Mental Health Matters: Mental Health Service Utilization Among African American Emerging Adults

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MENTAL HEALTH MATTERS:
MENTAL HEALTH SERVICE UTILIZATION AMONG AFRICAN AMERICAN EMERGING ADULTS

A Dissertation

Submitted to the Graduate Faculty of the
Louisiana State University and
Agricultural and Mechanical College
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in

The School of Social Work

by
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I would like to dedicate this work to my daughter, Ashay Jay Curry.

“Dear baby girl, remember that continual typing noise that you heard in my womb? Remember that computer screen light that never seemed to dim? This is the fruit of that labor and because you were present in the thick of it, please know that I consider you a co-author in my heart.”
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Evidence indicates that people of color underutilize mental health services, but little is known empirically about the help-seeking behaviors of African American emerging adults. The present mixed method study utilizes a concurrent design with nested samples for the qualitative and quantitative components to examine willingness to seek help and help-seeking intentions among college students. Data was collected from four location sites including Louisiana State University \((n=38)\), Texas State University \((n=15)\), The University of Southern Mississippi \((n=65)\) and Southern University and A&M College \((n=3)\). Minority and non-minority participants completed the Willingness-To-Seek-Help Questionnaire and the General Help-Seeking Questionnaire \((n=120; M \text{ age}=24 \text{ years}; \text{ range}= 18-29 \text{ years})\). Concurrently, African American emerging adult participants \((n=6)\) who have sought out professional mental health treatment within the past 12 months completed in-depth interviews. Main findings include that minority emerging adults report lower willingness to seek formal psychological help than non-minority emerging adults. Minority emerging adults report lower formal help-seeking intention for suicidal or emotional problems. Findings include causes of distress, sources of support, and factors that encourage and discourage formal help-seeking among African American emerging adults. Correlational analysis showed that, among African American emerging adults, race and age are predictive of low willingness to seek help and age, gender and school affiliation are predictive of general help-seeking behavior. Findings of a thematic analysis showed that perceived susceptibility, perceived severity, self-efficacy, perceived benefits, perceived barriers, cues to action and social support are all constructs that influence the formal help-seeking experience. A policy implication is to improve public health policies to increase access to formal mental health treatment. Policy and practice implications are to promote and support the use of
non-traditional formal support, such as teletherapy on college campuses and at community mental health centers. Other solutions for barriers to formal mental health services are discussed.
CHAPTER I. INTRODUCTION

Mental illness in America is prevalent. A mental illness is a condition that affects overall thinking, feelings, behavior or mood (National Institute of Mental Health (NAMI), 2020) and approximately 44.8% of individuals aged 18 or older have reported having a mental illness (Substance Abuse and Mental Health Services Administration (SAMHSA), 2019). Furthermore, 20.6% of all adults in the U.S. have a 12-month prevalence of mental illness, and approximately 5.2% of U.S. adults have a serious mental illness (SAMHSA, 2019); however, this statistic is different for each demographic subgroup. The social groups most likely to experience mental illness are individuals who are incarcerated in local jails and prisons (44% and 37%, respectively), and lesbian, gay, and bisexual (LGB) individuals (44.1%); (Bronson & Berzofsky, 2017; SAMHSA, 2018). While less is known about the prevalence of mental illness among other members of the lesbian, gay, bisexual, transgender, queer, and other sexual minorities (LGBTQ+) community, it is important to note that transgender individuals are 12 times more likely to attempt suicide than the general population (James et al., 2016). Veterans are also more likely to experience mental illness, with 41% of Veteran’s Health Administration patients having a diagnosis of a mental illness and being 22% more likely to die by suicide than the general population (U.S. Department of Veterans Affairs, 2017). The most likely racial groups to have a mental illness include multiracial adults (31.7%), White adults (22.2%), American Indian or Alaska Native adults (18.7%), Hispanic or Latino (18%), Black or African American (17.3%), Native Hawaiian or Pacific Islander (16.6%), and Asian (14.4%) (SAMHSA, 2020).

The most common mental disorders in the U.S. include anxiety disorders (19.1%), depression (7.8%), post-traumatic stress disorder (3.6%), bipolar disorder (2.8%), borderline personality disorder (1.4%), obsessive compulsive disorder (1.2%), and schizophrenia (>1%),
with 3.8% of adults experiencing comorbidity and 18.4% of adults with mental illness experiencing a co-occurring substance use disorder (Harvard Medical School, 2017; Moreno-Kustner, 2018; SAMHSA, 2019). Specifically, among emerging adults, individuals between the ages of 18 and 29 as defined by Arnett, (Arnett, 2000), the most commonly reported mental illnesses are anxiety and depression (Cadigan & Lee, 2019; Harvard Medical School, 2017; Moreno-Kustner, 2018; SAMHSA, 2019) supporting the need for appropriate research, policy and practice responses. Individuals aged 18-25 years report mental illness at a rate of 30% and adults aged 26-49 years report mental illness at a rate of 25.3% (NAMI, 2020).

In 2018, only 65.5% of individuals who reported having a mental illness sought out mental health services to meet their specific psychological and emotional needs (SAMHSA, 2019). These rates are reflective of the existing trend of underutilization of mental health services in America. Many adults with mental illnesses do not receive treatment, and for those who do receive treatment, the average delay between onset of symptoms and treatment is 11 years (Wang et al., 2004). When taking specific demographics into consideration, females (49.7%) are more likely than males (36.8%) to seek treatment for their mental illness (SAMHSA, 2020). Consider that 49.2% of lesbian, gay, bisexual, transgender, queer, and other sexual minorities with a mental illness seek treatment in the US (SAMHSA, 2018). The racial/ethnic groups that are most likely to seek treatment are as follows: white adults (50.3%), multiracial adults (43%), and Hispanic or Latino adults (33.9%); (SAMHSA, 2020). The racial/ethnic groups that are least likely to seek treatment are black or African American adults (32.9%), and Asian adults (23.3%) (SAMHSA, 2020). As reported, mental health illnesses are documented across groups of Americans, but groups of color are less likely to seek professional help in response to the presence of a mental health need (Stroul & Friedman, 2011).
Despite efforts to accommodate needs, improve and increase the delivery of services to children, adults, and families, participation in professional treatment for mental health among African Americans remains low (Stroul & Friedman, 2011). With mental health prevalence being identified, factors related to underutilization have been investigated through qualitative, quantitative and mixed methods research. Literature and research efforts referenced in this work will focus on a subgroup and reveal the current state of issues related to help-seeking among African American emerging adults.

