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Psychotherapy Utilization and Presenting Concerns Among Black International and African-

American Students in a University Counseling Center

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A dissertation submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of

Doctor of Philosophy

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ABSTRACT

Psychotherapy Utilization and Presenting Concerns Among Black International and African-American Students in a University Counseling Center

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Doctor of Philosophy

Little is known about the psychotherapy utilization, presenting concerns, and outcome differences between Black international and African American university students. The aim of this research is to identify potential similarities and differences between the two groups, as well as potential differences between the aforementioned groups and white students. This study examined archival data collected over the course of a 17-year period that focused on experiences of African-American, Black international, and White students at a large university in the Rocky Mountain West, United States. More specifically, archival data were analyzed to identify differences between the aforementioned groups of students in regard to psychotherapy utilization, presenting concerns, distress levels endorsed at intake, and distress levels endorsed at termination. Results indicate significant differences between African-American, Black international, and White student groups in terms of the maximum number of psychotherapy sessions attended and length of treatment in days. We found significant differences between these groups of students on several items assessed in the Presenting Problem Checklist and the Family Concerns Survey. We found no significant difference between African-American, Black international, and White student groups in the severity of presenting distress as measured by the Outcome Questionaire-45. We found a significant difference between groups in treatment improvement as measured by change scores on the Outcome Questionaire-45, with White students experiencing the greatest change, followed by Black international students and African-Americans. Possible explanations and implications for practice will be discussed in the body of the paper.

Keywords: Black students, African-Americans, Black international students, university counseling centers, utilization, outcome

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DESCRIPTION OF DISSERTATION FORMAT

Traditionally dissertations have been organized in a five-chapter format. However, this dissertation, *Psychotherapy Utilization and Presenting Concerns Among Black International and African American Students in a University Counseling Center*, is organized such that it is ready for publication in a standard peer-reviewed journal. A full literature review is included in Appendix B with other supporting documents after the discussion section concludes.

Introduction

"Education is the medium by which a people are prepared for the creation of their own particular civilization, and the advancement and glory of their own race." -Marcus Garvey

The first time mental health services were offered at a university was at Princeton in 1910 (Kraft, 2011). Since that time many universities across the country have started providing treatment for mental health concerns. As enrollment in universities across the country has steadily increased over time (U.S. Census Bureau, 2012), the number of students seeking mental health treatment has also increased (Benton, Robertson, Tseng, Newton, & Benton, 2003; Blanco et al., 2008; Hayes et al., 2011; Hunt & Eisenberg, 2010). M. David Rudd (2004) suggested that the increase in university enrollment is directly related to the increase in utilization of university counseling centers and that psychotropic medication is providing stability for students struggling with mental health concerns who, in years past, would have been unable to attend university due to their mental health issues.

Demographics of Students Who Use University Counseling Centers

Beyond the increased numbers of students with potentially more significant mental health concerns attending university, there has also been a significant shift in the overall demographic diversity of students aged 18–24 attending colleges and universities (U.S. Census Bureau, 2012). Across the country, institutions of higher learning are seeing an increase in the enrollment of racial and ethnic minorities. University counseling centers are also seeing more in diversity among the students they serve (Benton et al., 2003; Blanco et al., 2008; Hayes et al., 2011; Hunt & Eisenberg, 2010). This increased use of counseling center services by increasingly diverse

students with potentially higher levels of mental health concerns brings with it implications and complexities (Rudd, 2004).

Two groups that have increased counseling center utilization are international students and Black students (Gallagher, 2015; Gallagher, Gill, & Sysco, 2000; O'Malley, Wheeler, Murphey, O'Connell, & Waldo, 1990; Rudd, 2004). Studies have suggested that international students face unique challenges due to adjusting to a new culture, often with limited support (Schulte & Choudaha, 2014). International students tend to struggle with problems like financial worries, relationship concerns, depression, anxiety, and academic problems (Fan, 2000; Jenny, Lin, & Kishimoto, 2003; Nilsson, Berkel, Flores, & Lucas, 2004). They also often have difficulties with homesickness, language barriers, perfectionism, cultural isolation, visa status, and adjustment and acculturation problems (Choe, 1996; Furnham & Bochner, 1986; Jackson & Heggins, 2003; Pedersen, 1991; Pendse & Inman, 2017; Olivas & Li, 2006; Smith & Khawaja, 2011; Wehrly, 1988). Because of these nuanced experiences, international students may struggle with more psychological problems than their American counterparts and, as such, should be considered a high-risk group (Dillard & Chisholm, 1983; Hamamura & Laird, 2014; Jenny et al., 2003; Mori, 2000; Pedersen, 1991; Pendse & Inman, 2017; Sandhu & Asrabadi, 1994).

While counseling centers are a good option for international students to address their psychological concerns, as well as their adjustment and acculturation process, it is well documented that these students do not utilize these resources as much as American students (Choe, 1996; Furnham & Bochner, 1986; Hamanura & Laird, 2014; Jackson & Heggins, 2003; Pedersen, 1991; Pendse & Inman, 2017; Olivas & Li, 2006; Wehrly, 1988). Researchers suggest that international students may be less aware of the resources available on campus (Idowu, 1985; Mori, 2000). There may also be a cultural stigma associated with seeking treatment of mental

health concerns (Arthur, 1997; Lin, 1996; Mori, 2000; Nilsson, Butler, Shouse, & Joshi, 2008). Furthermore, seeking help from family may be a more familiar and acceptable option for some international students than receiving services in a formal setting (Al-Darmaki, 2014; Hamamura & Laird, 2014; Hayes & Lin, 1994; Heath, Vogel, & Al-Darmaki, 2016; Pederson, 1991; Pendse & Inman, 2017). However, international students do not have physical proximity with their families and their support structure is often disrupted when they move to the United States for school. University counseling centers can help alleviate many of these concerns and be a resource of support. Research suggests that international and minority students will be much better reached and served if counseling centers familiarize themselves with the unique needs of these underserved groups (Al-Darmaki, 2014; Davidson, Yakushka, & Sanford-Martens, 2004).

Likewise, Black students are presenting at increasing rates at university counseling centers. Historically, the utilization rates of mental health treatment by Black people have been lower than utilization rates among White people (Andrulis, 1977; Barksdale & Molock, 2009; Davidson et al., 2004; Neighbors & Jackson, 1984; Smead, Smithy-Willis, & Smead, 1982; Temkin-Greener & Clark, 1988). This underutilization of treatment has also been the case for Black college students compared to White college students (Barksdale & Molok, 2009; Davis & Swartz, 1972; Duncan, 2003; Gibbs, 1975; Kysar, 1966). The foundational study that examined university counseling center utilization rates among Black students was conducted nearly forty years ago by Thompson and Cimbolic (1978) who looked at racial preferences for therapists of Black students at university counseling centers. They found that, in general, Black students preferred to work with Black therapists. Follow-up studies have repeatedly validated this preference (Atkinson, 1983; Barksdale & Molock, 2009; Coleman, Wampold, & Casali, 1995; Parham & Helms, 1981; Speight & Vera, 1997; Thompson, Bazile, & Akbar, 2004).

Researchers have worked to identify why this preference exists. In examining the work of several studies, a few important themes have emerged. People are inextricably tied to their history and there is racial tension in the United States between Black and White people because of centuries of systematic oppression of Black people (Terrell & Terrell, 1981; Townes, Chavez-Korell, & Cunningham, 2009). A general mistrust or suspicion of White people is present for many Black people (Townes et al., 2009; Ward & Besson, 2013). This mistrust creates reluctance among Black individuals to seek mental health services (Hall & Tucker, 1985; Hamilton et al., 2006; Townes et al., 2009; Ward & Besson, 2013) which have typically been provided by White mental health workers.

Another theme that emerged from the research regarding Black people's preference for Black mental health workers involved ancestry. Black people in America of African ancestry have ancestral ties to the creation/discovery of numerous fields of study including math, astronomy, metallurgy and tools, architecture and engineering, medicine, and navigation (Blatch, 2013; Brooks, 1971; Kresge, 2011). While the aforementioned fields of study can be readily understood and accessed by Black people, psychology (based on rates of utilization) seems to be an area that is not as easily understood (Hall, 2001; Nobles, 1972; Pedersen, 2004; Thompson et al., 2004; Trusty, Davis, & Looby, 2002). Black Americans also tend to hold differentiated views of mental illness (Hall, & Tucker, 1985; Hamilton et al., 2006; Townes et al., 2009; Ward & Besson, 2013). Psychology is a western Eurocentric field of study (Hall, 2001; Ibaraki & Hall, 2014; Krause & Howard, 1883; Pedersen, 2004; Ponterotto, Casas, Suzuki, & Alexander, 2009; Trusty et al., 2002), and while African-American minds have become colonized through generations of living through and interacting within imperialistic societies (West, 1993), it seems that there is an inherent resistance to a field created by and for Europeans.

Given that many Black people have underutilized mental health services in the United States, many are left with untreated or under-treated mental illnesses (Whaley, 2001). It has been argued that when a significant population does not or cannot access mental health treatment, this then becomes a public health issue (Whaley, 2001). Black people are an underserved population, and until a transformation occurs within the field of mental health, clinicians should work to validate the nuanced concerns of Black clients (Whaley, 2001).

While it is beyond the scope of this paper to list all the ways that therapists can provide better services to underserved populations, becoming familiar with the multicultural competencies (awareness, knowledge, and skills) is an excellent first step. Becoming familiar with these competencies will help aid therapists in working around some of the barriers to alliance in therapeutic settings that individuals from minority backgrounds face (Sue, Arredondo, & McDavis, 1992; Sue, Bingham, Porche-Burke, & Vasquez, 1999). A brief review of multicultural competencies follows and readers are encouraged to more fully examine the works of Sue and colleagues (1992) and Arredondo and colleagues (1996). When a therapist is *aware* of their own ethnic identity and biases, they are better able to deconstruct their place of privilege and work to understand and advocate for their client. Becoming *knowledgeable* about the unique histories and challenges of oppressed people provides therapists with a base of understanding how and where therapy can be adapted. *Skills* essentially put the previous two competencies into action (Sue et al., 1992; Sue et al., 1999; Griner & Smith, 2006; Smith & Trimble, 2016).

Cultural Differences between African-American and Black International Students

Given that there are many unique differences among those from even the same ethnic/racial minority groups (Sue, 1998), it is important that university counseling center mental health providers not approach all students from the same minority background with the same

approach. For example, treating all international students with an "international student" approach may be problematic inasmuch as there are likely to be numerous distinct differences among international students from various ethnic, regional, and racial backgrounds. To date, research focused on Black individuals in university counseling centers has examined data for the Black student population as a whole (African-American and Black international combined), but has not separated or analyzed data for this population according to citizenship or nationality. Outside of counseling centers, there are a few, very nuanced studies that compare African-Americans and Black Caribbeans (Aranda et al., 2012) or African-Americans and Africans (Bagley & Copeland, 1994) on a specific issue or diagnosis. However, to our knowledge there have not been any studies that examine or compare the treatment utilization rates, reported distress levels, psychotherapy outcomes, or presenting concerns of Black international university students to African-American university students.

