non-English speaking subjects of subjects from a foreign culture will not be involved in this study.

Risks

1. This study will not present any physical, psychological, social, economic, or legal risks to the participants. No identifying information will be connected to the study participants; participants will be given pseudonyms.

2. This is not a medical study, so there are not any potential risks or likely adverse affects of any drugs, etc.

3. International research is not involved.

4. Community-based participatory research is not involved.

5. The risk associated with this study appears to be minimal.

6. Efforts will be made to prevent and minimize any risk by making sure all participants feel comfortable and at ease in the environment and with topics of discussion during the interview process and throughout the study. The primary investigator will remain aware and observant of any signs of risks to participants that may be apparent. Participants will be monitored by the primary investigator who will look for any signs of discomfort or uneasiness with may be expressed through the participants' written communications, verbal communications, or non-verbal communications.

7. Special Precautions/Safeguards Against Risks: While this study does not aim to exclusively target or recruit students with a diagnosed mental health need or disability, the primary researcher is cognizant that such students may potentially be recruited as participants. As a result, specific steps to safeguard participants from the minimal risk of heightened anxiety, stress or sadness that may arise during the interview, participants can, at any time, decide not to be in the study, refuse to answer a particular question, or not tell the interviewer things that they find to be sad or stressful. In addition, a list of local and national material pertaining to mental health services will be provided to all study participants for their own reference. Finally, campus counselors will be available during interviews should you desire to take advantage of them. The following campus counselors have been contacted and have provided resources that are available on their campuses for students who choose to participate in this study:

    a. Civitan University (pseudonym): Omitted for Confidentiality Purposes
    b. Arden University (pseudonym): Omitted for Confidentiality Purposes

Benefits

1. There are no direct benefits to the participants.

2. While there is no direct benefits for participating in this study, participants may find it pleasant to know that they have the opportunity to help students, faculty and campus staff better understand the experiences that they have on campus so that they can move past any misinformed perceptions that they may hold about mental health or mental illness.

Participation in this study provides participants with the opportunity to share their experiences in a way that can lead to policy and program changes for other students with mental health concerns. The potential benefits of this study appear to outweigh any potential risk involved.

3. This study does not involve foreign countries or community-based participatory research.

Privacy and Confidentiality

1. The primary investigator will only access the participants when it is necessary in direct relation to the study. The primary investigator will have access to the participants via email but only for providing the next steps of the study and scheduling the interviews. The participants' email address will not be shared with any other parties and will not be included in the study. The student interviews will be conducted in location chosen by the study participant. Only the primary investigator and the participant being interviewed at the time will be present during the interview. All interviews will take place at a location of the study participant's choosing. The location chosen by the study participant will be a private room that is conducive for a confidential one-on-one interview with the primary investigator. All interviews will be recorded using a digital recorder. Digital recordings of the interviews will be necessary to ensure the accurate analysis and interpretation of participants' responses. However, if the participant requests not to be recorded, the researcher will take handwritten notes. The audio, notes, and consent forms will be stored at the private residence of the primary investigator in a locked safe. Participants may refuse to answer a particular question or not disclose information that they find sad or stressful. In addition, the participant may stop the interview at any time.

2. The data collected will be used for research purposes only. Student participants may want their fellow classmates, faculty, staff, friends, and family to be unaware of their responses to interview questions. The primary investigator will reassure participants that what they all information shared during interviews will only be used for the specific research purposes of this study and will not be shared or discussed with others.

3. The audio, notes, and consent forms will be stored at the private residence of the primary investigator in a locked safe for twelve months, at which time all audio tapes will be destroyed. Only the primary investigator will have access to the data. Portions of the interview that need to be transcribed will be transcribed by the primary investigator only. No data collected will be given to other persons or shared with outside agencies.

4. While the race and gender of the study participants will be recorded, their names and the name of their institution will not. Personally identifiable information that may be expressed during participant interviews will be removed and participant transcripts will be assigned a number as a way to separate it from other transcripts. Additional measures of confidentiality will include using pseudonyms chosen by each participant in place of participant names and all research material will be stored in a locked safe at the residence of the primary researcher. Upon completion of the primary researcher's dissertation, all

research material will remain in a locked safe for twelve months, at which time it will be shredded and discarded by the primary researcher.

Incentives and Compensation

1. The study participants will each receive a $10.00 gift card to a local grocery store as an incentive for their participation in the study.

2. The gift cards will be given as remuneration to participants for their time and effort and for being willing to participate in the study. The gift cards will be distributed at the completion of their interview with the primary investigator. Participants who withdraw half-way through the interview will not receive a gift card.

Cost to Subjects

1. The only cost to participants associated with the research is the time spent in the interview.

Care for Research-Related Injury

1. There should not be any research-related injuries associated with this study, and therefore no need for reimbursement for research-related injury care. If there are any injuries to participants, the participant will need to bear this cost.

Informed Consent Process

1. Informed consent will be obtained from all participants. Once students express their interest in participating in the study, the primary investigator will briefly explain the purpose of the study (using the informed consent form as the script) and distribute the informed consent forms. Participants will sign and return the informed consent form to the investigator. In addition, participants will be provided with a copy of the consent form for their records.

2. In order to evaluate and confirm prospects' understanding of the research and their ability to provide legally effective informed consent, I will encourage all participants to ask questions before their interview is conducted to make sure that participants understand the study and their role in the study and can appropriately choose whether to consent or not. Also, participants will be encouraged to email or call me if they have questions later on. The primary language of the consent process will be English, and the informed consent document will be written on an 8th grade level to make sure that oral and written communication is understandable.

Informed Consent Documentation

1. Participants will have to read, sign, and return their written informed consent form to the researcher. These written consent forms must be signed and dated by the participant. The researcher will store these forms in a locked receptacle.

2. There will not be any use of deception/concealment required for this study.

3. The primary goal of informed consent is to express the voluntary nature of participation. Participants will be provided with two copies of an informed consent form; one to sign and return to the researcher and one of to keep for their own records. Informed consent forms will state the purpose of the study, the fact that participation in the study is voluntary, the fact that participants freely agree to participate, and that they are free to withdraw their participation at any time without penalty (Bieger & Gerlach, 1996). In addition, informed consent forms will provide participants with steps taken by the researcher to protect confidentiality and inform participants that interviews will be audio-taped as well as accompanied by field notes taken by the researcher (Heppner, Kivlighan, & Wampold, 1999). With the understanding that informed consent is a continuous process, the researcher will reiterate the rights of participants before and after all interviews and provide opportunities for participants to ask questions regarding informed consent at any time during the study (Madison, 2005).

4. Each study participant will be provided with the same informed consent form.

5. The reading level of the consent document will be an eighth grade reading level.

References

Bieger, G.R., & Gerlach, G.J. (1996). *Educational research: A practical approach.* Albany, New York: Delmar Publishers.

Heppner, P. P., Kivlighan, D. M., Jr., & Wampold, B. E. (1999). *Research design in counseling* (2nd ed.). New York: Brooks/Cole.

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Appendix B

IRB Certification

March 5, 2012

Office for Research

Institutional Review Board for the
Protection of Human Subjects

THE UNIVERSITY OF
ALABAMA
RESEARCH

Nadia Caesar-Richardson
Department of ELPTS
College of Education
Box 870118

Re: IRB # **12-OR-085-ME**: "Strength That Silences – Learning from the Experiences of Black Female College Students with Mental Health Concerns at a Predominantly White Institution"

Dear Ms. Caesar-Richardson,

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Your application will expire on March 4, 2013. If the study continues beyond that date, you must complete the IRB Renewal Application. If you modify the application, please complete the Modification of an Approved Protocol form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, please complete the Request for Study Closure (Investigator) form.

Should you need to submit any further correspondence regarding this application, please include the assigned IRB application number.

Good luck with your research.