**Why Mental Health Should Be Addressed: Framing Mental Illness as a Social Problem**

When defining mental health, there is a lack of consensus in the literature. To approach mental health as a social problem, it is vital to first explore the variation in definitions to establish an understanding of this form of health in relation to others. Mental health has been defined as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization (WHO), 2001, p.1). In addition, “mental health includes emotional, psychological, and social well-being affecting how one thinks, feels and behaves” (U.S. Department of Health and Human Services, 2019, p. 1). Bhugra et al. (2013) suggested that based on one’s mental health, there is an “ability or inability to form and maintain meaningful relationships, perform within social roles, [and] effectively communicate and manage emotions” (p. 3). While physical health is largely understood as the genetic determination underlying human motor capacity paired with the process of physical development and adaptation resulting from environmental conditions and standards of living (Koipysheva et al., 2019) mental health is essential to an individual's overall health as it is all encompassing. The definition of mental health comprises the presence of illness or psychological
Other definitions have incorporated the existence of spiritual and emotional awareness including that individual mindfulness in these areas extend to one’s mental health and psychological capacity (Health Education Authority (HEA), 1997). As mental health integrates functionality on the physical, emotional and spiritual domains, the lack of formal service utilization or underutilization of formal mental health services is addressed as a social problem in this work in efforts to address the consequential nature and negative impact associated with untreated mental illness and poor psychological outcomes. While the various definitions of mental health are acknowledged and considered, in this study mental health is understood as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2001, p.1).

Help-Seeking for Mental Health Needs among African Americans

African Americans have generally been cautious about mental health help-seeking as cultural beliefs have shaped their response to the presence of a personal mental health need. Past acts of dehumanization and oppression in America have led to various forms of structural racism adding to African Americans distrust of formal systems (Williams et al., 2022). Traditionally, seeking or receiving formal mental health services was not exercised within some minority subcultures. Within the context of the African American family, general attitudes reflected that the family would function as the primary safety net in meeting individual and familial mental health needs (Pattyn et al., 2014). Furthermore, subjecting a vulnerable family member to
professional mental healthcare services implied rejection of the mentally ill family member and ultimately brought shame and guilt to the family name (Mezzich et al., 1999). For members of generations aware of the detriment of the Tuskegee experiment (Alsan et al., 2020), ideas of mistrust have continued and been included in popular opinion (Lee et al., 2018), play writing and music lyrics (Bogart et al., 2021). In considering the lack of formal help-seeking, mental health illness and the current state of minority distress, the reality of personal and shared trauma among African Americans should be addressed. Far too often for far too many, the sting of mistrust related to formal help-seeking has extended beyond passive doubt and been consequential on individual health and safety.

While some communities have seen decrease or stagnation in deaths by suicide, others have continued to suffer at extreme costs. Suicide rates among white Americans have decreased by 3% (Ducharme & Ross, 2022), the suicide rates for most racial minorities have increased or stayed the same (Center for Disease Control (CDC), 2021; Curtin et al., 2021) both of which pose a threat to well-being. With the presence of minority mental illness documented and reports that African American adults (32.9%) are least likely to seek formal treatment (SAMHSA, 2020) it is urgent that the issue of formal service underutilization be further explored in the literature and promptly addressed by policy.

**Help-Seeking for Mental Health Needs among African American Women**

The help-seeking of formal mental health services among African American women is of importance due to the mental health risks associated with performance pressures and increased responsibilities in a postmodern society. The black woman of today is faced with oversexualization (Patton, 2001), issues of gender inequality (Reece, 2021), misportrayal in the media (Strutton & Lumpkin, 1993) and power imbalance (Simon et al., 2021). Within the
American culture, there is a collective struggle to understand the oppressive experiences, difficulty balancing expectations and vulnerabilities of black women. Managing such demands all while making contributions in various settings has led to the increase of depression, post-traumatic stress disorder (PTSD) and inflated the rates of suicide among black women (CDC, 2021). The impact of living under high levels of pressure are a reality for black women as early as girlhood. Among young black girls under the age of 18, there was a reported increase in deaths by suicide by 182% from 2001 to 2017 (Ducharme & Ross, 2022).

In considering help-seeking it is important to note that women of color are often sought out to extend support to others in need. While it is reported that women seek formal help for mental help needs at higher rates than men (CDC, 2021; SAMHSA, 2020) far too often black women find themselves assuming a central role of support by those occupying her personal and professional circle. In many families and communities, African American women provide irreplaceable support and their commitment to investing those around them present as a protective factor. This role is vital to the continuation of successful in various settings, and thus the underutilization of formal mental health services is of importance regarding African American women as they live with increased home, work, and communal responsibilities in a postmodern society.

**Mental Health Help-Seeking among African American Emerging Adults**

Examining mental health help-seeking behaviors among African American emerging adults is important for three primary reasons including documenting the prevalence of mental illness among the group, investigating the poor outcomes related to mental health concerns, and revealing the low utilization rates of formal mental health services geared towards combating poor mental health outcomes. Most concerning is that there are professional mental health
services that exist, but those services are underutilized by emerging African American emerging adults. While there are varying rates of formal mental health service utilization among racial minorities, a phenomenon of underutilization is documented as service rates are often significantly lower (Hunt & Eisenberg, 2010). Studies have shown that African American emerging adults utilize mental health outpatient services at about half the rate of white emerging adults (Davis & Ford, 2004; Snowden & Yamada, 1998; Thornicroft, 2008). Such rates are concerning since members of the emerging adult population report psychological distress (Cadigan & Lee, 2019). Mental health help-seeking should be prioritized as such distress can be related to racial trauma experienced by African American emerging adults.