Why is it important not to lump all Black students together? Again, people are tied to history, informed by culture, and experience the world though a contextual lens. America is considered a developed nation that embraces a predominantly "Western" culture (Hall, 2001; Ibaraki & Hall, 2014; Krause & Howard, 1883; Pedersen, 2004; Ponterotto et al., 2009; Trusty et al., 2002). Many Black international students are from non-Western cultures, and many come from economically disadvantaged/developing nations (World Bank, 2015). Those from more collectivistic communities will likely seek help and support from family or close friends, whereas people from more individualistic communities are more open to utilizing professional resources (Triandis, 1995). Different cultures view education in differentiated ways, which also impacts why and how students utilize campus resources (Neal & Heppner, 1986). In numerous ways, African Americans differ from their Black international peers, and viewing them through

parallel assumptions is naïve and culturally insensitive. Therapy cannot be effectively adapted if multiple cultures are being viewed and or treated as a single culture.

Some research has suggested that therapeutic outcomes for university students—according to the Outcome Questionnaire 45 (OQ; please see brief description of this measure in the instrument section)—are the same for White clients as they are for clients from racial/ethnic minority backgrounds (Lambert et al., 2006). This finding is based on data showing a similar interval of decrease in OQ scores between White and racial ethnic minority university students.

Lambert and colleagues (2006) further found that racial/ethnic minority students had higher levels of distress and left treatment with higher levels of distress compared to their White counterparts. That is, racial minority students tend to have higher levels of distress at intake and at the end of treatment in spite of having similar decreases in OQ scores. However, Lambert and colleagues (2006) did not specifically account for potential differences between international students and American racial minority students; these two groups were lumped together in the same ethnic group category.

While previous studies have examined the utilization and outcomes of Black students at university counseling centers (Kearny, Draper, & Barón, 2003; Lambert et al., 2006; Nickerson, Helms, & Terrell, 1994; Whaley, 2001), separating African-American and Black international students is an area that is still lacking. Understanding potential similarities and differences between these two groups will likely help clinicians in college counseling centers better know how to best serve these unique populations.

Research Questions

The purpose of this study is to provide more insight into the potential similarities and differences in treatment utilization and presenting concerns among African-American and Black international students. In this study, we addressed the following:

1. What are the utilization and dropout rates of African-American, Black international, and White students in psychotherapy in a university counseling center?

2. How are the presenting concerns that bring African American, Black international, and White students to therapy (as measured by the Family Concerns Survey and the Presenting Problems Checklist) similar to and/or different from one another? How do these concerns compare between African American, Black international, and White students?

3. What is the severity/frequency of concerns presented (as measured by the Presenting Problems Checklist and the OQ 45) at intake of African American, Black international, and White students?

4. What are treatment outcomes (as measured by differences between initial OQ-45 and final OQ-45 scores) for African American, Black international, and White students?

Methods

Participants

At a large, intermountain-area, private university in the mainland United States, all White and Black (African-American and Black international) students who completed an intake at this university's counseling center during the academic years 1996–2013 were included in the sample. We included White students as a comparison group as White students made up the vast majority of students attending this university (approx. 89%), and it made sense to compare the

experiences of African-American and Black international students to the experience of the

majority. This data, collected over 17 years, included a total of 116 African-American students,

53 Black international students, and 18,628 White students. (See Table 1 for more detailed

demographic information of each of these groups.)

The sample included individuals who identified as racially Black from a variety of

nationalities. In order to be included in the category of African-American, students needed to

identify their primary or secondary race (on the demographic questionnaire) as Black and mark

their citizenship or country of birth to be the United States. Students who marked their ethnic

identity as Black beyond the secondary level were not included. In order to be included in the

category of Black international, students needed to endorse their primary or secondary race as

Black and needed to mark their citizenship and country of birth from a nation outside of the

United States. Once again, students in this category who marked their ethnic identity as Black

beyond the secondary level were not included. Our purpose was to capture the experience of as

many Black students as possible, which was the rationale for including any student who was

racially Black regardless of nationality. In order to be included in the category of White,

students needed to endorse their primary race as White and mark their citizenship as United

States. We included only those who endorsed American citizenship to help rule out potential

differences that may exist should the White student be an international student. After creating

these categories, we analyzed the data in order to examine clinical differences between African-

American, Black international, and White students.

Setting

Over the 17 years that these data were collected, on a yearly basis this counseling center

employed a range of 21–28 full-time clinical faculty members, 3–4 pre-doctoral interns, and 16–

22 doctoral level practicum students. When students request counseling in this center, they are assigned to the first available counselor based on the availability of full- and part-time clinical faculty members, pre-doctoral interns, and doctoral practicum students. Considerations are taken to make sure that students presenting with a high severity in symptoms are assigned to clinicians with the appropriate level of competence. The full- and part-time clinical faculty, pre-doctoral interns, and doctoral practicum students at this center endorsed a variety of theoretical orientations (e.g., cognitive-behavioral, acceptance and commitment therapy, interpersonal). Unless students requested a specific type of treatment or a specific therapist, they were assigned at random to the first available counselor and received services as per that counselor's theoretical orientation. In addition to individual therapy, this counseling center has, on average, 25–30 different psychotherapy groups available each semester, as well as biofeedback services that the student may choose to participate in if applicable.

Counseling centers normally have systems in place for keeping data on clients past and present. The system for entering and storing this information is usually adequate; however, due to occasional clerical errors or system changes, it is possible that errors or inaccuracies could be present. In that we collected data from 1996–2013 (during which time the setting moved from paper to electronic records), it is likely that some data were inaccurate or incomplete. For this study only complete and accurate records that included the instruments listed below were included.

Instruments

A variety of instruments were utilized in this study: three gathered intake data, and an outcome measure was administered prior to each counseling session.

Demographic Questionnaire (DQ). This measure gathers general demographic information (e.g., gender, age, ethnicity, citizenship, religious preference), as well as previous counseling experience.

Family Concern Survey (FCS). The FCS is designed to assess the occurrence of traumatic family history events that may have influenced students' psychological development (Kearny, Draper, & Barón, 2003). Students are asked to indicate whether or not 18 particular events happened in their family during childhood or adolescence and are asked to mark "Yes," "Unsure," or "No" on the survey. The list of 18 family experiences includes a variety of areas of difficulty including abuse, divorce, and substance abuse. Though there is no reliability or validity data available for the FCS, the Cronbach's alpha for this study is .78.

The Presenting Problem Checklist (PPC). This 42-item self-report measure was designed to assess the degree to which students experience distress in several major areas of life functioning. Developed by the Counseling and Mental Health Center at the University of Texas at Austin (Draper, Jennings, & Barón, 2003), this checklist is used not only by the counseling center from which the data in this study were collected, but by many counseling centers across the country to comprehensively assess students' presenting concerns and difficulties. It was constructed based on a review of 12 presenting problem checklists submitted by various counseling centers. Items were rationally selected with the goal of constructing a list of problems that was comprehensive and not redundant.

The checklist was completed by those in this study as part of the intake procedure at the counseling center. Clients responded to each item twice, once using the stem "Indicate the extent to which the problem is currently causing you distress" and another time using the stem "For how long have you had the problem." A Likert scale of 0 (*none*) to 4 (*extreme*) was

employed for the first stem, and a Likert scale of 1 (*less than a week*) to 6 (*more than 3 years*) was employed for the second stem. The total scale shows a Cronbach's alpha of .90 (Draper et al., 2003). The Cronbach's alpha for this study was .94.

Based on the typical use of the data from the PPC and the FCS, we chose to use the item-level analytic strategy due to its clinical relevance. Clinicians at this counseling center viewed the data from these measures item by item. Each item helped psychotherapists at this targeted counseling center to make important decisions about the student/client and the approach to treatment.

The Outcome Questionnaire-45. The OQ-45 is an outcome measure commonly used with college students, as it has been shown to be sensitive to change among this population (Lambert & Finch, 1999). It is a 45-item, self-report measure designed to provide a global assessment of client distress (Lambert, Lunnen, Umphress, Hansen, & Burlingame, 1994). Items are rated on a 5-point scale from *never* to *almost always*. For example, item 2 reads, "I tire quickly," to which students respond with a 0 (*never*), 1 (*rarely*), 2 (*sometimes*), 3 (*frequently*), or 4 (*almost always*). Higher scores indicate greater levels of distress. Typically, a score of 63 or lower falls in the subclinical range, whereas scores above 63 represent a clinical population (Kadera, Lambert, & Andrews, 1996). The standard deviation for this measure is 15 points, and 14-point increases or decreases indicate reliable change. Prior research indicates that the OQ-45 has excellent internal reliability (alpha at .93), test-retest reliability (.84), and concurrent validity with other instruments ($r = .58$ to .84; Kadera et al., 1996). The Cronbach's alpha for the data in this study was .92. This measure has also been shown to be effective at detecting treatment deterioration in college counseling centers (Hannan et al., 2005) and across several ethnic minority groups in college counseling centers (Lambert et al., 2006).

Results

Treatment Utilization

While we have therapy attendance data for this counseling center from 1996–2013 (17 years), we were only able to obtain enrollment data for the university from 1997–2013 (16 years). Thus, we conducted odds ratios for the years 1997–2014 (16 years) to determine treatment utilization. All other analyses we conducted were from data collected in the counseling center over the 17-year period.

Over the 16-year data collection period, on average, around 1,200 students per year completed intake paperwork at this university's counseling center. Of those roughly 1,200 students, on average there were between three and four Black international students and between six and seven African American students in a given year who attended therapy in this counseling center. There is a wide range in the number of White students who attended therapy each year, but over the 16 years, the approximate range was 600–1,400. Enrollment data provided by the university over this 16-year period indicated that in any given year, there were approximately 30,021 students on campus. Of those roughly 30,021 enrolled students, on average in a given year, approximately 83 (<1%) were Black international students, approximately 123 (<1%) were African-American, and approximately 26,903 (89%) students enrolled were White.

Odds ratios were calculated across all 16 years of data to explore the likelihood of African-American students, Black international students, and White students attending therapy compared to the proportion of students on campus in each of the aforementioned groups. More specifically, these odds ratios indicated the proportion of students from each of the aforementioned groups who attended therapy, compared with the proportion of the total number of students from each of these groups attending the university.