Sincerely,

Carpantato T. Myles, MSM, CIM
Director & Research Compliance Officer
Office for Research Compliance
The University of Alabama

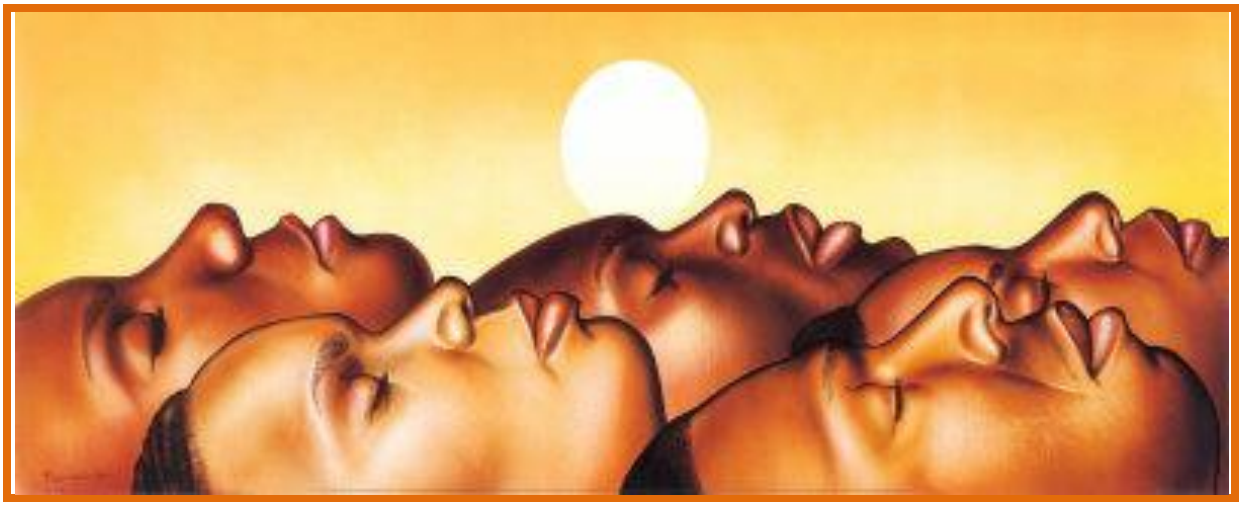
358 Rose Administration Building
Box 870127
Tuscaloosa, Alabama 35487-0127
(205) 348-8461
FAX (205) 348-7189
TOLL FREE (877) 820-3066

Appendix C

Research Flyer

Research Volunteers Needed

Black Female College Students with Mental Health Concerns



Are you a Black female college student with a mental health concern?

Are there times when you feel depressed, anxious, experience mood swings or feel overwhelmed by daily life demands?

My name is Nadia Richardson. I am a graduate student at The University of Alabama working on my doctorate in Higher Education Administration. At this time, I am conducting a study that explores the experiences of Black Female College Students with Mental Health Concerns.

This is an opportunity to share your experiences.

Whether you are currently seeing a counselor, have seen a counselor in the past, or have never seen a counselor, I would like the opportunity to speak with you.

Who can participate:	Black female college students with mental health concerns. Must be at least 19 years of age.
How to participate:	Selected participants will participate in a 45-60 minute interview. **All interviews will be kept strictly confidential.**

All study participants will receive a Wal-Mart or Target gift card.

To learn more about this study or sign up as a study participant, please contact Nadia Richardson at caesa001@bama.ua.edu.

Nadia Richardson	**Graduate Student Researcher**	**caesa001@bama.ua.edu**
Dr. Natalie Adams	**Faculty Advisor**	**nadams@ua.edu**

Appendix D

Informed Consent

Informed Consent Form

Participants: Please keep a copy of this consent form for your records.

Title of Project - Strength that Silences: Learning from the Experiences of Black Female College Students with Mental Health Concerns at a Predominantly White Institution

Primary Investigator
Nadia Caesar-Richardson
College of Education
Department of Educational Leadership, Policy, and Technology Studies
Area: Higher Education Administration
The University of Alabama
Box 870118
102 Rose Administration Building
Tuscaloosa, AL 35487-0118
caesa001@bama.ua.edu

Secondary Investigator
Dr. Natalie Adams
College of Education
Department of Educational Leadership, Policy, and Technology Studies
Area: Social Foundations of Education
The University of Alabama
Box 870118
102 Rose Administration Building
Tuscaloosa, AL 35487-0118
nadams@ua.edu

Please read this document and ask any questions that you may have before agreeing to participate in this study.

This study is being conducted by a doctoral student in higher education administration at The University of Alabama. This study is a dissertation research project and will be overseen by a committee of faculty members.

Background Information:

This study is designed to describe the experiences of Black female college students with mental health concerns. An interview format is proposed for this study in order to relay the narrative accounts of the study participants.

Procedure:

If you agree to be in this study, you will be asked to do the following: Participate in an audio-recorded interview in which you will be asked questions about your experiences as a Black female college student with mental health concerns. Each interview should take between 45-60 minutes. Your audio-recorded interview will be transcribed in full. During the course of the study, all audio-recorded interviews will be in a locked safe at the residence of the primary researcher.

What is this study about?

An increasing number of college students have mental health concerns. However, very few Black college students utilize available resources to manage their mental health concerns. This study is seeking to understand the nature of the experiences of Black female college students with mental health concerns. Specifically, the investigator would like to know how race and gender impact the experiences of the study participants.

Why is this study important—What good will the results do?

The findings will help campus professionals (staff, faculty, etc.) understand the issues that surround the experiences of Black female college students with mental health concerns.

Why have I been asked to take part in this study?

You responded to a flyer on your campus or that you received through a campus email list serv. You told us that you are a Black female college student with mental health concerns and that you are at least 19 years of age. You gave us your contact information.

How many other people will be in this study?

The investigator hopes to interview 15-30 Black female college students from Arden Univerrsity or Civitan University (pseudonyms). The investigator also hopes to conduct all interviews within the next six months.

What will I be asked to do in this study?

If you agree to be in this study, Nadia Caesar-Richardson will interview you in your home or a place of your own choosing about your experiences as a Black female college student with mental health concerns at a predominantly White institution. The interviewer would like to audiotape the interview to be sure that all your words are captured accurately. However, if you do not want to be taped, simply tell the interviewer, who will then take handwritten notes.

How much time will I spend being in this study?

The interview should last about 45-60 minutes, depending on how much information about your experiences you choose to share.

Will being in this study cost me anything?

The only cost to you from this study is your time.

Will I be compensated for being in this study?

In appreciation of your time, you will receive a $10 gift certificate to a local grocery store when the interview is completed. Participants who do not complete the full 45-60 interview will not be awarded a gift certificate.

How will my privacy be protected?

You are free to decide where we will visit you so we can talk without being overheard. We will visit you in the privacy of your home or in another place that is convenient for you. During the interview, you may refuse to answer a particular question or not share information you find sad or stressful.

What are the alternatives to being in this study?

The only alternative is not to participate.

What are my rights as a participant?

Being in this study is totally voluntary. It is your free choice. You may choose not to be in it at all. If you start the study, you can stop at any time. However, if you stop the interview, you will not receive the gift card. Not participating or stopping participation will have no effect on your relationships with the Civitan University or Arden University (pseudonyms).

The University of Alabama Institutional Review Board is a committee that looks out for the ethical treatment of people in research studies. They may review the study records if they wish. This is to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

Risks of Being in the Study:

The study may have the following risk: If you had a difficult experience that you share during the interview, you may experience heightened anxiety, stress, or sadness when sharing that experience with the interviewer. If this occurs, you will be given time to collect yourself before continuing, if you desire to do so. You can also control this possibility by not being in the study, by refusing to answer a particular question, or by not telling us things you find to be sad or stressful. In addition, all interviews will take place during regular campus office hours (8:00am – 5:00pm) so campus counselors will be available during interviews should you desire to take advantage of them. Seeing the counselor would be at your own expense. Finally, a list of local and national material pertaining to mental health services will be provided to all study participants for their own reference.

Benefits of Being in the Study:

The study may have the following benefit: While there is no direct benefits to you for participating in this study, you may find it pleasant to know that you have the opportunity to help students, faculty and campus staff better understand the experiences that you have on campus so that they can move past any misinformed perceptions that they may hold about mental health or mental illness. Your participation in this study provides you with the opportunity to share your experiences in a way that can lead to policy and program changes for other students with mental health concerns.

Confidentiality:

For research related purposes, the interviewer would like to record your race and gender. Your name and the name of your current institution will not be recorded. The transcripts of your interview will have any personally identifiable information removed. Your transcript will be assigned a number as a way to separate it from other transcripts. Additional measures of confidentiality will include reasonable steps to ensure that the only persons with access to research records is the primary researcher, Institutional Review Board (IRB) professionals and other persons or agencies required by law. Such steps include using pseudonyms chosen by each participant in place of participant names and storing all research material in a locked safe at the residence of the primary researcher. Upon completion of the primary researcher's dissertation, all research material will remain in a locked safe for six months, at which time it will be shredded and discarded by the primary researcher. Audio-taped interviews will also be destroyed one month after transcription. This information may be published, but your identity will be kept strictly confidential. No one will be able to recognize you as a study participant.