Racial trauma experienced by African American emerging adults stems from exposure to racism, racialized violence, or other race-related events (Williams et al., 2021) which has been evident in recent times. The psychological distress reported is understandable following the recent and seemingly continual exposure to stressful occurrences. Arguably, exposure to elevated stressors has shaped the presentation of mental health and influenced the general response, or lack thereof, to mental health needs. For example, current emerging adults have been exposed to reports of suicide taking place at universities (O’Keefe et al., 2021), traumatic church shootings (Iwuoha, 2021), footage of riots and lootings, recounts of police brutality against people of color (Alang et al., 2021), severe weather threats such as Hurricane Katrina (Tavernier et al., 2019), the terrorist acts of September 11th (O’Donohue et al., 2021), and the January 6th insurrection (Sorge et al., 2022). While the extent of impact may vary, emerging adults have been exposed to several untimely deaths of young people of color including Trayvon Martin, Eric Garner, Sandra Bland, Breonna Taylor, Ronald Green and George Floyd all challenged by another in an authoritative position. Because formal mental health services are delivered by a professional in a
position of power, it should be acknowledged that one could highlight a similar imbalance of power associated with formal service treatment promoting disinterest in formal mental health help-seeking in all. Stress affects one’s internal state and alters their worldview producing a failed sense of belonging, a growing mistrust for others, and increasing the desire to self-isolate (Williams et al., 2021) all incongruent with active help-seeking for mental health needs.

While exposure to tragedies is negatively impactful to many, African American emerging adults are faced with increased risk as such trauma related exposures makes them susceptible to suicidal behaviors. Across most ethnic groups, it is reported that middle aged and older individuals are the most likely to be afflicted by suicide; however, for black Americans, those 30 years of age and under are at the highest risk (Ducharme & Ross, 2022: Martinez-Ales et al., 2021). As a result, attention to the issue of underutilization of formal mental health services and sensitivity to minority mental health needs imperative in efforts to rebuild broken families and aid a vulnerable subgroup.

**Service Utilization Motivation**

According to the literature, there are a few common reasons why people utilize professional mental health services. In this section, three of the most common motivations are detailed with the understanding that help-seeking behaviors were an effort to overcome mental health disorders and associated symptoms. First, a common motivation for service utilization among the general American population, was a self-identified recognition of a need for professional help. This motivation is evident in the literature among females, living with depression (Castonguay et al., 2016) and individuals over the age of 18 who identified as Jewish (Nakash et al., 2019). A self-identified recognition of a need for professional help was also a motivator of mental health service utilization among African Americans between the age of 20
and 69 desiring treatment for substance use disorder (Dillon et al., 2020) and African Americans who were largely unemployed, economically disadvantaged, and parents of children with behavioral disorders (Ofonedu et al., 2017). In these cases, individuals felt as though the problem was bigger than oneself, and as a result, were motivated to follow up with supportive help-seeking amongst mental health professionals.

Secondly, a common motivation for service utilization was receiving a referral from a primary care provider. Among the general American population, the literature shows that individuals over the age of 18 who identified as religious, utilized professional mental health service far more after receiving a referral from a primary care provider (Nakasha et al., 2019). This motivation was also an influencer for service utilization among college-attending emerging adults, many who identified as non-Hispanic white (Nobiling & Maykrantz, 2017). This motivation was also found to be a trend among college-attending emerging adults (Nobiling & Maykrantz, 2017).

Lastly, having support from family and friends in the early stages of help-seeking was a motivating factor in mental health service utilization. The literature shows that such support served as a motivation among emerging adults aging out of foster care (Sakai et al., 2014) females living with depression (Castonguay et al., 2016) African Americans receiving treatment for substance use disorder (Dillon et al., 2020) and college attending emerging adults (Nobiling & Maykrantz, 2017).

**Benefits of Utilizing Mental Health Services**

According to the literature, there are a few common benefits associated with help seeking behavior. The most common benefits include gaining increased social support, gaining increased independence over symptoms associated with poor mental health, the development of a healthy
relationship with another person and the increased possibility for better life opportunities following treatment (Ben-David et al., 2019; Cassidy et al., 2019; Dillon et al., 2020; Nobiling & Maykrantz, 2017; Oedegaard et al., 2020; Sakai et al., 2014).

Following help-seeking, reconnecting with others and gaining additional social support was found to be a benefit of service utilization amongst individuals, majority male, over the age of 20 with a chronic mental illness (Cassidy et al., 2019). Increased social support was also found to be a benefit of utilizing mental health services among African Americans receiving treatment for substance use disorder (Dillon et al., 2020) and emerging adults aging out of foster care (Sakai et al., 2014). In these cases, the treatment process was impactful as reconnection was a promising benefit associated with service utilization. Secondly, establishing independence was found to be a benefit of mental health service utilization among emerging adults (Sakai et al., 2014), adult males (Cassidy et al., 2019) and individuals living with psychosis (Oedegaard et al., 2020). In these cases, not only did individuals report benefit through a gained independence but they reported an increased sense of control and coping skills. In third, mindfulness of the opportunity for a better life was found to benefit service utilization among females living with depression (Castonguay et al., 2016) and African Americans in substance use treatment (Dillon et al., 2020). Lastly, the formation of a healthy relationship with counselors was found to be a benefit of service utilization among individuals between the ages of 25-50 (Oedegaard et al., 2020), emerging adults with mental health disorders (Ben-David et al., 2019) non-Hispanic white college students (Nobiling & Maykrantz, 2017) and female emerging adults (Nobiling & Maykrantz, 2017).
Barriers to Utilizing Mental Health Services

According to the literature, there are several common barriers that negatively impact help seeking behavior which in turn reduces mental health service utilization rates. The most common barriers in the literature include “loss of face” or family dishonor (Gee et. al, 2020), the presence of stigma (Jennings et al., 2017), inability to pay for professional services (Cadigan & Lee, 2019), lack of time for treatment and service appointments (Cadigan & Lee, 2019), lack of confidence that professional treatment would decrease poor mental health outcomes, a lack of awareness or knowledge concerning treatment service location (Cadigan & Lee, 2019), and a low level of awareness as it relates to one having a mental illness that calls for formal treatment (Ben-David, 2019). While various barriers presented in the findings, all resulted in some level of impact on help-seeking behavior, willingness to seek help, or individual intention to seek help for a present mental health need.

The Primary Goals of This Study

This work has three goals. The first goal is to use a mixed method design to better understand the underutilization of professional mental health services. More specifically, this work aims to use a mixed method design to explore the relationship between many factors: minority status, age, gender, help-seeking intentions and willingness to seek help and help-seeking behaviors. Supportive objectives to this goal are to provide various definitions of key variables, conduct in-depth interviews and utilize tested instruments to collect data. The rationale includes utilizing a design that will exercise a feasible, two-phase approach that will not only yield needed information on the relationship between key variables (minority status, age, gender, help-seeking intentions, willingness to seek help, and stigma) but it will also further explain how
related factors could ultimately impact the utilization of mental health services among this subgroup.