Across all 16 years, the aggregate odds ratio for White students compared with African American students was 1.35, suggesting that African-American students were 35% more likely to attend therapy than their White peers during that timeframe. The aggregate odds ratio for White students compared with Black international students was .995, indicating essentially no difference between these two groups in regard to their likelihood of attending therapy (an odds ratio of 1.0 indicates identical likelihood). Thus, these results also indicate that the Black international students were 35% less likely to attend therapy than their African-American counterparts. In summary, Black international students and White students were equally likely to attend therapy in this counseling center, and African American students were more likely to attend. Although the overall number of clients seen at the counseling center did increase over time, no trends in attendance (increasing or decreasing) were discovered for any of the comparisons between groups. Variations in the odds ratio data from year to year (see Table 2) are likely due to the low numbers of Black international students and African-American students.

Attendance Trends in an Episode of Treatment

One way of analyzing the effectiveness or impact of therapy is to measure attendance trends or how long clients engaged in therapy—both the number of days in treatment and the number of sessions attended. We ran descriptive statistics to identify the attendance trends among these three groups. In order to be included in the data set, students had to attend at least one therapy session. The average number of sessions attended was 11.62. Eighty percent of the clients in our sample were seen for 16 or fewer sessions, and 78% of cases in our sample were in treatment for less than one year.

A Cox regression analysis was calculated to better understand the trends of attendance. Our findings concluded that the initial OQ score was most significantly related to attendance,

both in terms of length in days and number of sessions attended. The higher the OQ score (indicating a higher level of distress), the longer the episode of treatment for all three groups. While the OQ score was most closely related to length of treatment attendance, there were differences in attendance between the three groups. After controlling for gender, initial distress level, and age, Cox regression analyses were calculated to determine differences between African-American, Black international, and White students on both number of days in treatment and number of sessions attended.

In our analysis of length of days in treatment, we used a cutoff score of 120 days because the majority of university counseling centers are organized such that it was unlikely for students to be involved in counseling for more than 120 days in a given year. Black international students spent significantly fewer days in treatment ($p<.001$) when compared to the other two groups. There was no statistically significant difference between the length of days in treatment between African-American and White students (see Table 3 and Figure 1).

Because the data were skewed due to outliers (the highest number of sessions being 512), and because of the rationale explained below, we set a cutoff score of 16 sessions. Receiving services beyond 16 sessions is considered long-term treatment, and counseling centers typically provide brief therapy with session limits. African-American students attended a greater number of sessions when compared to the two other groups and were least likely to drop out of therapy ($p<.001$). Black international students attended the fewest number of therapy sessions, and White students fell in between the two groups in terms of number of therapy sessions attended (see Table 4 and Figure 2).

Presenting Problems Checklist

When clients attend therapy in university counseling centers, they present with a variety of concerns (Benton et al., 2003; Constantine, Chen, & Ceesay, 1997; Gallagher et al., 2000; O'Malley et al., 1990). Identifying what concerns are related to client distress is one way of exploring the nuances of the therapeutic experience of those attending therapy. A Kruskal-Wallis one-way analysis of variance (ANOVA) was used to identify potential differences between groups on their presenting concerns at intake. This non-parametric analysis assumes non-normal distributions of data. Participants' scores from our sample were analyzed on an item-by-item level because the PPC is used on an item-by-item level by clinicians. Differences on several items were identified between the three groups. Due to the large number of analyses conducted, a Bonferroni correction was conducted to help avoid making a Type 1 error. This changed the level of statistical significance to a p-value equal to or less than .0012.

The PPC measures individuals' reported levels of distress and reports duration of said distress. Table 5 provides the mean ranks for African-American, Black international, and White students on this measure with indications as to which reached statistical significance. Compared to White students, Black international students reported statistically significant higher levels of distress related to adjustment to the university, ethnic/racial discrimination, homesickness, and rape/sexual assault ($p<.001$). African-American students, when compared to White students, reported statistically higher levels of distress related to items of ethnic/racial discrimination and rape/sexual assault ($p<.001$). In regard to the duration of distress, both Black international and African-American students reported longer duration of stress related to ethnic/racial discrimination ($p<.001$) than White students. Differences between African-American and Black international students on the items mentioned above did not reach statistical significance for any

question on either level of distress or duration of distress. The items noted above are the only items that have statistically significant differences on level of endorsement between groups.

Family Concerns Survey

The FCS provides information about the distress a client may have experienced due to difficulties with family. Given the nominal nature of the data on the FCS, a chi-square test of independence was utilized to evaluate any disproportionate representation between the three groups. The possible endorsements that can be made on each item on the FCS are "no," "yes," and "unsure." As with the PPC, participants were analyzed on an item-by-item level because practitioners use the FCS on an item-by-item level clinically. Again, Bonferroni corrections were applied, which resulted in a .002 level of significance for these analyses. Participants in the three subgroups differed proportionately and significantly from one another in their "yes" responses on several of the 18 items (see Table 6). The three subgroups did not answer "no" or "unsure" at rates (either higher or lower) that differed proportionally from one another at statistically significant levels.

African-Americans endorsed "yes" to questions related to familial conflict, parental employment problems, and frequently moving at significantly higher rates than both Black international and White students. Both African-American and Black international students endorsed "yes" to questions regarding parents being divorced at significantly higher rates than their White peers, but the two groups were not significantly different from one another. White students did not endorse "yes," "no," or "unsure" to any familial concerns at a significantly higher or lower rates than the other two groups.

Severity of Presenting Concerns

In order to identify the level of distress at intake, initial distress levels were examined by looking at OQ-45 scores at intake. A one-way analysis of variance (ANOVA) yielded no significant differences between African-American, Black international, and White students on initial distress level.

Rate of improvement from treatment was analyzed with a repeated measures one-way analysis of covariance (ANCOVA), controlling for initial symptom severity as well as participant age and gender. The ANCOVA found that all groups improved across time (Wilks lambda .995, F= 75.2 p<.001 observe power = 1). The only significant difference that emerged between groups was between White students and African-American students, with African-American students having lower improvement rates than their White student counterparts ($F = 4.64$, $p = .031$).

<div align="center">Discussion</div>

To date there has been very little research exploring potential differing experiences of African-American and Black international students in the university counseling center setting. This study separated these groups and provides information about treatment utilization, presenting concerns, the severity of those concerns, and improvement rates for African-American, Black international, and White students.

Summary of Treatment Utilization

We found that both White students and Black international students were 35% less likely than African-American students to attend treatment at this university. While our findings indicate that the African-American students in our study tend to utilize treatment more frequently than White students, this is a departure from the current body of literature, which highlights

underutilization rates among Black university students (Davis & Swartz, 1972; Duncan, 2003; Gibbs, 1975; Hunt, Eisenberg, Lu, & Gathright, 2015; Kysar, 1966). Our findings for international students differed from the current research as well. Previous studies have found that, overall, international students tend to utilize counseling services less frequently than White domestic students (Nilsson et al., 2004; Smith & Khawaja, 2011).

One possible explanation for this difference is that international students have many unique needs (Hwang, Bennett, & Beauchemin, 2014) and as such, it is possible that during their time on campus interacting with a counseling center campus partner (e.g., international student services, residence life, student wellness center, multicultural student office) they may have been referred to the counseling center at higher rates than at other universities.

Another potential explanation of why analysis of the data from the target university differed from results of current research has to do with level of acculturation, which has also been shown to be a factor in rates of treatment utilization (Han & Pong, 2015). It is possible that the Black international students from our sample had higher levels of acculturation than international students in other universities due to the vast majority of our population being members of the same faith tradition. This faith is one the promotes a set of cultural values (more Western in nature), and it is possible that our population has more experience with Western culture due to their religious affiliation; however, this is speculation, as we did not have a way to determine levels of acculturation based on the data set we examined.

Furthermore, results for Black international students were based on a relatively small number of students when compared to the number of students from the other groups we examined, which may have impacted these results. While this is an important finding, it is

difficult to identify all the potential reasons for this difference and more exploration regarding the differences between these groups is warranted.

Summary of Therapy Attendance

While we found that initial level of distress was the most significant predictor of how long a client would attend treatment, our analysis also highlighted differences in both length of treatment in days and number of sessions attended among the three groups that we examined. African-American students had the longest treatment periods (measured by days in treatment) and attended the most sessions, followed by Whites, and finally Black international students. More specifically, amongst these three groups, Black international students attended the fewest number of therapy sessions. This finding is consistent with previous research (Choe, 1996; Furnham & Bochner, 1986; Han & Pong, 2015; Jackson & Heggins, 2003; Olivas & Li, 2006; Pedersen, 1991; Wehrly, 1988) that documents both the underutilization and early therapy discontinuance of international student groups at university counseling centers.

One possible explanation for this finding is that there may be a cultural disconnect between the Black international students and their assigned clinicians. While most therapists know the value of cultural competence (Sue & Arredondo, 1992), it is possible that the focus of training received by therapists at this center was directed toward American racial minorities rather than international racial minorities.

Another potential explanation is that college counseling center clinicians may have biases/stereotypes that impact therapy. Stereotypes create implicit biases that influence our perceptions and interactions with others (Abreu, 1999; Johnson, Price, Mehta, & Anderson, 2014), and if therapists are conceptualizing international clients based on inaccurate or incomplete stereotypes, treatment may be impacted by unintentional interactions/micro-

aggressions (Nadal, Griffin, Wong, Hamit, & Rasmus, 2014; Owen, Tao, Imel, Wampold, & Rodolfa, 2014), which ultimately hurt the relationship.

Our finding that African-American students were the least likely to drop out of therapy is a departure from previous literature, which suggests these students attend fewer therapy sessions than their White peers (Davis & Swartz, 1972; Duncan, 2003; Gibbs, 1975; Kysar, 1966). One suggested reason for early treatment discontinuance among Black clients is the paucity of Black clinicians with whom Black clients typically prefer to work (Atkinson, 1983; Barksdale & Molock, 2009; Coleman et al., 1995; Parham & Helms, 1981; Speight & Vera, 1997; Thompson et al., 2004). This counseling center employed only a handful of Black therapists (mainly interns and externs who stayed for only one year) over the 17 years that data were collected. Thus, it seems unlikely that racial match would account for African-American students at this center staying in therapy for longer periods of time.

One possible explanation for this finding may have to do with the level of racial identity development of African-American students in this population. Studies have found that racial minorities with higher levels of racial identity development tend to prefer therapists from their own racial group (Brinson & Kottler, 1995). An anecdotal explanation can be found in the possibility that the African-American populations attending services in this center could have lower levels of racial identity development, which could potentially explain why they continued in therapy longer than other samples of African-Americans in the literature. Being closely affiliated with a faith tradition that promotes a culture of shared values may become the primary source of identity, regardless of racial/ethnic identity. Given the archival nature of this data, we had no way to measure for levels of acculturation or racial identity development of these

participants, and these hypotheses remain speculative. More information is needed to draw any specific conclusions from this finding and further exploration is warranted.