Contacts and Questions:

The researchers conducting this study are: Nadia Caesar-Richardson, a doctoral student in higher education administration at The University of Alabama and Dr. Natalie Adams an associate professor of social foundations of education at The University of Alabama.

You may ask any questions you have now by contacting the researchers.

If you have questions about this study, you may contact the researchers at caesa001@bama.ua.edu. You may also contact the faculty advisor for this research, Dr. Natalie Adams, at (205)-348-1161, or by email at nadams@ua.edu.

If you have questions, concerns, or complaints about your rights as a participant in this research study, you may contact Ms. Tanta Myles, the Research Compliance Officer at the University of Alabama, at 205-348-8461 or toll-free at 1-877-820-3066.

If you decide to participate, you are free to withdraw at any time without penalty.

You may also ask questions, make a suggestion, or file complaints and concerns through the IRB Outreach Website at http://osp.ua.edu/site/PRCO_Welcome.html. After you participate, you are encouraged to complete the survey for research participants that is online there, or you may ask Nadia Caesar-Richardson for a copy of it. You may also e-mail the IRB Outreach Office at participantoutreach@bama.ua.edu.

Statement of Consent:

Please check the statements below to indicate your consent to participate in this study:

- o I have read the above information. I have asked questions and have received answers. I consent to participate in the study.

- o I understand that I must be at least 19 years of age to participate in this study.
- o I have received a copy of this document to save for my records.

_____

Signature of Participant

_____

Signature of Primary Researcher

Audio/Video Taping Consent

As mentioned above, the individual qualitative interview will be audio recorded for research purposes to describe the experiences of Black female college students with mental health concerns at a predominantly White institution. These tapes will be stored in a locked file cabinet and only available to Nadia Richardson (the primary investigator). We will only keep these tapes for no more than twelve months and will destroy them after they have been transcribed.

I understand that part of my participation in this research study will be audio-taped and I give my permission to the research team to record the interview.

☐ Yes, my participation in this interview can be audio recorded.

☐ No, I do not want my participation in this interview to be audio recorded.

Permission to Re-Contact Study Participants

Once study participants complete their interviews, the primary researcher will transcribe all interviews into text. Should the researcher need clarification on statements made by study participants, it may be necessary for the researcher to re-contact you for clarification purposes. Your permission is necessary before the primary researcher can contact you. Please indicate below whether or not you give the researcher permission to re-contact you.

☐ Yes, I give permission to the researcher to contact me should she needs me to clarify any statements made during my interview.

☐ No, I do not give permission to the researcher to contact me again after I have completed my interview.

Appendix E

Interview Protocol

Learning from the Experiences of Black Female College Students with Mental Health Concerns at a Predominantly White Institution

Interview Method and Protocol

Method: Interviews

- Start each interview with an introduction of the interviewer, an introduction to the study, and a review of the informed consent form. Allow time for study participants to ask questions. Ask again if recording the interview is acceptable to the study participant before beginning the interview.
- Each interview is planned to be 45-60 minutes long and will take place at a location of the study participant's choosing. The location chosen by the study participant will be a private room that is conducive for a confidential one-on-one interview with the primary investigator. Schedule 2 hour blocks for each interview to allow for a review of the informed consent and for participants who speak at greater lengths about their experiences.
- All interview questions will be general and open-ended in nature.
- The same interview questions will be used for every interview.
- Use probe questions to clarify participant responses (Ex. Would you give me an example? In what ways? What do you mean by that? Would you explain that further?)
- Upon completion of the interview, that the study participant for their participation, ask them if they have any questions and reassure them again of their confidentiality.

Interview Questions

Topic: Experiences of Black female college students with mental health concerns at a predominantly White institution.

- What is it like to be a Black female college student with mental health concerns at a predominantly White institution?
- How do you think your experiences as a Black female college student with mental health concerns differ from those other students at your current institution?
- When did your mental health concerns begin?
- Tell me about a typical day on campus.
- How do you feel mental health concerns impact you as a college student?
- What would you most like classmates, professors, administrators, family to know about your experiences as AA female students with mental health concerns?
- Can you tell me a story about your experiences with mental health concerns?
- Do you consider yourself as having a disability? Why?
- Why did you volunteer to participate in this study?

Topic: Impact of mental health concerns on the academic experiences of Black female college students at a predominantly White institution.

- Have you experienced barriers to your academic goals due to your mental health concerns? If so, how did you overcome these barriers?

- What kind of advice did you get about college? Who did you get it from?
- Have you ever shared your mental health concerns with a professor? If so, what was their reaction?
- Have you ever shared your mental health concerns with a fellow student? If so, what was their reaction?

Topic: Formal and informal methods of support accessed by Black female college students with mental health concerns at a predominantly White institution access.

- To what do you attribute your motivation towards completing your college degree?
- What types of services have you taken advantage of for your mental health concerns?
- Have there been times when you wanted to share your concerns with others but didn't? If so, why?
- What ways do you cope with your mental health concerns?
- What support systems to you utilize (on and off campus)?
- Who do you talk to about your problems?
- Who do you talk to for advice on a campus?
- Who do you socialize with on campus?
- What types of organizations or activities on campus are you involved in? Do you believe that your involvement helps you? How?
- Have you shared your concerns with family or friends? How did they react? Did you notice differences in their interactions with you?
- Some people make the claim that Black women don't seek help for their mental health concerns because of the idea of they possess the strength to manage any obstacle. Do you agree? Why?

Is there anything else you would like to add?

Thank you for your participation.

Appendix F

Introduction of Participants

Participants from Civitan University

Anne

Anne is a 23 year old graduate student at Civitan University working on a master's degree in human development and family studies. She has two part-time jobs; one on-campus and one off-campus. Though she was actively involved in student organizations as an undergraduate student, she now spends most of her time working or doing research. Anne is a first generation college student and feels a lot of pressure from her family to succeed. She takes pride in being able to juggle a heavy personal and professional workload at once and even remembers being 10 years old and knowing how to cook a meal and bathe her younger siblings while her parents were at work. She believes that her parents ingrained a sense of strength and perseverance in her. That lesson was particularly reinforced in her when, as a young student in the southern region of the United States, she had a teacher evaluate her as performing below standards and possibly suffering from a mental illness. It wasn't until Anne scored a nearly perfect score on her SAT that her teachers realized that, in fact, Anne was a gifted student. It was at this time that Anne's mother taught her never to show weakness and, when underestimated, that she should do all she can to prove her doubters wrong. Anne suffers from anxiety and, particularly, test anxiety. She believes that her mental health concerns started in elementary school and has gotten worse over the years. She remembers specifically getting a scholarship to begin college after high school. The scholarship required that she begin her studies immediately so she graduated high school in May and began college course that summer without taking a break. Unfortunately, at that time, her grandmother was diagnosed with cancer and given six months to live. Anne, who was enrolled in classes and working two jobs, began driving home on weekends to help her mother take care of her grandmother. Though the stress of her unexpected life circumstances, class, and work negatively impacted her ability to focus in class, she never let her grades drop low enough to lose her scholarship. It seems to Anne that, once she started college, she began to lose loved ones. In a matter of four years, she lost four close relatives, three of whom died from cancer. Anne chose not to tell many people about her mental health concerns. She never felt close enough to a professor to discuss personal issues and, when she told her fiancé, he didn't seem to understand. She tried to tell her mother about her anxiety but her mother insisted that she was too hard on herself. When Anne discovered that her grandfather had been living with depression for years and took medication to help him cope, she began to wonder if she was suffering from something that was hereditary. She always felt as though her father suffered from mental health concerns, which is why she never talked to him about her own. It wasn't until Anne began to lose weight and her hair began to fall out that her mother began to take her anxiety seriously. When her mother suggested that she sit out a semester, Anne insisted that she could manage and instead scheduled an appointment with the campus counseling center which she had heard about from a friend. During her counseling session, she felt uncomfortable because her counselor was a White male who she felt she couldn't relate to. In addition, she was concerned that her insurance wouldn't cover the cost of additional sessions so, after one session, she never went back. When Anne's health seemed to decline, she went to the doctor and was diagnosed with fibromyalgia, a condition that is linked to a chemical imbalance in the brain and increases the likelihood of having depression and anxiety. She was placed on three types of medication, one of which is serotonin, a medication that is often used as an antidepressant. Anne believes that, by taking this medication and improving her physical health, she is also improving her mental health. As a

result, she has put off going to counselor. She doesn't see going to a counselor as a priority because she notices a difference in her anxiety level, she doesn't think she has to time to invest, and she is not sure that her insurance will cover counseling in addition to her other expenses related to fibromyalgia. It took several years for Anne's father to admit that he had issues with anxiety. The family coerced him into getting assistance and, although he is no longer in denial and has visited a doctor, he still doesn't take his medication regularly. Anne believes that not knowing about her family history led her to believe that she was the only one who really had these problems so she spent several years managing her concerns on her own without telling anyone. She now has a vested interest in issues of mental health in the African American community. Her current research as a graduate student focuses on depression and anxiety during pregnancy and she aspires towards a career that will allow her to educate others on issues of mental illness.