The second goal of this research seeks to influence mental health professional practice and related stakeholders. The findings of this research could be beneficial to the target population and their families, policy makers, various mental health practitioners, and education leaders as it aims to meet the need for more specific, population driven research prompting a tactical response while informing best practice among helping professionals today.

The third goal of this continued research on help-seeking behaviors is to provide more specific evidence and further addresses the problem of underutilization of mental health services as it relates to minority Americans and in this case a specific, understudied, growing subgroup.

**Significance of the Study**

There are three reasons why this work is important. First, there is a lack of studies focusing on emerging adults. “Emerging adults” describes the demographic group of individuals between the ages of 18 and 29. Emerging adults consist of individuals born between the years 1993 and 2004. Categorized by name, current emerging adults are described as “Millennials” and “Gen Zers”. Arnett notes that it is important to consider the lack of research studying emerging adults, especially those who are not enrolled in college (Arnett, 2000). Due to issues related to practicality and accessibility, it is difficult to know much about the “other half” of emerging adults because they are rarely represented in the literature (Arnett, 2000). Due to difficulty sampling a large number of emerging adults outside of the university, where there are clusters of these individuals, literature exploring emerging adulthood continues to be limited. The recognition of emerging adults as demographically distinguished from other age groups further contributes to the need for continual literary support entailing the specified needs of the
population as well as special topics by which they are affected, such as mental health service utilization (Arnett, 2000).

Secondly, this work will focus on the experiences of African Americans emerging adults, an area of less frequent empirical report. In general, there is literature detailing the experiences of emerging adults (Arnett, 2000), however fewer scholars have focused on African American emerging adults, thus highlighting a gap in research (Miranda et al., 2015, Williams, 2018). Also, while some quantitative studies have captured the past prevalence of mental health needs among African American emerging adults (Davis & Ford, 2004; Jackson et al., 2004), continual research is needed to further conceptualize mental health prevalence in a 21st century and pandemic era.

Finally, there is limited updated literature that explores minority emerging adult experiences as it relates to help-seeking behaviors and professional mental health treatment. This gap in the literature is particularly concerning when one considers national news coverage which suggests that African American emerging adults are likely to experience mental health issues associated with the current political and racial climate in America (Williams, 2018). Exposure to news stories supports a narrative detailing that African Americans could disproportionately be at an increased risk for psychological and emotional distress. With knowledge of the impact of trauma, continual research is necessary to identify recent causes for mental distress among African American emerging adults. As a result, one question supported by qualitative methods will explore recent causes of mental distress among African American emerging adults.

Quantitative and qualitative research aims that align with the study significance have been provided. Through quantitative methods, one research question asks if minority status, age, gender and stigma predict help-seeking behaviors for mental health needs among African
American emerging adults. Another question asks if minority status, age and gender predict help-seeking behaviors for African American emerging adults with mental health needs. Through qualitative methods, research questions explore attitudes impacting help-seeking behaviors for mental health needs among African American emerging adults. This is addressed by exploring factors that encourage and discourage African American emerging adults in the help-seeking process. Another research question addressed through qualitative methods, explores sources of support for mental health needs following mental distress.

**What This Study Will Accomplish**

There are four ways that this study can actively promote mental health service utilization among African Americans. First, the results of this study can serve as the foundation for educational curricula that could encourage mental health utilization. Secondly, the results of this study can lead to the creation of a set of applied deliverables that service providers can use to encourage the use of mental health services. In third, the findings of this study can result in web-based resources for practitioners, clergy and educators who work to support mental health services usage among the target population. Lastly, findings will identify alternative behaviors practiced in place of formal help-seeking for mental health needs among African American emerging adults.
CHAPTER II. LITERATURE REVIEW

How Mental Health has Been Defined in Past Studies

There are various definitions that shape the understanding of mental health. In defining mental health at a conceptual level, it is suggested that a state of mental health includes the ability to form and maintain healthy relationships, perform appropriate social roles that are expected in their culture, manage emotions, and the competence to recognize, acknowledge, and communicate positive actions, thoughts, and feelings (Bhugra et al., 2013). Similarly, mental health is defined as a state of well-being in which an individual is able to recognize their own abilities and weaknesses and can cope with the everyday stresses of life while maintaining the ability to be productive, fruitful, and contribute to their community (WHO, 2001).

Other definitions of mental health include the presence of illness or psychological disease, a state of mind that grants full performance of all bodily functions or as a state of equilibrium in relation to one’s inner being, physical and social environment (Sartorius, 2002). Mental wellbeing, specifically among college students, is characterized by positive feelings and a healthy self-esteem that reflects an inner capacity to cope with challenges and difficulties of student life (Barkham et al., 2019). Contrarily, mental health issues occur when specific issues such as excessive worry or sadness are having a negative impact on a person’s ability to function, and the individual is unable to cope with these feelings or experiences in a healthy way (Barkham et al., 2019). Mental health involves many aspects of a person’s wellbeing, including how they think, feel, and act. A person’s mental health determines how that person will handle challenges like stress and grief as well as their ability to relate to others and make choices. Because of the holistic impact mental health has on a person’s life, it is necessary to assess and address mental health issues at every stage of life (U.S. Department of Health and Human
Common definitions of mental health focus on social, psychological, and physical factors, but these definitions also take into account the ratio of resources to challenges that individuals and communities experience; many people describe well-being as the equilibrium between these challenges and resources, resulting in what is commonly considered “resiliency” (Dodge et al., 2012). Furthermore, other definitions have incorporated the existence of spiritual and emotional awareness including that individual mindfulness in these areas extend to one’s mental health and psychological capacity (HEA, 1997). Contributing factors of mental health outcomes are also believed to include biological factors, life experiences, and familial mental health history (U.S. Department of Health and Human Services, 2019). While there is variation in how mental health is defined, there are enough commonalities amongst the professional community to approach mental health literature with foundational understanding. The following work reviews how mental health among emerging adults has been studied in the past.