Summary of Initial Distress Level as Measured by the OQ-45

Our analysis yielded no significant differences between White students, African-American students, and Black international students on initial distress level. This finding is consistent with a previous study conducted at the same institution (Lambert et al., 2006). However, our findings differ from other studies in the current body of research, which have shown that both international students and Black students initially present with higher levels of distress/general symptomology (Bagley & Copeland, 1994; Kearny et al., 2003; Whaley, 2001).

International student groups are often described as a high-risk population due to the unique challenges they face (Dillard & Chisholm, 1983; Jenny et al., 2003; Mori, 2000; Pedersen, 1991; Sandhu & Asrabadi, 1994). While it is somewhat surprising that Black international students did not present with higher levels of distress, one possible explanation is the concept of cultural incongruence of concerns. Different cultural groups define distress and mental health in different ways. Some groups will see a particular set of circumstances as clinically distressing whereas others may view them as an inconvenience (Brinson & Kottler, 1995). Therefore, what may lead to one person seeking professional help for their distress may lead another to reach out for social support or improve their self-care routine. As mentioned previously, results for Black international students were based on a relatively small number of students when compared to the number of students from the other groups, which may have impacted these results. Future research into this particular trend would be a benefit to the field.

Summary of Differences in Distress and Duration of Presenting Problems as Measured by the Presenting Problems Checklist

Our results found only a few items that were endorsed as significantly more distressing for one or more of the three groups on the PPC. African-American and Black international students reported significantly higher levels of distress than White Students for ethnic/racial discrimination and rape/sexual assault. Based on enrollment data of the university where these data were collected, African-American and Black international students made up less than 1% of the student population for each academic year that was included in this study. Being such a small minority at this university, it is not surprising that African-American and Black international students experienced more ethnic/racial discrimination than White students.

While there are countless factors influencing the presence and embodiment of racism, racial discrimination on university campuses is not new (Solorzano, Ceja, & Yosso, 2000). More specifically, racial micro-aggressions are abundant across university campuses (Franklin, 2016; Solorzano et al., 2000). Constant micro-aggressions can lead to racial battle fatigue (Smith, Allen, & Danley, 2007) or psychological distress due to racial slights. Having so few Black students on campus means that they will inevitably stand out, making them accessible targets for discrimination.

Based on the results of this study, it is impossible to determine why Black international and African-American students endorsed more distress related to rape/sexual assault. One possible explanation is that Black bodies have a long history of objectification in this country (Bakare-Yusuf, 1999; Yancy, 2008), from being stripped naked on the auction block over 400 years ago (Thomas, 1999) to the filming of black bodies being murdered by police today. Sexual

assault is a physical embodiment of objectification; it is physical ownership and oppression of a body (even for a moment) that is not seen as connected to humanness (Coates, 2016).

Americans have been socialized under the regime of white supremacy for centuries, and the colonization of American minds has built our social DNA. Today, the least insidious consequence of such conditioning is implicit biases, while the most heinous are racially motivated assaults on the body (e.g., sexual assault and physical violence). There are likely many factors that warrant further exploration, but our most deep-seated biases most likely impact the rates of sexual assault that Black people endure.

Summary of Family Concerns as Measured by FCS

The FCS was specifically designed to measure, at intake, how often students endorsed "yes," "no," or "unsure" to a series of items involving familial difficulties. The FCS asks about a breadth of familial difficulties with topics ranging from divorce and substance use to abuse (specific questions can be found in Appendix A). What we can glean from the response patterns of our three groups is that Black students, both international and domestic, endorsed more familial difficulties than their White peers. African-American students endorsed the highest levels of familial concerns.

These findings are consistent with national data (U.S. Census, 2010) and there are countless theories and studies that attempt to answer why higher rates of unhealthful circumstances are present for Black people in America. Negative stereotypes and systemic and institutional dimensions of racism persist today (e.g., Harrell, 2000; Takeuchi & Williams, 2003; Williams & Mohammed, 2009). In order to attempt to understand the difficulties that Black people in America face on a daily basis, it is important to consider these systemic differences that collectively exist for Black individuals in regard to socio-economic status, access to

education, the school-to-prison pipeline (Wald & Losen, 2003), the war on drugs (Moore & Elkavich, 2008), and geographic segregation/redlining (Zenou & Boccard, 2000), to name just a few. Furthermore, despite the popular perceptions in society that racism is an artifact of the past, a continually growing body of research indicates that racism is alive and well and continues to negatively impact the mental health and well-being of those from minority backgrounds encountering racial discrimination (e.g., Brondolo, Gallo, & Myers, 2009; Yoo & Pituc, 2013).

It appears that the Black students in our study face the same challenges as other Black people across America. Again, because of the archival nature of the data we examined, we cannot state why Black students in this university endorsed more family concerns than their White counterparts, but it seems likely that these concerns are linked to history. History impacts humans. The history of Black families in early colonial America is one of separation and oppression. Black people in America as a collective have lived through transgenerational trauma (Apprey, 1993) and are experiencing the symptoms of Post Traumatic Slavery Syndrome (DeGruy, 2017; Hammond & Davis, 2004). Unhealthy familial dynamics are one of the harsh realities of a community in recovery. While the systems of public education, law enforcement, housing, commerce, etc., currently in place benefit White Americans they can harm Black Americans and other racial minorities.

Summary of Treatment Improvement Rates as Measured by the OQ-45

Our findings concluded that all three groups we examined improved (i.e., their OQ-45 score was lower upon leaving treatment than when they initially presented at intake). Therapy was effective at some level for African-American, Black international, and White students. However, African-American students show the least amount of improvement of the three groups. This finding is consistent with previous research (Barksdale & Molock, 2009; Nobles, 1972;

Whaley, 2001). African-American students stayed in therapy longer than their peers, but they improved less than their peers. While there is a myriad of potential reasons for this finding, one possible explanation is an avoidance of talking about race/ethnicity in therapy. Avoidance is the most frequently perpetuated racial micro-aggression in therapy (Sue et al., 2007). If clinicians are avoiding addressing racial concerns due to discomfort or incompetence, African-American clients will not have a safe space to process race-related distress, which seems likely to have an impact on therapy outcome. This explanation is again speculative in nature as we were unable to follow up with either the clients or their therapists regarding ways that race/ethnicity was or was not addressed in therapy. This finding warrants future empirical examination.

Implications for Practice

Because African-Americans were the least likely to attend therapy, we suggest focusing efforts on outreach to this population on campus. Counseling centers are encouraged to reach out to the Black Student Union, Multicultural Student Services, and other campus partners that serve Black students. The "Let's Talk" program, wherein a staff psychologist provides a brief consultation onsite to students seeking services through a campus partner, has been shown to be an effective way to have contact with students who may be less likely to seek out the counseling center (Boone et al., 2011). While the Let's Talk program is not technically therapy, it is therapeutic and extends the reach of the counseling center (Boone et al., 2011). The Let's Talk program has been launched and is seeing success at several universities across the country, including University of Washington, University of Minnesota, University of Wisconsin-Madison, and UC Berkeley, to name a few.

Meta-analyses have shown that culturally adapting therapy is in fact effective (Benish, Quintana, & Wampold, 2011; Chowdhary et al., 2014; Griner & Smith, 2006; Smith, Rodriguez,

& Bernal, 2011; VanLoon, VanSchaik, Dekker, & Beekman, 2013). Based on the differing trends that were identified through this study, it would be appropriate to make adaptions when working with Black international or African-American clients. One recommendation is that clinicians seek additional training or supervision on navigating micro-aggressions.

Because international students face unique challenges and are considered a high-risk population (Dillard & Chisholm, 1983; Jenny et al., 2003; Mori, 2000; Pedersen, 1991; Sandhu & Asrabadi, 1994) and they stay in treatment for less time and fewer sessions than their domestic peers, meeting their needs becomes critical. Adopting mutual goals early on has been shown in other research to maximize the way time is used in therapy (Klein, Stone, Hicks, & Pritchard, 2003). We know that the therapeutic alliance is crucial for therapy to be effective (Coleman et al., 1995), and it is imperative that relationship be a primary focus of therapy when working with diverse others.

Our findings suggest that clinicians may have fewer sessions with Black international students than their African-American or White counterparts. Given that clinicians are likely to have fewer sessions with Black international clients, it becomes imperative to capitalize on that time in order to make the most of each session.

Typically, an intake session is used for gathering background information and history on the client; however, it may be useful to also engage in therapeutic interventions during the intake session. One practical recommendation in working with Black international students is for college counselors to be willing to take on the role of educator/advocate perhaps more than may be customary with a student from the United States, as international students may need more direct answers, depending on their level of acculturation and adaptation to the environment. Being flexible about one's role as clinician to meet the needs of this population will likely impact

the relationship positively. In the initial session, therapists are further encouraged to gauge the

level of English proficiency when working with international students and provide additional

language support services (e.g., matching client with therapist who speaks the same language,

interpreter) when available and appropriate (APA, 1991).

Assessing an African-American student's level of racial identity development will help to

gauge whether or not racial matching would be beneficial for the client. For students with high

levels of racial identity development, racial matching is one way to potentially bypass delays in

establishing therapeutic trust (Atkinson, 1983; Barksdale & Molock, 2009; Coleman et al., 1995;

Parham & Helms, 1981; Speight & Vera, 1997; Thompson et al., 2004).

Counseling centers would also benefit from having a Black student specialist on staff. A

staff psychologist who is a competent clinician as well as a liaison to the Black student body and

associated organizations can specialize in meeting the clinical needs of the Black students. This

specialist would serve in the role of building a bridge from the counseling center to Black

campus. Clinicians are encouraged to lean into creativity when working with clients from

minority backgrounds. Thinking outside the box and even stretching outside of one's standard

theoretical orientation can benefit minority clients. Clinicians are encouraged to incorporate

culturally relevant material into practice, particularly when a client leads into a specific event or

topic.

For example, the album *Lemonade* by Beyonce has had a monumental impact on Black

women in America. While academic literature has not explored this cultural nuance, there are

many non-academic (newspapers, magazines, blogs) individuals who have generated "think

pieces" reflecting on the impact of *Lemonade* and other culturally relevant works of art. If a

client mentions the album, this would be the perfect time to use it as a backdrop to process with

the client. This may mean that clinicians need to expand their own cultural awareness by becoming familiar with Black culture. Beyond popular cultural phenomena, culturally relevant metaphors can assist clinicians in building meaningful therapeutic relationships (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009). Participating in socially just spaces and events outside of the office (e.g., on campus outreach, community direct action) is a way to be informed about and keep connected to marginalized populations.