Sarah

Sarah is a 21 year old undergraduate student at Civitan University majoring in criminal justice and psychology. She is a very proud and dedicated big sister and views her younger brother and sister as a motivating force for completing her degree, so that she can be an educational role model for them, in spite of the fact that their mother has a bachelor's degree and two master's degrees. Her parents are divorced. She hasn't seen her father since she was in high school which she finds very hurtful since she was a self-proclaimed Daddy's girl. She wrote him a letter explaining how hurtful his absence was but he never responded, so she has essentially put him out of her mind. Even though she routinely speaks to her mother twice a day, they do not have a close relationship and, at times, have arguments that result in them not speaking for weeks at a time. After their divorce, Sarah describes her mother has having a breakdown and bouts of depression though she never sought assistance for either, although Sarah suggested it. The divorce also brought on financial strain since Sarah's father stopped contributing to the household budget so her mother had to get a job. Reflecting on this time, Sarah felt obligated to step up and help since, in her eyes, her mother was either working or sulking. Sarah began a routine of coming home from school, cooking meals, helping her siblings with home, and then getting them bathed and put to bed. She believes that, while her mother expected this assistance from her, it caused a strain on their relationship because her siblings appeared to have more respect for her then their own mother. When she left for college, Sarah said she almost didn't know what to do with all the free time she had in between her classes because she was so used to taking care of her siblings. She began working a full-time on-campus job and developed a close mentor-mentee relationship with her manager. As she continued her studies, she began dating and became pregnant, which ended in a miscarriage. She later learned that the father of her child had gotten someone else pregnant around the same time even though they were in a relationship. It was at this time that Sarah noticed a shift in her personality. She noticed that she had a negative, rude and defensive attitude towards her friends. This resulted in her losing close friends that she has seen as a support system. Eventually, she began another relationship but suffered another loss when her boyfriend, whose family she had grown close to, died from sickle cell anemia. Though she still remains close to his family, she felt alone. She did not have friends that she could talk to and she wasn't speaking to her mother. Sarah confided to her manager on campus who referred her to the campus counseling center after she broke down crying in her office. She believes that the counseling sessions have made a tremendous difference in her life

and continues to meet with a counselor regularly. She learned that her attitude towards her friends was misdirected anger that she felt after her miscarriage. She even sees an off-campus Christian counselor that was referred to her by the college minister at her church. She freely shares with others that she is taking advantage of counseling and actually feels obligated to share experience so that others will know what kind of resources are available to them. Now, she is excited and hopeful about her future as she completes her final semester and prepares for graduation.

Naomi

Naomi is a 19 year old undergraduate student at Civitan University majoring in political science. She is an active freshman who is a part of the honors program, holds offices in student organizations, performs well academically, and is involved in organizing volunteer event because she sees volunteerism as a moral obligation. When she was born, she had a blood transfusion. This serves as motivation for her future goals of going to graduate school for public policy and working on donor related issues for the government. She grew up in a conservative Christian family in a community that has a large White and Hispanic population; very few Black people lived in her community. Her father is Black and her mother is White. She doesn't necessarily believe that she connects to the Black community but she doesn't completely identify with the White community either so, when given a choice, she completes forms that ask for race by clicking the White box or both the Black and White box. However, if she doesn't have the option to check both, she may check Native American box because her grandmother was Native American and because it makes her mad when she feels like she is being forced to pick one or the other. Naomi never felt that race was an issue until she came to Civitan University. Her high school was primarily Hispanic. She felt she fit in because her multi-racial background gave her a brown complexion that was very similar to most of her Hispanic classmates. However, at Civitan University, she feels as though the only brown faces that she sees are the ones that belong to international students. Naomi didn't feel welcomed by her campus Greek system because it, as well as the rest of the campus, is so segregated by race. She felt like some the girls in the sororities were not nice. As a result, she and a group of friends made up their own Greek organization that currently consists of eight members. They created their own sweatshirts to wear to campus events, have regular organization meetings and designated a friend's dorm room as the organization's headquarters. Though not recognized by the university as an official organization, Naomi's group serves as a powerful support system for her. During her interactions with them, she noticed that the differences that she felt all her life were exacerbated. She noticed that she feels intensely uncomfortable and extremely anxious in social settings like parties. She suffers with test anxiety and has struggles not to walk out of tests as she has in the past. In addition, because of her conservative Christian upbringing, she has internalized the idea that guys are evil. She feels uncomfortable getting compliments and struggles with dating because he it makes her feel dirty. She even referred to her own sister as a whore for having a boyfriend. She started to wonder how she would ever get married and frustrated that she wasn't able to do the normal things that other students her age were doing. She finally decided to get help when she noticed that she would spend hours picking her skin before going to bed at night which took time away from her studies and required her to find clothes to cover her scars. She wanted to know why she was so different. Naomi learned about the campus counseling center by searching the university website. She was glad that she could take advantage of this resource without her

parent's permission. Naomi began going to sessions and the campus counselor referred her to an off-campus psychiatrist that diagnosed her with obsessive-compulsive disorder (OCD). Because of the misconceptions that exist about OCD, she has not shared her diagnosis with many people. She did share it with a few select friends. The only relative that she has shared her diagnosis with is her sister and the only reason she did that was because her sister made a suicide attempt and she wanted to let her know that she wasn't alone in her struggles. She did not tell her parents because she doesn't think they need to know. Naomi continues to see her campus counselor and off-campus psychiatrist while using her faith to help her cope with her OCD and continue with her studies.

Danielle

Danielle is a 21 year old graduate student at Civitan University majoring in chemistry. She works part-time on campus and, even though she has an older sister who gave her advice about college, she feels as though she wasn't as prepared for graduate school as she thought. She anticipated that graduate school would consist of long 8 hour days but, instead, she finds that she easily works 12-13 hours a day in classes and labs. While Danielle feels as though her mental health concerns started in undergraduate, she believes that stress made them flare up in graduate school. She began having panic attacks that made her lose her breath, get hot and dizzy, headaches and cry. She recognized these were panic attacks because of pre-health classes she had taken in the past. She noticed that she tends to get panic attacks when she feels as though she is being pulled in several different directions by professors who insist that she makes their work her priority. At first, Danielle tries her best to manage her mental health concerns on her own. When she feels a panic attack starting, she removes herself from the situation which might require her to step out of class. However, she felt that this tactic negatively impacted her academically because she misses information when she steps out of class and has a hard time focusing while in class. In addition to her panic attacks, she began to experience extreme anxiety when required to answer questions in class which results in her losing participation points. She spoke to two professors about her anxiety. One professor was understanding and started using a clicker system in class for answering questions but another professor insists that she speak up in class. Danielle believes that this professor views her anxiety as an excuse for being lazy or being a know it all. She was aware that a friend at another institution was taking advantage of on-campus counseling services. Danielle, who started to notice that her concerns contributed to uncharacteristic periods of sadness, decided to Google and find and whether or not counseling was available to her at Civitan University. After a Google search, she found the information for Civitan University's counseling center and scheduled an appointment. After speaking to a counselor, she was referred to the on-campus psychology clinic which ran some tests and diagnosed Danielle with dyslexia. However, professionals at the psychology clinic noticed Danielle's extreme anxiety and, after additional tests, also diagnosed her with a panic disorder. She has now registered for on-campus accommodations for her dyslexia through her campus disability services office and regularly visits the campus counseling center. She notices a positive change and credits the counseling center for helping her put things into perspective. Though she doesn't share her diagnosis with many people, she has shared it with a few friends and her parents. Her friends are supportive except for one friend that believes that Danielle should pray and ask Jesus for help. Danielle agrees but believes that Jesus put people in place to provide the kind of help that she is taking advantage of. Her mother was also skeptical because she is religious but noticed that the

counseling sessions seemed to have a positive impact. Danielle is glad that her parents don't treat her any different although she does believe that they take her stress more seriously. In addition to her regular counseling sessions, Danielle copes with her mental health concerns by reading, writing and organizing wine and home work nights which create a social and somewhat relaxed atmosphere for working on assignments (although she admits that sometimes more socializing gets done then actual academic work). She also enjoys occasional social outings with students from the chemistry department and has joined the department's intramural softball team. She continues to persist through her program and is motivated by the lack of Black people, and especially Black women, in the field of chemistry. Danielle also feels that she has to prove herself since no Black woman has ever graduated from her department with a PhD in chemistry.