**How Mental Health has been Studied among College Students**

In assessing the presence of mental illnesses on American college campuses, commonly referenced studies are presented in this work. In one study using screenings to report rates of depression, findings show that African American college-attending emerging adults experienced higher depression rates than their white counterparts (Eisenberg et al., 2013). African American emerging adults also reported experiencing suicidal ideations at greater rates than other students on campus (Eisenberg et al., 2013). In a study examining the prevalence of mental health symptoms amongst emerging adults, 32.4% of participants screened positive for depression symptoms, 24.6% screened positive for anxiety symptoms, 21.8% screened positive for both
depression and anxiety symptoms, and 35.2% screened positive for depression or anxiety symptoms (Cadigan & Lee, 2019).

Mental health among emerging adult college students has also been studied in terms of intervention and various treatment effectiveness. In a qualitative study, Conley et al. (2020) studied the effectiveness of a mental health intervention called Honest, Open, Proud- College (HOP-C). HOP-C is a peer-led, group-based intervention for college students living with a mental illness. The program focuses on empowering individuals to have control over disclosing their mental illness to others when and how they see fit. The program also exists to help reduce stigma and spread mental illness awareness. The researchers recruited 118 students from three university campuses in two urban settings in the U.S. The universities were ranging in size from 3,000 to 12,000 undergrads and 3,000 to 5,000 graduate students. The majority of participants (63.6%) represented campus 1, 21.2% represented campus 2, and 15.3% represented campus 3. The majority (82.2%) were female, and the average age of participants was 20.8 years. 68.6% were white, 17.8% were Asian American, 7.6% were African American, and less than 1% identified as Native American or Pacific Islander, with 82.2% reporting non-Hispanic ethnicity (Conley et al., 2020, p.172). More than 85% of participants were undergrad students. 61.9% of students lived on campus. 66.9% of students identified as heterosexual, 18.6% as bisexual, 6.8% as gay or lesbian, and 7.6% as other. The majority of participants (80.5%) reported having received counseling, and 63.6% reported having ever taken medication for a mental illness. At the start of the trial, 43.6% were actively receiving counseling, and 56.4% were taking psychiatric medication. 85.5% of participants had a baseline depression score above the clinical at-risk cutoff, and 69.2% had a baseline anxiety score above the clinical at-risk cutoff (Conley et al., 2020, p. 172).
Participants were recruited through flyers, emails, social media, student services, and in-person recruitment (Conley et al., 2020). Informed consent was provided in person at two of the campuses and online at the other (Conley et al., 2020). Participants were randomly assigned to HOP-C or a control group. A survey was designed to measure the program’s effectiveness in reducing self-stigma, mental health symptoms, and stress, and promoting coping skills and self-efficacy. There were three tiers to this study. First, the participants received online survey links prior to the start of the intervention (T1). Then, follow-up survey links were sent to participants three days after the end of the intervention (T2), and three days after the booster session (T3) (Conley et al., 2020).

The intervention included three weekly lessons and a booster two to three weeks after the last main lesson. The booster was unique to this study and had not been included in previous studies. The first lesson included a discussion of what it is like to live with a mental illness and the risks and benefits of disclosure. The second lesson taught about different forms of disclosure, including social media disclosure (Conley et al., 2020, p. 170). Lesson three allowed participants to create their own disclosure story and practice disclosing to others, and the booster was simply a check-in to see if and how participants had decided to disclose to anyone since the last session.

In total, 79.7% of participants completed all three steps of the survey process. There were no statistically significant differences in the demographics of those who completed all surveys and those who completed only one or two. The study found that the intervention reduced the level of harm from self-stigma among participants. Additionally, while the study did not reduce stigma-related stress, participants reported that they felt more equipped to cope with this stress. There was also a significant increase in self-efficacy about disclosure. Lastly, the intervention had no impact on anxiety and depressive symptoms (Conley et al., 2020).
The limitations of this study include a short observation period, so it would be beneficial to have a longer period before implementing the booster. Additionally, the demographics of the sample did not adequately reflect the average population of universities across the U.S. since most participants were female and there was little racial diversity among participants. This study also did not screen individuals for disclosure-related stress as researchers have done in previous studies, which makes it difficult to compare the findings. Another limitation to consider is that the participants were not required to submit a formal mental health diagnosis. They were only asked if they personally identify as having a mental illness, and this level of ambiguity could have an impact on internal validity. Additionally, recruiting participants at a college campus could imply that the participants have less severe mental illness symptoms than those in the general population. Lastly, the study did not consider the length of time each participant has been living with a mental illness, which could have an impact on the effectiveness of the intervention (Conley et al., 2020).

**Mental Health Assessment Tools**

The study of mental health has advanced using various assessment tools. The following assessment tools are used by mental health and health professionals to measure various mental illnesses. These assessment tools are specifically designed to assess symptoms of depression and anxiety, which are two of the most common mental health conditions (Harvard Medical School, 2017; Moreno-Kustner, 2018; SAMHSA, 2019). For this reason, the current study recognizes depression and anxiety as influencers of emerging adult mental health in their decision to exercise help-seeking behavior for formal mental health services.
DSM-5

The *Diagnostic and Statistical Manual for Mental Disorders- Fifth Edition* (DSM-5) was developed by the American Psychiatric Association (APA) and is the basis for most standard approaches to assessing and diagnosing mental disorders (APA, 2013; Tarescavage, 2021). The DSM-5 often serves as the guiding tool to developing screening tools for mental disorders (Pawluk, 2021). The DSM-5 is developed through research, and the changes in each new edition are fueled by scientific advancements and public health needs (Regier et al., 2013; Tarescavage, 2021). The DSM-5 lists out almost every known mental disorder and includes information that assists in diagnosis, including symptoms, risk factors, age of onset, duration, and more (APA, 2013). The DSM-5 also includes a list of assessments that have been found to be valid and reliable and can be used to diagnose mental disorders (Tarescavage, 2021).