Limitations

The main limitation of this study is the small sample size of both Black international and African-American students. Ideally the sample would be larger and the statistical analyses would yield results with greater power. Another limitation of this study is that all participants in our sample come from one large, private, religiously oriented university. Most students who attend this university (98.8%) are members of a common faith, and several scholarship opportunities exist to appeal to international students of this same faith. Thus, despite considerable cultural differences that likely exist between African-American, Black international, and White students, they have all committed to live a particular lifestyle, which may create sameness or cohesion between the groups. Participants were also likely to share various world views based on the teachings of the dominant religion on campus. Therapeutic trends may have been different if this study had been conducted at a secular university.

Another limitation is that this research used archival data, which did not include direct information regarding the socio economics, level of racial identity development, or acculturation of students in the study. Furthermore, based on the data that we had, we were unable to see if Black students matched with any of the Black therapists, and we are, therefore, unable to make any determinations about the potential moderating effects of racial match. Based on the data

available, criteria were set to best capture the experiences of as many students as we could, but we may have missed some students based on the stringent criteria that was set. There was also no way to gather additional information regarding the level of multicultural training/competence of therapists or therapists' specific treatment interventions.

Also, because of the archival nature of the data, we were able to examine only the measures used in this counseling center during the 17-year period. While the psychometric properties of these measures tend to be strong, there may have been some confounding factors in completing these measures (e.g., limited English proficiency among some students or intra-psychic insight). The measures used in this study were theoretically and pragmatically created for a White clinical population and were also largely normed on White populations, which also may have impacted the manner in which African-American and Black international students took these measures.

Finally, while the data set was quite large, the total number of Black students, both international and domestic, were far fewer than the majority population of Whites at this school. Results may look different coming from a public university or historically Black college or university.

Conclusion

To date there has been a gap in the literature regarding the similarities and differences of therapy experiences of Black international and African-American college students. To our knowledge, this is the first study to compare and contrast African-American and Black international university students in the area of therapeutic utilization and outcome. This research was designed to begin to close that gap and gain a better understanding of the experiences of these two groups regarding treatment concerns. We analyzed archival data from the year 1996 to

2013 on demographic information, family concerns, presenting problems, initial level of distress, discontinuance rates, and treatment improvement rates using the Family Concerns Survey, Presenting Problem Checklist, and Outcome Questionnaire-45.

Our findings indicate that African-American students are staying in therapy longer than their peers, but are also improving less than their peers. While retention in therapy is generally considered to be positive, it is distressing that African-American students are not improving at the same rates as their peers. Racial discrimination was a significant concern endorsed by both African-American and Black international students in this study and is an area in treatment that needs immediate attention. While we were unable to ascertain whether or not experiences of racial/ethnic discrimination were addressed in treatment, or if clinicians were avoiding this topic for any reason (e.g., discomfort, incompetence, lack of awareness), African-American and Black international clients are not likely to have a safe space to process race-related distress and their outcomes will very likely be negatively impacted. Therapists are strongly encouraged to approach the topic of racial/ethnic discrimination in therapy. Future empirical research would likely benefit by examining how addressing such discrimination in therapy impacts client outcomes.

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APPENDIX A

Tables and Figures

Table 1 *Demographic Information*

Racial Group	Mean Age	% Female	% Male	% Married	% Single	% Divorced
White	22.4	54.8	38.9	42.4	49.9	1.4
African American	22.5	67.2	27.6	25	67.2	1.7
Black International	24.3	49.1	43.4	28.3	58.5	3.8

Note. The percentages do not add to 100% as several of those who participated in this study did not provide information regarding some of the demographic information above.

Table 2 *Odds Ratios Comparing Therapy Utilization Rates of White (W), Black International (BI), and African-American (AA) Students*

Year	Comparing W and BI		Comparing W and AA	
	Odds Ratio	SE	Odds Ratio	SE
1997	0.28	0.72	0.12	1.01
1998	-0.93	1.01	-0.5	1.01
1999	0.66	0.52	0.51	0.52
2000	-1.1	1.01	0.59	0.47
2001	0.09	0.59	0.34	0.51
2002	-0.11	0.59	0.81	0.37
2003	-0.27	0.59	-0.19	0.51
2004	-0.3	0.59	0.71	0.33
2005	-0.75	0.72	0.43	0.37
2006	1.04	0.4	0.01	0.39
2007	-1.48	1.01	0.19	0.42
2008	0.19	0.46	0.24	0.39
2009	-0.67	0.59	0.63	0.37
2010	0.84	0.4	0.29	0.33
2011	0.1	0.52	-0.03	0.36
2012	-0.4	0.72	0.48	0.25
2013	0.07	0.72	-0.31	0.39
Total	.99	-0.005	1.35	0.30

Note. The *n* for each group varied each year. When comparing each group, an odds ratio greater than 1 indicates a greater treatment utilization rate among the first group being compared and is based on the proportion of students from each group attending therapy compared to the proportion of the total number of students from each group attending this university.

Table 3 *Cox Regression Analysis Comparing Days in Treatment of White, African-American, and Black International Students*

Variable	Sig.	Exp(B)	SE
Ethnicity	0.01		
Initial OQ	<.001	0.99	<.001

Note. Cox regression analysis comparing the likelihood of discontinuance of therapy between White, African-American, and Black international student when controlling for treatment length (120 days) and initial OQ score. Initial OQ scores were significantly related to attendance in terms of length of treatment in days. Black international students spent significantly less time in treatment.

Table 4 *Cox Regression Analysis Analyzing Differences in Number of Sessions Attended by White, African-American, and Black International Students*

Variable	Sig.	Exp(B)	SE
Ethnicity	0.01		
Initial OQ	<.001	0.99	<.001

Note. Cox regression analysis comparing the likelihood of discontinuance of therapy between White, African-American, and Black international student when controlling for number of sessions (16) and initial OQ score. Initial OQ scores were significantly related to attendance in terms of number of treatment sessions. African-American students attended the most number of sessions, followed by White students, followed by Black international students.

Table 5 *Mean Rank Differences Between White (W), African-American (AA), and Black International (BI) Students on the Presenting Problem Checklist (PPC)*

PPC Question	Distress Sig.	Mean Rank W	AA	BI	Duration Sig.	Mean Rank W	AA	BI
1. Academics or school work or grades	.316	8770	9347	9434	.596	8773	8891	9460
2. Adjustment to the university	<.001	8764	9429	11391**	.067	8770	9209	9960
3. Alcohol or drugs	.277	8775	8929	8524	.231	8777	8614	8614
4. Anxiety, fear, worries, or nervousness	.459	8779	8619	7912	.443	8780	8382	8180
5. Assertiveness	.517	8777	8854	8059	.286	8774	9219	8416
6. Breakup/loss of a relationship	.204	8781	8063	8526	.162	8781	8050	8569
7. Concentration	.135	8770	9081	10120	.726	8773	9101	8982
8. Confusion about beliefs or values	.625	8778	8479	8429	.691	8785	7721	7552
9. Dating concerns	.165	8780	8530	7515	.008	8776	8818	8382
10. Death or impending death of a significant person	.131	8772	9399	8762	.605	8786	8818	8382
11. Decisions about career or major	.509	8779	8279	8474	.003	8786	7911	6936
12. Depression	.767	8777	8813	8258	.022	8784	7967	7468
13. Developing independence from family	.345	8778	8745	7881	.312	8778	8684	7931
14. Ethnic/racial discrimination	<.001	8757	11146**	10307**	<.001	8767	9843**	9641**
15. Eating: binging, vomiting, dieting, laxatives, etc.	.342	8779	8500	8157	.360	8777	8412	8910
16. Fasting or avoiding food	.214	8777	8291	9381	.417	8776	8532	9258
17. Finances	.163	8773	9495	7986	.194	8779	8662	7570
18. Homesickness	<.001	8768	9083	11014**	.005	8770	8880	10434
19. Irritability, anger, or hostility	.275	8776	9116	7861	.169	8780	8481	7757
20. Making friends	.595	8778	8646	8141	.865	8777	8609	8621
21. Perfectionism	.336	8780	8096	8786	.368	8778	8349	8740
22. Physical health problems (ie: headaches, etc.)	.935	8775	8898	8630	.549	8777	8731	8182
23. Problem pregnancy	.562	8776	8711	8631	.622	8775	8832	8668
24. Procrastination or getting motivated	.507	8773	8770	8795	.951	8775	8832	8961
25. Rape, sexual assault, or unwanted sex	<.001	8768	9485**	9743**	.028	8774	9106	8538
26. Reading or study skills problems	.079	8768	9485	9743	.257	8773	8814	9693
27. Relationship with family, parents, or siblings	.025	8769	9920	8377	.288	8779	8450	8147
28. Relationships with friends, roommates, or peers	.359	8979	8649	7878	.042	8780	8714	7302
29. Relationship with romantic partner or spouse	.015	8784	7862	7648	.113	8781	8111	8105

	Sig.	W	AA	BI		Sig.	W	AA	BI
30. Religious or spiritual concerns	.658	8778	8634	8251		.105	8781	8140	8114
31. Self-esteem or self-confidence	.003	8781	8890	6364		.219	8780	8507	7845
32. Sexual concerns	.146	8781	8289	7967		.303	8778	8563	8203
33. Sexual identity or orientation issues	.602	8778	8948	8949		.561	8775	8908	8770
34. Sexually transmitted disease(s)	.202	8775	8738	9034		.533	8776	8706	8706
35. Shyness, being ill at ease with people	.015	8777	9235	7095		.185	8773	9268	8673
36. Sleeping problems	.046	8769	9849	8721		.781	8775	8966	8479
37. Stress management	.167	8770	9636	8954		.655	8474	8829	9336
38. Suicidal feelings or thoughts	.288	8778	8717	7920		.018	8782	8159	7891
39. Test, speech, or performance anxiety	.037	8772	9647	7996		.537	8773	9107	8827
40. Time management	.386	8872	9379	8515		.911	8775	8821	9028
41. Uncertain about future or life after college	.988	8776	8719	8707		.127	8782	8193	7764
42. Weight problems or body image	.004	8780	9051	6583		.581	8778	8606	8331

Note. PCC distress and duration subscales are reported. Differences between White (W), African-American (AA), and Black international (BI) students were analyzed using a Kruskal-Wallis One-way ANOVA and the Sig. column indicates p-values for each item. Because of the number of analyses run, Bonferroni corrections were applied and significant differences between groups at the .0012 level are denoted with **. If a ** is present in more than one column, this signifies that both are significant but not from one another as African American and Black international students reported significantly higher levels of distress and duration of distress than Whites, but did not differ significantly from one another.