Erica

Erica is a 19 year old undergraduate student at Civitan University majoring in international studies and French. She works part-time on campus and is active in a couple of campus organizations. Before coming to Civitan University, Erica was diagnosed with depression and placed on anti-depressants as a high school student. She did not think her medication was working so stopped taking them. She feels her depression distracts her from her work sometimes and makes her tired and unmotivated. She visited the on-campus counseling center and counselors there felt as though she might actually be suffering from bi-polar depression. However, Erica didn't feel as though the sessions were helping and because of cost, stopped taking advantage of services at the counseling center. She is a fiercely private person and has not told anyone about her concerns or her diagnosis of depression. She actually didn't even tell her parents when she went to the doctor's office as a high school student. The only reason her parents know about that doctor's visit is because they found out that she had been taking antidepressants. They were not happy about Erica's decision to visit the doctor for her mental health concerns, or for her decision to try antidepressants. However, Erica did not tell her parents because she felt as though do not believe in mental health concerns such as depression and that they would not want her to go to a doctor for those types of issues. For example, when she told her father about her concerns, he suggested that her feelings were actually karma for something she had done in the past. Erica continues to manage her depression without taking advantage of any on or off-campus resources and without sharing her concerns with anyone. She is a good student and is preparing for a study abroad trip to Africa.

Rachel

Rachel is a 23 year old graduate student at Civitan University working in social psychology. She works part-time on campus and is a member of a few student organizations although she admits that she doesn't regularly attend organization meetings. She is a first generation college student who feels that it is imperative for her to be a successful role model for her family and her community. Rachel is frustrated by what she describes as the racist campus culture of her current institution. She is often the only Black student in her classes and feels that her opinion is only valued when discussing issues of race. She is also frustrated by the cultural ignorance of her department who refers to students who graduate as Master and classmates who seem fascinated with her natural hair. For example, she recently got into an argument with a White male student who touched her hair and referred to it as wool or cotton like. When she vehemently expressed

her disdain for his comments and for touching her without her permission, other students accused her of overreacting. She is concerned that she has given her classmates a reason to see her as an 'angry black woman'. Rachel feels as though she is suffering from anxiety. She has always been a good student and has always enjoyed school but she feels that, because of Civitan University's campus culture and lack of diverse faculty, there is no one on campus that she can talk to who will understand her sadness and anxiety. She now finds that she procrastinates on assignments, which she never did as an undergraduate student and she questions whether or not she wants her graduate degree badly enough. She tries to hide the fact that her anxiety makes her feel like she is drowning, especially when giving class presentations. She feels as though her identity as a student has changed. She feels out of place and is just doing the bare minimum to get by in her classes. She completed her undergraduate degree at an HBCU and still communicates with her some of her undergraduate professors who serve as mentors to her. Many of her undergraduate professors were also first generation college students and Rachel finds them encouraging and supportive. Though she has close friends, she has not confided her concerns to them because she is typically the one that they rely on for guidance and support. She also hasn't shared her concerns with her father or her siblings. She talked to her mother who encourages Rachel to get some help for her anxiety. Rachel calls the counseling center to schedule an appointment but feels as though the person she spoke to was very short so she ultimately decides not to go to her appointment. Instead, Rachel manages her concerns on her own. She finds support talking to other Black graduate students on her campus and expressing herself through creative writing. She also finds that it helps when she is not on campus so she travels to visit friends and she frequently presents her research at academic conferences.

Susan

Susan is a 39 year old graduate student at Civitan University working on a master's in journalism. She commutes five hours roundtrip to Civitan University several days a week and works part-time on campus. She admits that the drive is stressful. For the first time in 5-10 years, Susan is a student again. This is her second attempt at a master's program. The first time she enrolled in a master's program, she felt that the campus that she enrolled in was racist and ultimately not a good institutional fit. However, at Civitan University, she feels academically supported and mentored in her program. As an undergraduate student, Susan was a scholarship recipient to an HBCU. However, because she graduated from a predominantly White high school, she felt being a student at an HBCU was a culture shock for her because she was used to be one of very few Black students. As an undergraduate student, Susan was date raped. When the incident happened, she went to the campus counseling center but didn't feel as though it was helping so she stopped. When she graduated and got a job, she started seeing a therapist. It took her three different therapists before she found one that she liked. She felt that the first therapist insisted that Susan have a pity party by constantly rehashing her date rape experience. The second therapist turned out to have his own issues with drugs and mysteriously disappeared from his practice. Finally, the third counselor gave Susan empowering tools and self help therapy that she found beneficial. Susan was diagnosed with an anxiety disorder and began taking medication to help with her symptoms. However, she did not stay on the medication for long because she began having side effects that her doctor prescribed additional medications to manage. When Susan initially told her mother and sister that she was seeing a therapist and taking medication, they didn't understand and reacted as though she had told them see was crazy or taking an illegal

drug. However, now that her mother is educated on mental health, she is under the care of a professional and takes anxiety pills. Susan has not shared her experiences with any professors or classmates at Civitan University. She also feels like her level of maturity allows her to handle certain situations better than her younger classmates. She is presently not seeing a therapist and, although she is aware that there is a counseling center on campus, she feels as though she is not on campus enough to utilize the service. Instead, she copes with her concerns by planning ahead, exercising and journaling. She also runs her own publication and hopes to write a book in the future about Black people's misconceptions of mental illness.

Lisa

Lisa is a 25 year old graduate student at Civitan University studying human performance. She was raised by her grandmother and describes her mother as having problems. Though she completed her undergraduate degree at a predominantly White liberal arts school, she feels as though she has never experienced the racial tension that she believes exists on the campus of Civitan University. She is in a 2 year program and was enthusiastic when she first started classes. However, several life circumstances have arisen. Within the past year, she has ended a relationship, put her father in rehab, and took guardianship of her 8 year old niece. She started to experience a mixture of depression and stress to the point where she thought she was going to have a nervous breakdown. She started visiting the student health center and, in one semester, saw doctors there on three separate occasions for infections and other illnesses that she sees as stress related. She has seen ads for the counseling center but has never been. She finds it hard to concentrate in class and feels as though life is requiring her to put school on the backburner. She doesn't share her concerns with many people. She told her aunt who was surprised and concerned. She also confides occasionally to her supervisor at work who she sees as a listening ear. Not only does she feel as though her department doesn't understand her circumstances but they don't pay any attention to her at all. She also feels as though there is an unspoken expectation that student spend most of their time physically in the department doing work which isn't possible for students who work or have children to take care of. Lisa feels frustrated. She doesn't care much about her studies anymore and believes that her department sees that mentality in her demeanor. She continues to persist through her studies and work part-time on campus. She has good days and bad days when she cries. But overall, she feels as though she is managing well and, though she doesn't have much of a social life, she copes by praying, exercising and sleeping.