PHQ-9

The Patient Health Questionnaire-9 (PHQ-9) is a shortened version of the Patient Health Questionnaire that serves as a brief screen tool for depression (Dadfar et al., 2021). The screening tool is based on the DSM-V criteria for major depressive disorder and uses Likert scale questions to specifically assess for common symptoms such as sleep disruption and hopelessness (Kroenke et al., 2001). If at least five of the nine symptoms have been present for “more than half the days” (Kroenke et al., 2001; p. 607) in the past two weeks, the patient is further assessed for major depressive disorder. The nine items can be rated from zero to three (not at all to every day, respectively), meaning that the highest score a patient can receive is 27. The assessment can be self-administered in under ten minutes and reviewed by the clinician for scoring (Kroenke et al., 2001). The instrument includes an additional question at the end that states, “How difficult have these problems made it for you to do your work, take care of things at home, or get along
with other people?” (Fisher, 2010; Kroenke et al., 2001). The test is free to use and can be downloaded from the internet for anyone to use (Fisher, 2010). The PHQ-9 has been found to have high validity and reliability in several studies (Kroenke et al., 2001; Peng et al., 2020; Sun et al., 2020). Kroenke et al. (2001) calculated a Cronbach’s score of .86-.89, a test-retest reliability score of .84, and a criterion validity of .93-.95; Peng et al. (2020) calculated a Chronbach’s score of .85 and a structure validity score of .86; and Sun et al. (2020) calculated an internal consistency of .89 (Chronbach’s) and a test-retest reliability score of .74. This assessment has been found to have good sensitivity (88%) and specificity (88%) in detecting major depressive disorder (Kroenke et al., 2001). The limitation of this test is that it only assesses for depressive symptoms, so if a patient is experiencing symptoms of some other disorder, the assessment will not identify it.

**GAD-7**

The Generalized Anxiety Disorder-7 (GAD-7) is a brief screening tool that assesses for generalized anxiety disorder (Spitzer et al., 2006). This assessment tool is based on the DSM-V, is somewhat similar to the PHQ-9, and is often administered simultaneously with the PHQ-9 due to the similarities between anxiety symptoms and depression symptoms (Butcher et al., 2021; Tran, 2020). Like the PHQ-9, the GAD-7 is a self-rated Likert scale questionnaire that measures the frequency of symptoms from 0 (not at all) to 3 (nearly every day) for the past two weeks (Butcher et al., 2021). The screening alone is not supposed to be the basis for a diagnosis but is supposed to be immediately followed by a clinical interview (PHQ-9 and GAD-7 instruction manual, n.d.). The GAD-7 addresses symptoms such as excessive worry and sleep disruptions (Butcher et al., 2021). This assessment has been found to have good sensitivity (89%) and specificity (82%) in detecting generalized anxiety disorder (Spitzer et al., 2006). The assessment
is free to use and available online (PHQ-9 and GAD-7 instruction manual, n.d.). This assessment has been found to have excellent reliability in several studies (Rutter & Brown, 2017; Tran, 2020; Zhong et al., 2015). Rutter & Brown (2017) calculated a Cronbach’s score of .85 and a moderate convergent validity (.52-.68); Tran (2020, p. 303) calculated a Cronbach’s score of .91; and Zhong et al. (2015) calculated a Cronbach’s score of .89. The limitations of the GAD-7 include the fact that it only addresses 7 questions and may not accurately address all symptoms of anxiety and may be and the fact that it only addresses anxiety symptoms and may overlook symptoms of other disorders.

Through use of self-report and engagement in qualitative methods, this research will study the presence of mental health as it relates to service barriers, stigma, age, gender and help-seeking behaviors among African American emerging adults.

**How Mental Health Utilization Has Been Previously Examined**

There is a body of literature that provides further understanding of how mental health utilization has been examined in the past. At a conceptual level, mental health utilization has been defined as attaining mental health treatment from family doctors, psychiatrists, psychologists, nurses, social workers and other mental health professionals (Simo et al., 2018, p. 678). It is believed that mental health service utilization is dependent upon three factors: a person’s experience with formal services, barriers and motivators of service use, and the level of need for care (Andersen, 1995).

Defining mental health utilization operationally in empirical research has resulted in two common findings. First, at an operational level, mental health utilization has been defined as “receiving mental health services offered in settings such as hospitals, private clinics, pharmacies, mental health community centers, rehabilitation centers, support groups, and crisis...
line services at least once” (Simo et al., 2018, p. 678). Similarly, meeting with at least one health professional at some point for mental health purposes has been recognized as mental health service utilization (Simo et al., 2018). Secondly, mental health service utilization has been defined by how often an individual seeks professional treatment. Evidence of mental health service utilization was defined as having seen a health professional for mental health service needs within the past year (SAMHSA, 2015). Help-seeking has been defined as the process of searching for resources or requesting assistance to solve a personal, medical, emotional, or other problem one is experiencing (Unrau & Grinnell, 2005; Zartaloudi & Madianos, 2010). Help-seeking behaviors can also present as a request for assistance from informal supports (e.g., friends, family, and mentors) or formalized (institutional) services (e.g., professional, and clergy) for the purpose of resolving emotional, behavioral, or health problems (Srebnik et al., 1996). Lastly, help-seeking has been described as the decision to seek out professional assistance and the decision to receive assistance from a particular source (Neighbors, 1985).

In one quantitative study, participants were recruited from a single college counseling center in the northeastern part of the United States. Of the 124 college students who completed intake assessments at the university counseling center 122 were invited to participate. Of the 122 participants, 86 identified as female and 36 identified as male. The age of participants ranged from 17-34. The participants included: “36% white, 28% Asian, 16% Latino, 3% black, 13% multiracial, and 4% other races. Forty-three percent reported a lifetime history of suicidal ideation at intake, and 15% reported a lifetime suicide attempt history” (Miranda et al., 2015, p. 292). To participate in the study, students were contacted by email 6 months after their intake visit and invited to complete a 30-minute online survey and received $20 in the form of a gift card or cash. Following consent, the email containing a link to a survey was disbursed to
participants. Findings show that minority students reported seeking professional treatment less frequently than non-Hispanic white students in the past (53% vs 89%), and “minorities reported seeking treatment in the form of follow up services less frequently than white students” (31% vs 52%) (Miranda et al., 2015, p. 294).

In another study that inquired about mental health service utilization following alcohol use, anxiety symptoms and depressive symptoms among American students, “28.4% reported that they had used mental health services in the past year, and 40.8% reported that they had an unmet service need in the past year” (Cadigan & Lee, 2019, p. 588).

Following the empirical influence and through use of two self-report instruments and engagement in narrative, this research will study mental health service utilization among African American emerging adults as evidenced by the number of times one has been seen by a health professional for mental health needs within the past year.

**The Barriers to Formal Service Action**

Research has explored barriers that exist for individuals who are seeking formal mental health services and several barriers continuously present. These barriers include stigma, family perception, low self-efficacy, financial burdens, lack of time and transportation, lack of trust and confidence in therapeutic services, and a lack of mental health education at the individual and community level (Ben-David, 2019; Cadigan & Lee, 2019; Gee et al., 2020; Jennings et al., 2017). Studies have detailed not only what barriers exist, but how those factors impede the help-seeking process.