Table 6 *Responses of White (W), African-American (AA), and Black International (BI) students to the "Yes" Response Option on the Family Concern Survey (FCS)*

FCS Question	Chi-square	*p-value*	White Yes	AA Yes	BI Yes
1. Parents divorce or permanently separated before you were 18 years old.	144.55	<.001	13%	*40%	32%
2. Family frequently moved.	27.24	<.001	20%	*35%	18%
3. Parent(s) unemployed for an extended period of time.	40.36	<.001	17%	*36%	18%
4. Frequent, hostile arguing among family members.	33.03	<.001	33%	*49%	30%
5. Death of parent(s) before you were 18 years old.	14.94	.02	3%	5%	8%
6. Parent(s) with a drinking problem.	136.09	<.001	4%	*17%	10%
7. Parent(s) with a drug problem.	37.70	<.001	2%	11%	2%
8. Parent(s) with a gambling problem.	55.48	<.001	1%	2%	6%
9. Physical abuse in your family.	45.60	<.001	9%	*20%	14%
10. Sexual abuse in your family.	16.47	.011	6%	14%	4%
11. Rape/sexual assault of yourself or family member.	52.72	.01	0.0%	0.0%	0.0%
12. Family member hospitalized for emotional problems.	11.23	.26	0.0%	0.0%	0.0%
13. Family member diagnosed with a mental disorder.	30.01	<.001	0.0%	0.0%	0.0%
14. Family member attempted suicide.	9.23	.16	11%	16%	8%
15. Family member committed suicide.	4.07	.66	3%	2%	0%
16. Family member with a debilitating illness, injury, or handicap.	3.34	.76	15%	17%	10%
17. Family member prosecuted for criminal activity.	106.24	<.001	0.0%	0.0%	0.0%
18. Family member with an eating problem.	13.99	.03	17%	2%	.2%

Note. The FCS analyzed for significant differences using Pearson chi-square test between White, African-American, and Black international students. Because the answers "no" and "unsure" were not endorsed by any group at significantly higher or lower rates than would be expected, this table includes only "yes" responses that were endorsed at higher rates than would be expected (no group responded "yes" at lower rates than expected). Percentages that are reported for each of the student groups are the percentage of students from that particular group that answered "yes" to the particular item. Because of the number of analyses run, Bonferroni corrections were implemented and a *p*-value of .002 was needed to reach statistical significance. If a cell is marked with an * it denotes that the item was endorsed at a rate that was proportionally higher at a statistically significant level.
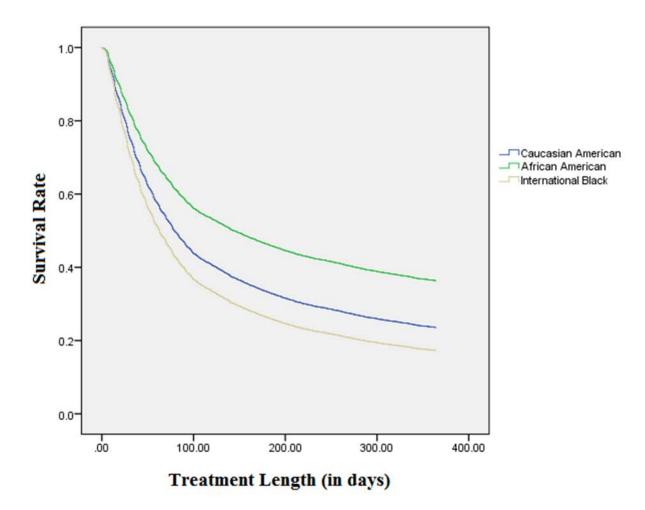
Figure 1. Survival rate by ethnic group measured by days in treatment. The graph displays the days in treatment survival curves for all categories.
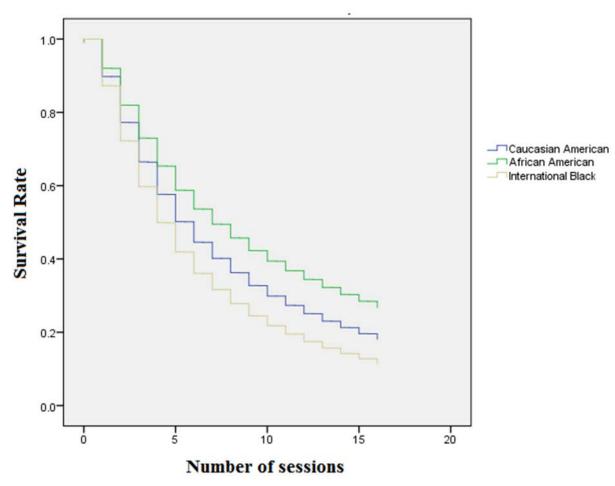
Figure 2. Treatment survival rate by session number broken down by ethnicity. The graph displays the session number survival curves for all categories.

APPENDIX B

Review of Literature

The first time mental health services were offered at a university was at Princeton in 1910 (Kraft, 2011). Since that time universities across the country have started providing treatment for mental health concerns. As enrollment in universities across the country has steadily increased over time (U.S. Census Bureau, 2016), the number of students seeking mental health treatment has also increased (Benton et al. 2003; Blanco et al. 2008; Hayes et al., 2011; Hunt & Eisenberg, 2010). M. David Rudd (2004) suggests that the increase in university enrollment is directly related to the increase in utilization of university counseling centers. More specifically, Rudd (2004) posits that one possible explanation for the increase of university enrollment is that psychotropic medication is providing stability for students struggling with mental health concerns who, in years past, would have been unable to attend university due to their mental health concerns. Furthermore, the general trend toward increased use of selective serotonin reuptake inhibitors in young people likely contributes to the increased numbers of students attending universities across the United States (Finn, 2000; Rudd, 2004). Beyond the increased numbers of students with potentially more significant mental health concerns attending university, there has also been a significant shift in the overall demographic diversity of students aged 18–24 attending colleges and universities (U.S. Census Bureau, 2016). Across the country, institutions of higher learning are seeing an increase in the enrollment of racial and ethnic minorities.

One among several departments, university counseling centers seeing an increase in diversity among the students they serve as well as an increase in the utilization of the services they provide. This increased use of counseling center services by increasingly diverse students

with potentially higher levels of mental health concerns brings with it implications and complexities that will be explored throughout the review of the literature and serve as a basis for the rationale of the proposed research.

Increase in Utilization of University Counseling Centers

The increase of student utilization of university counseling centers creates complexities that must be considered (Rudd, 2004; Riba, Kirsch, Martel, & Goldsmith, 2015; Watkins, Hunt, & Eisenberg, 2012). Meeting the needs of students while also working within the scope and mission of the university poses numerous challenges to university counseling centers (American College Health Association, 2010; Fuchs et al., 2014; Riba et al., 2015; Rudd, 2004). In past years, counseling centers mainly addressed developmental concerns (Gallagher et al., 2000; O'Malley et al., 1990); however, now the same sites are seeing an increase in levels of symptom distress. Thus, finding new ways of meeting clients' needs is a major challenge faced by counseling centers (Benton et al., 2003; Gallagher et al., 2000; O'Malley et al., 1990). In order to best meet the needs of the students seeking mental health treatment, considerations must be made at the administrative, training, and clinical levels (Riba et al., 2015; Watkins et al., 2012). Considerations like session limits, continuity of care, crisis intervention, and multiculturally competent care are examples of issues that need to be addressed (Benton et al. 2003; Riba et al. 2015; Watkins et al., 2012). University counseling centers are becoming increasingly important as they continue to provide helpful services (i.e., support through treatment of mental health concerns) that ultimately assist students in their university experience and help move students toward graduation (Hayes et al. 2011; Minami, 2009; Turner & Berry, 2000; Winterrowd, Priniski, Achter, & Abhold, 2016). It is therefore very important that challenges faced by university counseling centers are identified and addressed.

Value of Post-Secondary Education

"Only the Educated are free." -Epictetus

Society values education for a myriad of reasons, and in past generations its value materialized in tangible ways (Schneider, 2009). In today's society, the benefits of a university education are not as readily apparent (Rose, 2013). In years past, outcomes associated with a college education such as employment and earnings, debt and financial issues, and learning gains were all linked to the completion of a baccalaureate degree (Rose, 2013). Today, some argue that outcomes associated with a baccalaureate degree do not necessarily produce an adequate return on the investment many make to attend university (Schneider, 2009). For example, James Altucher (2011) and other researchers claim that attending university is no longer worthwhile because of the high cost and debt incurred to pay for an undergraduate education (Altucher, 2011; Callender & Jackson, 2005).

However, the 2009 Beginning Postsecondary Students (BPS) survey found that 79% of respondents believed that a college degree was worth earning (BPS, 2009). Even in the face of a weak labor market, students and employers alike value the skills acquired through a college degree, as demonstrated through the high baccalaureate wage premium (Rose, 2013). For example, in 2013 the median earnings for young adults (24–35) with a baccalaureate degree were $50,000 compared with $25,000 for those without a high school diploma (National Center for Education Statistics, 2016). Although statistics suggest that obtaining a baccalaureate degree does not lead to material outcomes (e.g., long-term financial gains, employment, learning gains) in the way that it once did, universities are still seeing an increase in enrollment (U.S. Census Bureau, 2016). It is clear that people in the United States still value education, and the impact is far reaching (i.e., increases in enrollment). Enrollment increases have also extended beyond the

majority population; racial minorities, economically disadvantaged, and international student enrollment has also increased (U.S. Census Bureau, 2016).

Increase in Diversity of Students and Symptom Severity in University Settings

As university enrollment continues to increase, the demand for services among various university departments and programs increases as well. Among those, university counseling centers are seeing an increase each year in the number of students to whom they are providing mental health services (Arria et al., 2011; Gallagher, 2015; Kitzrow, 2003; Kitzrow, 2009; Locke et al., 2012). Heightened psychological concerns among students attending university (Arria et al., 2011; Gallagher, 2015; Kitzrow, 2003; Locke et al., 2012) have made campus mental health treatment more important than ever before.

Every university counseling center is unique in the services that they choose to provide and in the manner in which such services are delivered (Archer & Cooper, 1998; Cooper et al., 2008; Locke et al., 2012; Reetz, Barr, & Krylowicz, 2014). Some of these services include individual psychotherapy, group psychotherapy, biofeedback services, outreach, and consultation. Furthermore, with the increased demand for services, counseling centers use a variety of methods to treat as many students as possible (e.g., triage/referral system vs. in-house counseling, short-term and solution-focused therapy, increased focus on outreach) (Benton et al., 2003; Gallagher et al., 2000; Locke et al., 2012; Reetz et al., 2014). Adding to the complexity of providing services to the ever-increasing number of students is the responsibility of mental health professionals to provide competent and ethical care to students from diverse backgrounds. Numerous authors have recommended that the most effective psychotherapy interventions for individuals from a variety of diverse backgrounds are those that are culturally modified (Griner & Smith, 2006; Smith & Trimble, 2016).