Melissa

Melissa is a 21 year old undergraduate student at Civitan University majoring in Spanish. Her mother passed away when she was 11 years old and she was raised by a father that she describes as verbally abusive. He would regularly yell, scream and curse around their home. Though she and her brother saw a counselor for two years after her mother's death, she found the experience of seeing a counselor to be embarrassing and yet beneficial. Despite her counselor's support, she remembers struggling in high school. She felt as though she did not have a female role model available to teach her certain things such as how to groom her hair. She was regularly teased at school for her appearance. While she had some family available to support her in other ways, she doesn't think that anyone realized that she needed a woman to show her or teach her those

things. In high school, she felt that she had no one at home to talk to and that no one at school cared about her situation. Melissa felt stuck in her situation and thought about suicide. Her suicidal thoughts stopped when she graduated from high school, moved out of her father's house and began classes at Civitan University. She is a first generation college student who feels poor and believes that her education is important so that she can get a job and not be poor anymore. Melissa finds the campus culture of Civitan University to be more accepting of White students than Black students. Similar to high school, she feels judged by her classmates, especially for her appearance. She feels as though her classmates are afraid of her or presume that she isn't intelligent because she is shy and quiet in class or that she doesn't know how to take care of herself because her hair is messy. Her grades begin to decline as she struggles to pay attention in her classes. She doesn't feel as though she came to Civitan University prepared and, when her thoughts of suicide begin to resurface, she contacts the campus counseling center. Melissa thought she had depression but, when she meets with a campus counselor, she is diagnosed with anxiety. Her campus counselor all but insists that Melissa take antidepressants for her suicidal thoughts. However, Melissa is also prescribed sleeping pills to assists with her insomnia. She continues to utilize the campus counseling center for four months until the counselor suggests that additional sessions are no longer needed. Melissa doesn't feel as though her antidepressants work so she stops taking them but still occasionally takes her sleeping pills. She is an extremely private person and does not share her mental health concerns with anyone but her sister and a roommate. Melissa feels as though she needs a change of scenery in order to improve her mental health. She plans to transfer to another institution at the end of the semester. She feels as though if she says at Civitan University, she will not successfully complete her coursework and persist towards graduation.

Ashley

Ashley is a 19 year old first generation college student at Civitan University majoring in psychology (pre-medical). When she came to Civitan University, she found it difficult to make friends. She thinks the campus is very large and that it's difficult to get connected to people. As a result, she spends most of her days alone. Her closest friend is a young lady that she knew from high school who now lives in Africa. She feels like they have so much in common that they are basically the same person and they keep in touch through Facebook and Skype. Some of Ashley's classes make her feel stupid and she has a hard time getting out of bed. She has noticed a decrease in her motivation towards her classes but doesn't want to drop out of school because she doesn't want to live in debt and have nothing to show for it. She looks forward to one day graduating, paying off her student loans, making her mother proud, sending her mother on the vacation and owning a house with a garden and big garage. Though she is a pre-medical student, she doubts her ability to be accepted into and successfully complete medical school. Her grades are strong enough to get her inducted into honor societies but she feels as though she has to force herself to study. She would rather stay in bed and do nothing. She tries to get involved in student organizations on campus but finds that she feels uncomfortable in crowds of people and begins to avoid social interaction. She begins to have panic attacks when she thinks about her future and fears that she is suffering from depression and anxiety. Ashley feels that her depression and anxiety may have started her freshman year of high school when her parents got a divorce. It still distresses her that she doesn't know why the divorce occurred and feels as though she could be to blame for her parent's failed marriage. She remembers vividly the day her father stormed out

after a fight and initially blamed her mother for letting him leave. Once the divorce took place, Ashley felt as though her world was turned upside down. She was moved to a new school and then recruited into a cohort of advanced students. Since most the students in her new cohort were White, she remembers losing most of her Black friends because they felt as though she was too smart to hang out with them anymore. Ashley cries when she recalls this difficult time in her life. She felt alone, especially since it took two years for her relationship with her mother to become strong again. She has not told her mother about her mental health concerns and still does not have a relationship with her father. At one point, her mother feared that she had an eating disorder because, after a physical, her doctor found that certain nutrients missing her from blood work. Ashley insisted that she did not have an eating disorder but that she had lost her appetite and would occasionally skip meals. When venting some of her academic concerns to a staff person on campus, Ashley is told that she may benefit from visiting the campus counseling center. Ashley has heard about the counseling center in the past through informational workshops on campus but has never visited the office and is unsure of what services they offer. Since she generally doesn't like to talk about her problems and isn't sure if she can afford to pay for counseling sessions, Ashley decides not to visit the campus counseling center and, instead, manages her concerns on her own.

Kim

Kim is a 27 year old graduate student at Civitan University studying in the chemistry department. She is married with a young daughter. She is also a first generation college student who feels isolated on campus. She feels as though there is an atmosphere of competition in graduate school that she wasn't expecting. She began her graduate studies in chemistry with two other African American female students. They all had the same fellowship and, as a result, Kim felt as though they were under a microscope. She finds graduate school challenging because, on top of all the normal academic concerns, she is worried about misrepresenting her race and gender. She feels as though she has to prove that she is as capable as her classmates. She feels added pressure now because the two other students that she came in with left to pursue their graduate studies at other institutions. She feels as though she has extra pressure to perform especially when she experiences things like overhearing professors discussing their relief for not having to admit any more minority students for the semester. She feels her motivation lacking and fights periods of sadness and self-doubt. She encourages herself with inspirational quotes and by participating in student organizations that provide support to graduate students as well as opportunities to meet graduate students from other departments across campus. She copes by spending time with her family, lunch date with friends, and occasional cocktails. She also enjoys taking her daughter to classes like ballet because it gives her the opportunity to relax and interact with other mothers. She feels supported by her family and friends but doesn't believe that they understand the pressures of graduate school. She thought about telling a professor about her mental health concerns but felt weak and decided not to. She has a hard time asking for help because she feels that it communicates that she is not smart enough or lacks the ability to do her work. She finds that she gets defensive, emotional and argumentative when she feels as though anyone is questioning her ability and is fearful that she may come across as a stereotypical 'angry black woman'. Although she has seen ads for the campus counseling center, she has never taken advantage of their services because she feels as though she can handle her anxiety, depression,

angry, self-esteem, and pride on her own. However, she insists that she would consider reaching out to the campus counseling center if she felt like she was on the brink of a breakdown.

Jane

Jane is a 24 year old undergraduate student at Civitan University majoring in social work. She feels as though there is an implied racism on the campus and, as a result, she is cautious of whom she speaks to because she doesn't know how they truly feel about her. She is a first generation student who works part-time on campus. Though she admits that she was a bit of a wallflower in high school, Jane is active in student organizations and serves as president of a student organization council. She also competes in beauty pageants and currently holds regional and statewide titles. She wants to be a social worker because she believes a good social worker could have made a difference in her life. Jane was raised by her grandmother who legally adopted her and her siblings after they were removed from her mother. Her mother suffers from bipolar depression but she wasn't diagnosed until she was a middle-aged adult. Jane believes that many of the bad decisions that her mother made in her life are a result of her illness. She worries about her own mental health because she knows that bipolar depression is hereditary. However, when she first experienced a bout of depression in high school, she felt dismissed when her grandmother suggested that she just read the bible and pray. When she began classes at Civitan University, she began to separate herself from her family's beliefs which are aligned with the Nation of Islam. She feels that this separation from what she was raised to belief has contributed to some struggles with her identity. In addition to her identity issues, Jane feels that she suffers from situational depression because, when she is faced certain situations, she reacts emotionally and finds it difficult to handle. She finds it hard to concentrate on her studies and fails one of her classes. When she learns that her boyfriend, to whom she had lost her virginity, got another girl pregnant, Jane feels as though her life is upside down and reaches out to the campus counseling center. The campus counselor suggested that Jane see a psychiatrist off campus and that she consider taking medication. However, Jane is afraid of the side effects that may come with antidepressants and ultimately does not feel that she can afford to see a psychiatrist off campus. She does not share her concerns with her family members, many of whom distrust White people and specifically, the medical field which they perceive as White dominated. Instead, she continues to pursue her studies and manages her concerns on her own through prayer and the support of friends. Jane continues to sporadically utilize the campus counseling center. However, she only utilizes their services as a last resort when she finds that she cannot control her emotions.

<u>Participants from Arden University</u>

Katherine

Katherine is a 21 year old undergraduate nursing student at Arden University. She is from one of the largest countries in Africa and is proud to wear her cultural attire to special campus events. Katherine has been diagnosed as suffering from depression and an eating disorder. She is also a cutter, a person who deliberately inflicts harm to herself by cutting her skin. She believes that her mental health concerns started in high school around the age of 14 and that she got in trouble a lot in because of her unhappy home life. It was during this time that her extreme dieting started.