In a study examining college students’ personality traits as it related to perceptions of service barriers experienced and their likeliness to receive formal mental health treatment, findings show that perceived barriers and self-stigma are strong predictors of seeking or having
sought formal mental health treatment (Jennings et al., 2017). The participants in this study included 263 college students from a southeastern university, with the average age being 18.76 years old. The majority were female (63%) and white (88.5%). 5.7% were African American, 1.9% were Asian/Pacific Islander, 1.5% were Hispanic, and 2.3% other. “Each participant received a self-report survey that included measures of personality (FFM), perceived stigma, self-stigma, practical barriers to treatment, negative attitudes about treatment, a measure of depression, self-reported mental health problems and treatment seeking behaviors, and questions assessing the perceived effort in completing some measures” (Jennings et al., 2017, p. 516). Longitudinal regressions were conducted to examine associated factors.

A total of 115 (44%) participants reported experiencing a current mental health problem, but only 21 (18%) reported seeking treatment for that problem in the past 6 months. Findings show that all perceived barriers reported were associated with a lower likelihood of seeking treatment. “Specifically, increased levels of perceived stigma, self-stigma, negative attitudes and practical barriers” were associated with a lower likelihood of seeking mental health treatment (Jennings et al., 2017, p. 518). Additionally, extraversion and agreeableness were both associated with lower perceived stigma, and agreeableness was associated with fewer negative attitudes toward treatment. Conscientiousness was associated with fewer perceived practical barriers. One limitation of this study is that the design was cross-sectional, which limits the ability to make causal inferences. Additionally, the study utilized self-reports, with a broad definition of what defines a mental disorder, so there is a chance for bias or incorrect information in the responses. Another limitation is that the researchers used a very simple set of criteria to determine if the participants were experiencing a problem, which oversimplified the issue and did not account for
differences in severity. The researchers also only controlled for depressive symptoms and no other mental health symptoms.

In another study that examined barriers and predictors of mental health service use among Asian American and European American college students who experienced mental health problems in the past year, findings show that Asian Americans reported greater barriers to mental health service (Gee et. al, 2020). The participants included 153 Asian Americans and 136 European Americans, with a median age of 19.1, from a large private university in the mid-Atlantic U.S. The participants were majority female (69.3%). The Asian American group was divided into subgroups for separate analyses (35.9% East Asian, 48.4% South Asian, 12.4% Southeast Asian, and 2.6% were multiethnic). The majority of participants (74.7%) reported a family income of greater than $100,000, and 38.4% reported family income of greater than $200,000. The participants were selected from a larger study on the basis that they reported experiencing a serious emotional or interpersonal problem in the past year. The majority of participants were recruited in their psychology courses and were given the opportunity to complete the assessment to get a research credit for their courses.

The participants completed an online survey that consisted of Likert scale questions that inquired about demographics, barriers to help-seeking, Asian cultural values, family stigma, “loss of face” (embarrassment, humiliation, or ruining a reputation), and mental health service use. Hierarchical logistic regressions were used for some data analyses. Asian Americans not only reported greater barriers to mental health service use but also carried negative attitudes about professional mental health service engagement. Asian Americans reported greater concern for “loss of face”, family stigma, and adherence to Asian values than European Americans. Among subgroups, the only significant finding was that South Asians had a greater concern for
family stigma than other Asian Americans. Even among European Americans, findings show greater perceived barriers had a negative impact on service use (Gee et. al, 2020). One limitation of this study is that the study did not account for attrition, which could have impacted the results because statistically, Asian Americans are more likely to drop out of a study than European Americans. Additionally, service use was only measured in the past year, and any prior service use was ignored.

Another study examined the prevalence of mental health symptoms, mental health service utilization, perceived unmet service need, and investigated barriers impacting service utilization. The participants included 142 community college students in the Pacific Northwest. The sample was majority female (69.7%) with a median age of 22.75. “58.9% were White, 12.8% Asian, 5.7% Black, 14.9% Multiracial, and 2.8% American Indian/Alaskan Native, 2.8% Native Hawaiian/ Pacific Islander, and 2.1% other” (Cadigan & Lee, 2019, p. 587). Eligibility requirements included participant age range from 18 and 29 years old, community college class enrollment, a history of alcohol use and cellular text messaging access. The participants were recruited from a larger study through handouts, newspaper ads, posters, and emails. Interested participants completed an online eligibility survey to determine if they were eligible to participate, and those who were deemed eligible were invited to be part of this study. Individuals who completed the eligibility survey were entered into a drawing for $250, and those who completed the current study were paid $30, with the chance to get $80 through follow-up assessments. A total of 142 (90%) eligible participants agreed to take part in the study and were randomized into an intervention and control group.

Students reporting mental health symptoms were found to be more likely to cite cost as a barrier to treatment than those without mental health symptoms. Additionally, individuals with
more serious drinking problems were more likely to report the reason for lack of treatment was due to inability to pay for services, lack of time, or ideas that stigma associated with receiving mental health treatment might affect their job. The most common responses to the lack of help seeking behavior were “beliefs in the ability to self-manage the without treatment (74.1%), a lack of time because due to other responsibilities such as jobs, childcare, or other commitments (48.3%), treatment cost being unaffordable (37.9%), lack in confidence in treatment resulting in decreased outcomes (36.2%), and a lack on education concerning treatment serve location (31.0%)” (Cadigan & Lee, 2019, p. 589). One limitation of this study is that mental health symptoms were assessed using a brief screening tool rather than an in-depth interview. Additionally, all participants were from the same geographic location, so the results may not be generalizable to other areas. Another limitation is that the questions were specific to counseling or outpatient treatment and may exclude individuals who received psychiatric medication. Lastly, the study did not assess comorbidity.

Another study was examined perceptions of formal mental health treatment. The purpose of this study was to explore mental health service utilization barriers and examine overall messages concerning formal help-seeking from community members (Ben-David et al., 2019). The participants included 30 young adults aged 18-30 from a clinic in an eastern state in the U.S. All participants were receiving formal mental health services and were excluded if they were “actively psychotic, a harm to themselves or others, lacked capacity to give informed consent, or could not speak English” (Ben-David et al., 2019, p.18).