Volume and diversity of students are not the only challenges that counseling centers are encountering. University counseling centers also face increased severity of presenting concerns (Gallagher, 2015; Reetz et al., 2014; Watkins et al., 2012). While in society there is a stigma that only severely mentally ill individuals seek therapy (Rüsch, Angermeyer, & Corrigan, 2005), there is another myth that university counseling centers serve only those with less severe psychopathology (Beiter et al., 2015; Sharkin & Coulter, 2005). Yet the first manifestations of severe mental illness such as severe depression, manic episodes (Bipolar), and psychosis (Schizophrenia) often occur in young adulthood (Kessler et al., 2005), a time when individuals are often enrolled in university settings.

A comprehensive look at this issue was conducted by Benton et al. in 2003 in which she and her colleagues examined the severity of problems of students at university counseling centers across a 13-year period. In an analysis of archival data spanning 13 years, several domains of pathology were examined to identify trends of severity among students at a university counseling center. They examined 19 different domains and found that the severity of 14 of the 19 areas had increased. The domains that increased in severity included developmental, situational, depression, academic skills, grief, medication use, relationships, stress/anxiety, family issues, physical problems, personality disorders, suicidal thoughts, and sexual assault. The five areas that remained stable were substance abuse, educational vocational, eating disorders, legal problems, and chronic mental illness (Benton et al., 2003). These findings are similar to those of Gallagher et al. (2001), whose research also included learning disabilities as one of the severe problems faced by students. Gallagher followed his first study with an additional comprehensive survey (2015) where his findings were again supported.

A follow-up and response to the Benton study was completed by M. David Rudd (2004), who proposed possible explanations for the observed changes. He explored the idea that university counseling centers are beginning to look more like community mental health centers. He provided several theories and citations for his assertion. One such theory, previously mentioned, is that more and more young people are using psychotropic medications, particularly selective serotonin reuptake inhibitors (Finn, 2000), which are allowing people to achieve a level of stability that was not obtained in previous years (Rudd, 2004). Another possible explanation is the current higher proportion of students with comorbid psychological disorders (particularly between Axis I and Axis II disorders [note: Axes were standard DSM-IV classifications]) compared to previous years (Rudd, 2004), which has increased the complexity of presenting concerns at university counseling centers. Treatment of complex or comorbid disorders can require more intense or longer term care (Rudd, 2004), and treatment of comorbid disorders is a common occurrence in community mental health centers.

Rudd (2004) further proposed that the changes being observed in treatment trends in university counseling centers may be due to changes in student population (e.g., racial/ethnic diversity, socio-economic status) (Gallagher et al., 2000; O'Malley et al., 1990) rather than an emergence of more severe psychopathology. Again, in recent years there has been an increase in university enrollment of racial minorities, the economically disadvantaged, international students (U.S. Census Bureau, 2016), and young people who have become stabilized through the use of psychotropic medication. Universities across the nation are seeing dramatic increases in the diversity of student enrollment (U.S. Census Bureau, 2016), and people with a multiplicity of contexts will likely have a multiplicity of difficulties navigating school systems that were likely originally designed for middle-class, White Americans. These nuanced and intersecting

difficulties likely influence the level of distress experienced by diverse students in universities

nationwide (American College Health Association, 2008; Hunt & Eisenberg, 2010; Rudd, 2004).

Regardless of the reason for the trends toward increased utilization of counseling center

services, it is clear that university counseling centers will need to respond to these new and

complex demands. Training, resources, and staffing are all essential areas to examine (Archer &

Cooper, 1998; Cooper, Resnick, Rodolfa, & Douce, 2008; Locke et al., 2012; Rudd, 2004).

Outpatient management discussion about serious mental health issues like suicidality, Axis II

diagnoses, and addressing nuanced issues like sexual assault are becoming increasingly relevant

(American College Health Association, 2008; Buccholz, 2015; Rudd, 2004). Some have argued

that counseling centers may need to prepare to provide longer term care given the complexity of

students' needs (Barreira & Snider, 2010; Hayes et al., 2011; Kraft, 2011; Rudd, 2004).

In order to provide the best care possible, researchers suggest that it is crucial that

counseling centers receive support of other departments on campus, as those providing

therapeutic services will likely become more efficient and more effective if they are supported by

senior administration (Hayes et al. 2011; Kitzrow, 2003; Sharkin & Coulter, 2010). Researchers

further posit that universities should account for the mental health of their students using a top

down philosophy; when mental health is a priority, administrators will assure that funding is

available and abundant (Fuchs et al. 2014; Kitzrow, 2003; Locke et al., 2012).

Managing the Increase in Numbers and Diversity of Students

There are several strategies that have been proposed to help mental health professionals

in college counseling centers meet the needs of students. In regards to clinical services,

counseling centers should be accessible; students (particularly those in crisis) should be seen as

quickly as possible. Crisis services, such as walk-in hours and an after-hours phone line, should

also be readily accessible (Cooper et al., 2008; Kitzrow, 2003; Locke et al., 2012). The more "hands on deck," so to speak, equates to an increase in the number of students served. Another strategy proposed is that university counseling centers use some of their resources (e.g., licensed professionals supervising trainees) to train budding psychologists as a means to increase the number of therapists for students to see (Kitzrow, 2003; Romero, Munir, & Runnels, 2015; Watkins et al., 2011). An increase in the number of therapists will likely diminish the amount of time a student must wait to begin treatment. Group therapy is another strategy for optimizing the amount of students who are treated (Burlingame, Fuhriman, & Mosier, 2003; Corey, Corey, & Corey, 2013; Kitzrow, 2003) and has been shown to be as effective as individual therapy (Burlingame et al., 2003). Consultation and outreach is another method in which counseling centers can have a far-reaching effect across campus (Hayes et al., 2011; Kitzrow, 2003; Locke et al., 2012). Consultation can be done through a variety of channels such as orientation programs, guest lectures around campus, or screenings (Kitzrow, 2003).

Managing increasingly large caseloads is another critical element when examining how to best manage care at university counseling centers. The following are suggestions that have been explored and implemented at numerous counseling center sites (Kitzrow, 2003).

- 73% use a brief therapy model that has been demonstrated to be an "effective and often viable option for many counseling center clients" (Stone & Archer, 1990, p. 600).
- 44% limit the number of individual counseling sessions per student.
- 16% assign students to group counseling directly after an intake session.
- 68% see students less than once a week for counseling.
- 9% shorten the length of counseling sessions.

- 41% refer to off-campus resources.

Ninety percent of centers also reserve the right to deny services to students whose mental health needs exceed the center treatment resources (Gallagher, Sysko, & Zhang, 2001).

The denial of treatment brings an important question to the conversation. What is the scope and mission of university counseling centers? The answer to this question undoubtedly varies from school to school. Even so, while many university counseling centers may increasingly resemble community mental health centers at some level, they certainly are distinct due to being a branch of a college or university. Previously university counseling centers functioned as long-term treatment centers, today most have shifted to a shorter-term model (Arria et al. 2011; Gallagher et al., 2000; Riba et al., 2015). Counseling centers today have an emphasis on stabilization and retention of students (Arria et al. 2011; Bishop, 2010; Gallagher et al., 2000; Locke et al., 2012).

According to a national survey that utilized information data from the National Comorbidity Survey, 5% of college students withdrew from school due to psychiatric disorders (Kessler, Foster, Saunders, & Stang, 1995; Zivin, Eisenberg, Gollust, & Golberstein, 2009). Mood disorders, anxiety, substance abuse, and conduct disorders were found to be "significant predictors of failure" (Kessler et al., 1995, p. 1,029). Transition and adjustment issues have also been identified as having a negative impact on retention (Anderson, 1985; Bishop, 2010; Gallagher et al., 2000; Tinto, 1985). As counseling centers become more equipped to address many of the issues students are facing (specifically those that are impacting retention), they become an important resource in assisting universities in supporting students.

Who are these students? Based on current statistics, we know that White students are utilizing their university counseling centers at disproportionally higher rates when compared to

their racial minority counter parts (Davidson et al., 2004; Hayes et al., 2011; Kearny et al., 2005).

Racial/Ethnic Minority Student Utilization

In general, racial/ethnic minorities typically consume mental health services at lower rates than their White peers (Hayes et al., 2010). This trend holds true at universities' counseling centers as well as in the community (Carr & West, 2013). This statistic has held true over many years and it is a concern for universities committed to better serving multicultural students (Barksdale & Molock, 2009; Davidson et al., 2004; Kearny et al., 2005). One particularly troubling statistic is that minority students tend to seek services less frequently and are diagnosed with higher levels of distress at intake at university counseling centers (Kearny et al., 2005; Sue & Sue, 1990).

For example, several race-related differences can be found in the diagnostic rates of OCD, anxiety, phobias, alcohol abuse, and somatic symptoms, with racial minorities having a higher diagnostic rate (Adebimpe, 1994; Fernando, 2010). Previous studies have offered numerous possible explanations for the higher diagnostic rates of mental illness and lower treatment utilization rates among racial minority individuals. One hypothesis is that racial/ethnic minorities experience more frequent and intense social stressors than Caucasians and that the increased reporting of negative symptoms by racial/ethnic minorities may be related to increased stress levels due to more poverty and higher unemployment rates, discrimination and racism, recent moves, and loss of support systems (Atkinson, Morten, & Sue, 1998; Zane & Ku, 2014). If racial/ethnic minorities believe or sense that therapists are lacking cultural sensitivity or knowledge (Atkinson et al., 1990, 1998; Sue et al., 1999; Zane & Ku, 2014), they may postpone seeking out of services, which will also lead to an increase of symptom distress at intake. If

individuals from minority backgrounds feel that mental health services are not related to their

needs, they are not likely to seek such services (Atkinson et al., 1998; Davidson et al., 2004;

Hayes et al., 2011).

       Another possible explanation is that cultural stigma around help-seeking behaviors and

mental health treatment vary from culture to culture and could deter minority students from

seeking services (Brook, Lee, Balka, Finch, & Brook, 2014; Davidson et al., 2004; Neighbors,

Caldwell, Thompson, & Jackson, 1994; Ponterotto, Casas, Suzuki, & Alexander, 1995; Sue,

1994; Thorn & Sarata, 1998). For example, Asians may view seeking help as a sign of weakness

(Chen & Danish, 2010; Meyer, Zane, & Cho, 2011; Root, 1989; Zane & Ku, 2014), Latinos may

believe that it is better to get support from family or ecclesiastical leaders (Altarriba & Bauer,

1998; Bermúdez, Kirkpatrick, Hecker, & Torres-Robles, 2010; Braithwait, Taylor, & Treadwell,

2009), and African-Americans and Latinos alike are more likely to seek help from family

members than White individuals (McMiller & Weisz, 1996; Thompson et al., 2004). These

factors can also explain why some minorities may not return to therapy once they have initially

begun treatment (Hayes et al., 2009; Johnson et al., 2014; Kearny et al., 2005).