She is the third of four children and describes her family as extremely unaffectionate towards her. She believes that this has a great deal to do with the fact that she has an older brother with special needs and so the family's concern and attention are primarily focused on his needs. Her extreme dieting worsened when she entered college. In addition, she began to experience bouts of depression that resulted in her staying in her rooms for days at a time crying. Though she learned about the campus counseling center through a brochure, she didn't begin counseling until friends on campus all but insisted that she get help after noticing a change in her personality. Normally involved in campus activities such as the dance team, Katherine began to withdraw from her social interactions with friends and regularly skip classes (once for a month straight). When her grades began to suffer, she reached out to a professor who suggested that she try harder. Feeling helpless, she finally took the advice of her friends and reached out to the counseling center when she began having thoughts of suicide. The campus counselor recommended that Katherine seek the assistance of an off-campus psychiatrist. She now sees her off-campus psychiatrist on a weekly basis who created a treatment plan that consists of regular sessions with the campus counseling center. In addition, she takes medication. Though she feels that these services and resources have made a positive impact on her life, she has given up on her plans to apply to graduate school. Additionally, because of their strained and at times volatile relationship, she has yet to tell anyone in her family that she has been diagnosed with anything.

Christine

Christine is a 24 year old undergraduate student majoring in respiratory therapy at Arden University. She is a first generation college student who wants to make her family proud. She has an older brother and younger sister. Christine is eager to graduate and begin a career after changing her major and prolonging her years at Arden. She admits to feeling as though she doesn't fit in with many of her White classmates, because she worries about what they would think if they knew her parents did not go to college and she doesn't feel they can relate to her financial concerns, or the fact that she had to work a part-time job on campus to pay for school. She recognizes that worrying about her financial concerns negatively impacts her ability to focus on her studies but doesn't communicate her concerns to professors because she believes that they are not encouraging or understanding of the off-campus responsibilities and concerns of students. Her experience with the campus counseling center came about in a most unexpected manner. During a particularly stressful semester, Christine became extremely worried about how she was going to pay for her classes and her dorm. In a letter that she wrote to the dorm bookkeeper, she expressed her financial distress and confessed that, in her opinion, it would have been easier if she was never born. The dorm bookkeeper interpreted Christine's comments as suicidal in nature and passed them along to her supervisor. Her supervisor then went to Christine's room and walked her over to the campus counseling center himself. He insisted that Christine speak to someone right away. Though Christine was aware through word of mouth and campus brochures that the counseling center existed, she never thought about visiting it. She admits that the counseling session was helpful. She cried and was able to share her concerns. She found the counselor to be comforting and helpful. Though she was never diagnosed, she began to understand and admit to her battle with worry and depression, which was largely due to her financial concerns. Despite finding her impromptu counseling session helpful, Christine never returned for any additional sessions. She felt that it was more beneficial to pray, volunteer and talk to friends rather than to a counselor who hadn't necessarily experienced the same things. She

has not expressed her concerns to anyone in her family. While she considers them supportive, she doesn't believe that they, especially her mother, would understand. For years, she has struggled to communicate effectively with her mother. Though encouraging, Christine believes that her mother places a great deal of pressure on her. Christine attempted to remedy their strained relationship by writing letters to her mother like the one she wrote letting her mother know that she had lost her virginity. Her mother found the letter silly and unnecessary and ultimately used the letter's content to attempt to start an argument between Christine and her father. Christine's father on the other hand, expresses indifference and views Christine as an adult who can make her own decisions. Feeling as though she has few people that she can talk to, Christine relies on prayer and primarily confides in one friend on campus who has similar financial concerns.

Michelle

Michelle is a 22 year old undergraduate student at Arden University majoring in biology and Spanish. She grew up in a military family traveling and living in different cities until her father retired from the air force. Growing up, Michelle and her sister were always concerned about their mother's mental wellness. In Michelle's opinion, her mother has been in denial about her own depression for years. In middle school, when Michelle began to experience depression herself, she was afraid that perhaps her mother did have depression and passed it on to her and her sister. She expressed her concern to her father who gave her and her sister advice on how to cope with their mother and to manage their own depression by finding different ways of processing things. Even now, as a college student, Michelle calls her father and he prays over the phone with her, making himself available even at 2:00am and 3:00am. She decides not to share her mental health concerns with her mother because she doesn't want her to feel any guilt for possibly passing it on to her and her sister. During her sophomore year of college, her mother finally acknowledges that she has some issues but does not seek assistance. Instead, she attempts to manage her concerns on her own. Michelle continues her studies, works part-time on campus, and is involved in different campus organizations. She has what she refers to as mental breakdowns which are the suppressed emotions that rise to the surface and result in long periods of crying. Some of these breakdowns have resulted in her failing tests and assignments. Only a few friends know about these breakdowns. One friend in particular happens to be suffering from a mental health concern for which she takes medication. She told Michelle about the counseling center and invited her to walk there with her one day. Michelle agreed and, while waiting for her friend's session to end, she decided to schedule an appointment of her own. However, before the date of her appointment arrived, she decided that she felt better and canceled it. She admits that her main reason for not going to the session was that she didn't want to talk to a stranger about her business but, she does recognize that she has a pattern of feeling good and then feeling bad so she is thinking of visiting a counselor bi-weekly as a preventative measure. Until then, she is too busy and excited about her upcoming graduation.

Nicole

Nicole is a 20 year old undergraduate student at Arden University majoring in biology. She works part-time on campus and she is a member of several student organizations and even holds

a few positions in them. Nicole feels pressured to over exceed as an African American female student on campus because she believes there are people who feel as though her race is the lowest of all races. Despite this pressure that fuels her drive to succeed, she doesn't feel as though her pre-collegiate education prepared her for college. She didn't attend the best schools and had to take a few remedial courses which put her slightly behind. Nicole, her mother and her sister are victims of hurricane Katrina. Nicole and her sister had the opportunity to see a psychiatrist after the storm impacted their family but they never took advantage of that resource. She can't explain why they chose not to utilize those services. Last semester was the first time that she felt as though she may have some mental health issues. It was the hardest semester she ever had. She took a very heavy course load include two classes that she had to retake and a few difficult core courses. She felt that stress, depression and anxiety negatively impacted her ability to focus and perform well in class. In addition, she enjoys dating and being in relationships but begins to recognize a somewhat unhealthy need to be with someone and, when she is not in a relationship, she gets depressed. There are even times when her depression results in what she refers to as breakdowns which she describes as crying sessions that rejuvenate her. Despite her occasional crying sessions and poor academic performance, she begins to use prayer and faith to stay optimistic and guard her against the discouragement and doubt that she feels regarding her career goal of one day owning her own dental practice. Though she doesn't consider herself as having a disability, there are times when her mother exhibits symptoms of depression and utilizes a counselor. Nicole also knows of other family members who have been diagnosed with mood disorders and depression so she worries that perhaps it is hereditary and that she is in fact dealing with something that hasn't been diagnosed. She is aware of the counseling center and even knows of a friend who took advantage of their services and found them beneficial. However, Nicole feels as though she can manage her concerns on her own. Rather than visit the counseling center, she attends inspirational and motivational forums and seminars on campus and through her church. She also talks to her Mom who she describes as a realistic, direct and encouraging person who is easy to talk to even though it isn't always easy hearing her advice. Nicole continues to manage her concerns on her own.

Kate

Kate is a 22 year old undergraduate student majoring in respiratory therapy at Arden University. She is a first generation college student who is performing extremely well academically. She believes that her young daughter motivates her to succeed. Kate is a senior. During her sophomore year of college, she found out she was pregnant and had a baby girl. Though she loves her daughter, she believes her depression was triggered when she got pregnant. She was raised in a religious home and taught to abstain from sex until marriage. Instead, she lost her virginity and, after the first time, got pregnant. She felt as though she lost her identity. A child was not in her plans and she had gone against the religious lessons that she had been taught. After her daughter was born, Kate returned to school leaving her daughter at home. She tries to see her daughter every weekend but it depends on her class schedule. She believes that being away from her daughter also contributes to her depression. Once back in school, she settled back into a regular routine. She noticed that she began having text anxiety but it did not negatively impact her academic performance. She began dating again and unfortunately met someone that she thought she could trust and was date raped. She did not report the incident. She coped the best way she felt she could but didn't share her experience because she didn't want to be judged.