       In a study by Brinson and Kottler (1995) examining why minority students underutilize

treatment at university counseling centers, two primary factors were identified. The first was the

incongruence between mainstream and minority worldview, particularly around the definition of

mental health and behavior that is socially acceptable. Different cultural groups will define

distress and mental health in different ways. Some groups will see a particular set of

circumstances as clinically distressing whereas others may view them as an inconvenience.

Seeking treatment will likely be related to how symptoms are being. The second factor was the

impact of racial/ethnic identity development relative to the utilization of university counseling

centers. Minorities with higher levels of racial identity development tended to prefer therapists from their racial group. Based on the current literature, more multicultural sensitivity and competence is needed in order to reach out to and provide effective treatment to those from multicultural backgrounds (Brinson & Kottler, 1995; Griner & Smith, 2006; Sue, 1998; Smith & Trimble, 2016). Each racial/ethnic group has unique nuances in regards to utilization of mental health treatment; Black students too have unique perspectives on mental health.

Utilization of University Counseling Services by Black Students

Historically, the utilization rates of mental health treatment by Black people have been less than White people (Andrulis, 1977; Davidson et al., 2004; Hunt et al., 2015; Neighbors & Jackson, 1984; Smead et al., 1982; Temkin-Greener & Clark, 1988). This underutilization of treatment has also been the case for Black college students compared to White college students (Davis & Swartz, 1972; Duncan, 2003; Gibbs, 1975; Hayes et al., 2011; Kysar, 1966; Reetz et al., 2014). The foundational study that examined university counseling center utilization rates among Black students was conducted nearly thirty years ago by Thompson and Cimbolic (1978), who looked at racial preferences of Black students at university counseling centers. They found that, in general, Black students preferred to work with Black therapists. In follow-up studies, this preference has been replicated again and again (Atkinson, 1983; Barksdale & Molock, 2009; Coleman et al., 1995; Parham & Helms, 1981; Speight & Vera, 1997; Thompson et al., 2004).

Researchers have worked to identify why this preference exists. In examining the work of several studies, a few important themes have emerged. People are inextricably tied to their history and there is racial tension in the United States between Black and White people because of centuries of systematic oppression of Black people (Terrell & Terrell, 1981; Townes et al., 2009). A general mistrust or suspicion of White people is present for many Black people

(Masuda, Anderson, & Edmonds, 2012; Townes et al., 2009). This mistrust creates reluctance among Black individuals to seek mental health services (Hall & Tucker, 1985; Masuda et al., 2012; Townes et al., 2009), which have typically been provided by White mental health workers.

African-Americans also tend to hold differentiated views of mental illness (Hall, & Tucker, 1985). Black people who have African ancestry have ancestral ties to the creation/discovery of numerous fields of study including math, astronomy, metallurgy and tools, architecture and engineering, medicine, and navigation (Blatch, 2013). While the aforementioned fields of study can be readily understood and accessed by Black people, psychology (based on rates of utilization) seems to be an area that is not as easily understood (Nobles, 1972). Psychology is a Western, Eurocentric field of study (Ibaraki & Hall, 2014; Hall, 2001; Krause & Howard, 1883; Pedersen, 2004; Ponterotto et al., 2009; Trusty et al., 2002), and while African-Americans' minds have become colonized through generations of living through and interacting within imperialistic societies (West, 1993), it seems that there is an inherent resistance to a field created by and for Europeans.

Given that many Black people have underutilized mental health services in the United States, many are left with untreated or undertreated mental illnesses (Whaley, 2001). It has been argued that when a significant population does not or cannot access mental health treatment, the situation becomes a public health issue (Whaley, 2001). Black people are an underserved population, and until a transformation occurs within the field of mental health, clinicians should work to validate the nuanced concerns of Black clients (Whaley, 2001).

While it is beyond the scope of this paper to list all the ways that therapists can help to provide better services to this particular population, becoming familiar with the multicultural competencies—awareness, knowledge, and skills—is an excellent first step in aiding therapists

in working around some of the barriers to alliance in therapeutic settings that Black individuals face (Sue et al., 1992; Sue et al., 1999). A brief review of multicultural competencies follows and readers are encouraged to more fully examine the works of Sue and colleagues (1992) and Arredondo and colleagues (1996). When a therapist is *aware* of their own ethnic identity and biases, they are better able to deconstruct their place of privilege and work to understand and advocate for their client. Becoming *knowledgeable* about the unique histories and challenges of oppressed people provides therapists with a base of understanding how and where therapy can be adapted. *Skills* essentially put the previous two competencies into action (Griner & Smith, 2006; Smith & Trimble, 2016; Sue et al., 1992; Sue et al., 1999).

American students from minority populations are not the only students who need to be met with competence and sensitivity. International students are also a community on the majority of university campuses who will benefit from added support (Schulte & Choudaha, 2014).

Utilization of University Counseling Services by International Students

Studies have suggested that international students face unique challenges due to adjusting to a new culture, often with limited support (Schulte & Choudaha, 2014). Because of these nuanced experiences, international students may struggle with more psychological problems than their American counterparts and, as such, should be considered a high risk group (Dillard & Chisolm, 1983; Jenny et al., 2003; Mori, 2000; Pedersen, 1991; Sandhu & Asrabadi, 1994). International students also struggle with problems like financial worries, relationship concerns, depression, anxiety, relationship concerns, and academic difficulties (Al-Darmaki, 2014; Fan, 2000; Jenny et al., 2003; Hamamura & Laird, 2014; Heath et al., 2016; Nilsson et al., 2004; Pendse & Inman, 2017), as well as homesickness, language barriers, cultural isolation, visa

status, and adjustment and acculturation problems (Al-Darmaki, 2014; Choe, 1996; Furnham & Bochner, 1986; Hamamura & Laird, 2014; Heath et al., 2016; Jackson & Heggins, 2003; Olivas & Li, 2006; Pedersen, 1991; Pendse & Inman, 2017; Smith & Khawaja, 2011; Wehrly, 1988).

While counseling centers are a good option for international students to address their psychological concerns, as well as their adjustment and acculturation process, it is well documented that these students do not utilize these resources as much as American students (Al-Darmaki, 2014; Choe, 1996; Furnham & Bochner, 1986; Hamamura & Laird, 2014; Heath et al., 2016; Jackson & Heggins, 2003; Olivas & Li, 2006; Pedersen, 1991; Pendse & Inman, 2017; Wehrly, 1988). Why do international students underutilize university counseling centers? Several possibilities have been suggested by researchers who have studied this phenomenon. For example, international students may be less aware of the resources available on campus (Idowu, 1985; Mori, 2000). There may be a cultural stigma associated with seeking treatment of mental health concerns (Arthur, 1997; Lin, 1996: Mori, 2000). Furthermore, seeking help from family may be a more familiar and acceptable option for some international students (Hayes & Lin, 1994; Pederson, 1991). However, international students do not have physical proximity with their families, and their support structure may have been disrupted due to their move to the United States for school. University counseling centers can help alleviate many of these concerns and be a resource of support. Research suggests that international and minority students will be much better reached and served if counseling centers familiarize themselves with the unique needs of these underserved groups (Davidson et al., 2004).

Cultural Differences between African-American and Black International Students

In providing services to students from unique backgrounds, it is important that university counseling center mental health providers not lump all ethnic minority students together as there

are many unique differences among those even from the same ethnic/racial minority groups (Sue, 1998). Furthermore, it is important to recognize that treating all international students with an "international student" approach may be problematic inasmuch as there are likely to be numerous distinct differences among international students from various ethnic, regional, and racial backgrounds. To date, research focused on Black individuals in university counseling centers have typically combined African-American and Black international students. The separation of African-American students and Black international students when discussing mental health in university counseling center settings is virtually non-existent in the literature. There are very nuanced studies that compare African-Americans and Black Caribbeans (Aranda et al., 2012) or African-Americans and citizens of a particular African nation on a specific issue or diagnosis. However, to date, there have not been any studies that examine or compare the treatment utilization rates, reported distress levels, psychotherapy outcomes, or presenting concerns of Black international students compared to African-American students.

Why is it important not to lump all Black students together? Again, people are tied to history, informed by culture, and experience the world through a contextual lens. America is considered a "developed" nation that embraces a predominantly "Western" culture. Many Black international students are coming from non-Western cultures, and many come from economically disadvantaged ("developing") nations, based on disparate gross domestic product (GDPs) (World Bank, 2015). Those from more collectivistic communities will likely seek help and support from family or close friends, whereas people from more individualistic communities are more open to utilizing professional resources (Triandis, 1995). Different cultures view education in differentiated ways, which also impacts why and how students utilize campus resources (Neal & Heppner, 1986). African-Americans differ from their international peers in numerous ways, and

viewing them through parallel assumptions is naïve and culturally insensitive. Therapy cannot be effectively culturally adapted if multiple cultures are being viewed and/or treated as a single culture.

Some research has supported the finding that therapeutic outcomes, according to the Outcome Questionnaire 45 (please see brief description of this measure in the instrument section), is the same for White clients as it is for clients from racial/ethnic minority backgrounds (Lambert et al., 2006). However, a review of the literature has shown underutilization of mental health services by ethnic/racial minority groups and particularly by Black students (Barksdale & Molock, 2009; Davidson et al., 2004; Hayes et al., 2011). While racial/ethnic minority and White students were similar in terms of OQ-45 change from initial to final session in the study conducted by Lambert and colleagues (2006), they found that racial/ethnic minority students presented with higher levels of distress and left treatment with higher levels of distress when compared to their White counterparts (Lambert et al., 2006). That is, racial minority students tend to have higher levels of distress going into and leaving treatment in spite of having similar decreases in OQ-45 scores.

Perhaps treatment as usual is adequate. However, if Black students are underutilizing resources, they are left with limited options for treatment and support. One aspect that Lambert and colleagues (2006) did not specifically account for in their study was the potential differences between international students and American racial minority students that were lumped together in the same ethnic group. This study attempted to narrow the gap in the literature around comparing utilization and outcomes for African-American and Black international students in a university setting. Gathering more information about treatment utilization, treatment outcome,

presenting concerns, and reported distress levels will hopefully help provide information that

may be helpful for mental health workers employed by university counseling centers.

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