When she is alone, Kate finds herself crying day and night. At one point, her sister walked in on her crying. Kate told her about the incident in hopes that her sister, a freshman in college, would use it as a cautionary tale. Her sister sat with her, let her cry, and gave a few words of encouragement and support. Though this was several months after the rape, it was during this time that Kate decided to visit the campus counseling center. She knew that the counseling center existed because of information that was shared during orientation, through campus brochures and word of mouth from other students on campus. She found her counselor to be patient, attentive and informative. She assured Kate that the rape was not her fault and suggested that she begin keeping a journal; a suggestion that Kate has found helpful. The counselor also provided Kate with activities for boosting her self-esteem. After only a few sessions, Kate decided that she was feeling better and stopped utilizing the counseling center. She was active in campus activities in the past but decided to only continue with some of her volunteerism and, instead, focus on her upcoming graduation. Though she feels better about her experiences, she still does not share them with others. As a matter of fact, she has not told her mother about the rape, her depression or her anxiety. Her main reason for not telling her mother is that she doesn't want to worry her.

Alesia

Alesia is a 21 year old undergraduate student at Arden University majoring in communications management. She enjoys the diversity of the campus but feels as though the students self-segregate and she finds that disheartening. She is an artistic student who plays guitar, sings and writes music. She also works part-time off campus and is involved in student organizations on campus. Her parents are not together and have not been for years. Because of their separation, she spent time growing up in two different states. Though she has never taken advantage of the counseling center, she is aware that it exists because a classmate told her about it. Alesia feels as though she has obsessive-compulsive disorder (OCD) that also triggers depression, anxiety and anger. Despite being an active high school student who was voted class president twice, she remembers vividly that she noticed OCD related symptoms when she was 15 years old because she was transitioning from chemically processed hair to natural hair and, three days before school started, she cut off all her hair. She remembers crying and being upset because she thought that she looked like a man. She couldn't sleep that night and remembers staying up and taking all of the posters off of her walls but then putting them all back up in the exact same way they were hanging before. Ever since that night, she noticed small things that caused her anxiety like cabinets being open and buttons on shirts being undone. She thinks her anxiety started when she was 17 years old. During that time, she was preparing for college and felt as though her mother put a lot of pressure on her to complete college and scholarship applications. She remembers crying as she completed her applications and being afraid of making a mistake on them or not being accepted into college. As she reflects on when she believes her mental health concerns started, she shares that she feels as though her concerns might be hereditary. She is extremely close to her grandfather who is a hoarder and admits that she sees some of his hoarding characteristics in herself. She also has an aunt who exhibits symptoms of OCD. However, neither of them has been evaluated and other relatives laughingly refer to them as having unique, quirky personalities. When Alesia conducted an internet search of OCD on Google and learned more about the symptoms, her concerns were reinforced. Now, as a college student, she feels as though her concerns have followed her through the years and, after having two uncles pass away in the past six months, she has become preoccupied with concerns of who

in her family might be next to die. Her uncontrollable thoughts and concerns are negatively impacting her ability to concentrate in class and contribute to her being a procrastinator. Despite her concerns however, Alesia is performing extremely well and making the best grades she has ever made. She doesn't feel as though she can talk to her family about her concerns because past attempts to talk to her mother and sister left her feeling judged and patronized. She has a strained relationship with her father and avoids expressing her feelings to him. However, her boss at work expressed concerns about Alesia's scattered personality. She decides to confide her concerns to a professor that she felt like she had things in common with. She was surprised to learn that he also suffers from anxiety. He jokingly told her that, because they are artists, they are destined to be a little crazy. He also shared his experiences with taking medication and making the decision to stop because he felt it made him lose himself and his creativity. Finally, he shared other ways channeling his anxious energy such as meditation. Alesia attempts meditation but finds that her mind races too much for meditation to work effectively for her. When she saw the flyer for this study, she took two weeks to build up the courage to volunteer. Once she volunteers, she uses that momentum to also schedule an appointment at her campus counseling center.

Angela

Angela is a 19 year old undergraduate student at Arden University majoring in nursing. Though she was an active high school student who played in the band, she is currently not a member of any organizations on her campus. She works part-time off campus and works with children through her volunteer work. Angela has a younger brother who was born prematurely. After his birth, he stayed in the hospital for a month. Inspired by how the nurses lovingly took care of her brother during this time, she made the decision to pursue a career as a neonatal nurse. Also, while in high school, Angela's sister was diagnosed with a reoccurring cancerous brain tumor. This is when she feels as though she began to suffer from depression. Normally beaming with a comical and funny personality, Angela began to shut down when her sister started chemotherapy and radiation. She noticed that she wasn't interested in her regular school activities or with hanging out with friends. She also noticed that her grades, which were normally great, started to decline. She decided to search the internet to learn more about her symptoms and self-diagnosed herself with depression. Her grandmother and an uncle noticed a difference in a personality but she never talked to them in detail about her concerns. She has a strained relationship with her mother who, because of her fierce focus on her career as a lawyer, Angela believes should have never had children. When she did decide to express her concerns to her mother, she was advised that staying busy would help keep her mind off of her worries. Angela noticed that sleeping and staying busy did seem to help. She began to sleep a lot. When she graduated from high school, she felt that leaving home would cure her depression because she wouldn't have to deal with the sadness of her sister's illness. When she began classes at Arden University, she felt that her depression drastically dissipated. However, when she goes home, it quickly returns and she finds that she spends most of her visits home in bed. For example, she spent the last summer at home and, when she realized that she was sleeping all day, she decided to keep busy with an online class. She proudly shares that she made an A in the course. Angela has never been to the campus counseling center and doesn't know where it is located but she knows that is exists because she heard about it during orientation and during campus informational workshops. However, at this point in her life, she feels as though she is too busy with work and school to take the time to

speak to a counselor. Plus, she ultimately feels that she can manage her depression on her own by staying busy and staying away from home.

Audrey

Audrey is a 25 year old graduate student at Arden University working towards a degree in public health. She describes her father as a verbally abusive man who made fun of her hair and dark complexion and her mom as unaffectionate woman with insecurities because of her failed marriage. Though she has always prided herself on being a strong academic student, Audrey struggles when she begins classes at Arden University. She finds it difficult to focus. When her grades begin to decline, she begins to question her abilities and career aspirations. By chance, the instructor of one of her classes was a counselor in the campus counseling center. One of their assignments was to visit the counseling center to get some information. Audrey misunderstood the assignment and, while visiting the counseling center, completed a questionnaire. A few days later, someone from the center called to let her know that, though she wasn't required to complete the questionnaire, the results reflected that she could potentially benefit from speaking with a counselor. Audrey agreed to meet with a counselor and felt that it was perfect timing because her grandmother recently encouraged her to talk to someone. She found the sessions beneficial. However, her concerns continued to mount. When she tried to talk to family, they encouraged her to pray and stay strong. When she joined a sorority, she thought she would find support amongst her organization members but she faced some negativity and criticism about her appearance and was told that she looks like a man. Consumed in her worries, Audrey spent an entire weekend in bed considering how to commit suicide. She felt overwhelmed by life, classes and even her pledging responsibilities with her sorority. She imagined how many pills she would take and how long it would take for her body to be found. The following week, she rushed to her counseling center and broke down in uncontrollable tears. At that point, she was placed on antidepressants. Her family did not approve of her taking medication but she felt as though she needed them. She feels as though there is a history of depression in her family because her mother takes two antidepressants. However, she doesn't know anything about her mother's mental health concerns. And, to Audrey's surprise and confusion, her mother is not accepting of Audrey's own decision to take antidepressants. Despite her family's disapproval, Audrey believes that her medication helps her focus, engage, and understand in her classes. She believes that acknowledging and treating her depression and self-esteem issues has made her a better communicator because she is more accepting of herself. She also believes that she is a better leader now and shares her experiences through campus speeches to classes and student organizations. She has a fear of relapsing to a period of considering suicide. Though she attempted to wean herself off of her antidepressant, she ultimately began taking them again when she started applying to grad school because she was worried that she wouldn't be able to focus in graduate level classes without it. She feels as though she found herself with therapy and antidepressants and doesn't want to lose herself again.