The study consisted of in-depth semi-structured, open-ended interviews with the participants. However, prior to the interviews, participants completed a brief survey to collect demographic information and were then asked four closed-ended questions to assess social
desirability and ensure that the participants understood the importance of being honest in the study. The data were analyzed using thematic analysis. Two coders met continuously throughout the process to compare codes and a third analyst assisted in building the consensus. The coders used focused coding and axial coding in their analyses. Theoretical sampling refined the categories and themes and led to category saturation (Ben-David et al., 2019).

“Six major categories emerged from the data: (1) networks, (2) stigma, (3) level of awareness, (4) emotions, (5) facilitators of service use, and (6) barriers of service use” (Ben-David et al., 2019, p. 19). Within the category of networks, community networks, social networks, and online networks were all cited as either barriers or facilitators of mental health service use. Community networks were cited as a barrier for five individuals from racial/ethnic minority communities as one participant reported “in black communities all around the world, mental health is not seen as a good thing” (Ben-David et al., 2019, pp. 20-21). Social networks, including informal supports such as family members, were cited as a barrier by 15 participants, while 7 participants cited mixed views from their social networks, and 2 cited positive experiences with their social networks regarding mental health services.

A factor that presents as a common barrier but also contributes to general attitudes regarding African American mental health is the presence of stigma. Stigma refers to negative beliefs, ideas, thoughts, and behaviors that ultimately influence the individual (Conner et al., 2009). The presence of stigma has also led to fear, public judgement, avoidance, rejection, and discrimination against individuals with mental needs. Previous literature shows that stigma influences attitudes regarding mental health and mental health seeking leaving individuals reluctant or refusing to seek help due to the potential of discrimination and fear of rejection by others (Corrigan et. al, 2001; Corrigan et. al, 2004; Corrigan & Penn, 1999).
Historically, mental illness has been stigmatized in its association with demonic possession, ill personal moral, or evil spiritual intent in many groups of color (Pattyn et. al., 2014). Admitting suspected presence of mental health illness for self or a loved one would not have been a popular choice as individuals did not want to poorly label themselves or a loved one and endure the public scrutiny. The literature is supportive in this as studies show that for African Americans, stigma, and the fear of being labeled or discriminated against have been influential factors associated with attitudes towards mental health and mental health seeking (Gee et al., 2020; Miranda et al., 2015).

In a study, 25 participants reported that they have partially disclosed their service use to friends and family but are not comfortable sharing extensive information with them, while 2 of them stated that they are not comfortable disclosing at all, and 3 stated that they have no problem disclosing because it is nothing to be ashamed of (Ben-David, 2019). Level of awareness was cited as an important aspect of the participants’ feelings regarding their mental health services. A total of 17 participants said that they were ambivalent toward services, 17 endorsed awareness about services, and 11 seemed to have insight into their service use and needs. Emotions were also cited as a major factor of service use perceptions. Specifically, these 11 participants reported a wide range of emotions from feelings of shame, fear and confusion, to feelings of hope or relief. The major barriers that were reported in this study include “(a) lack of access, (b) physical environment, (c) services lead to negative emotions, and (d) clinical barriers” (Ben-David, 2019, p. 22).

The findings of this study led the researchers to develop a conceptual model of service utilization. The data found that there are community, social, and online networks that are influencing young adults and their feelings toward mental health services. Additionally, a young
person may be deliberating their need to seek services (awareness of treatment), their feelings towards seeking services (emotional reactions), and the potential stigma of seeking mental health services (Ben-David et al., 2019). Lastly, when a young adult is seeking mental health services, they often experience environmental barriers or facilitators that impact their ability to receive services. A major limitation of this study highlights the use of a small sample size.

In a study examining the impact of barriers on mental health service utilization amongst non-Hispanic white and racially diverse college students, researchers developed a survey (Experience with Mental Health Treatment Questionnaire) to examine the students’ service experience, interest in current mental health treatment, and possible barriers that could prevent further treatment. The survey included questions about the participants’ history with mental health usage and whether they remembered the provider’s recommendations and agreed with and/or followed through with them. The survey included 11 possible barriers to mental health treatment plus an “other” option for the students to fill in other barriers that were not on the list. Included in the list were “fear of reactions from family or friends, not knowing if a problem warrants treatment, too little time to dedicate to treatment, preferring to deal with problems on their own, preferring to seek help from other sources, and financial concerns (eg, not having insurance)” (Miranda et al., 2015, p. 293). The survey inquired about the participants’ mental health experience in the 6 months since their intake visit, including whether or not they have had suicidal ideations. Findings show that minority students reported a greater number of barriers present within the past six months and minority students anticipated future barriers to be more likely than non-Hispanic white students (Miranda et al., 2015). The most commonly cited barriers to mental health treatment amongst racially diverse participants were “financial concerns as it relates to treatment cost (61%), a lack of time to engage in professional services (51%), a
preference to keep personal information private (48%), and uncertainty related to if mental health concerns warranted treatment (47%)” (Miranda et al., 2015, p. 295). In comparison to the impact of barriers on non-Hispanic white participants, minorities reported a lack of time as a barrier far more often than non-Hispanic white participants (Miranda et al., 2015). In specifically considering the impact of stigma, minority students reported “fear of what others would think of them” as a barrier more often than white students (28% vs 9%) (Miranda et al., 2015, p. 295).

In confirming that the presence of barriers can negatively impact mental health service utilization, findings show that the total number of treatment barriers reported by participants were associated with lower odds of following through with treatment recommendations (Miranda et al., 2015).

Limitations of this study include a majority female sample, which implies that the results may not be indicative of most male college students, and the lack of a separate analysis between minority groups. Combining the groups together into a mass “racial/ethnic minority” ignores potential unique variables between different races. Additionally, the researchers relied on a single-item measure of suicidality and did not confirm suicidality at follow-up. Lastly, within-group factors such as socioeconomic status, language proficiency, and country of origin were not considered. Despite limitations, findings of this work contribute to a greater understanding of how treatment experiences translate into active mental health service barriers for emerging adults of color.

In one study, African American women revealed that their lack of trust in mental health institutions contributed to their reason for not seeking or continuing with services (Johnson et al., 2014). Another study showed that 26.4% of single African American women reported fear as a reason for not seeking treatment despite wanting it (Rosen et al., 2004). Men of color have
reported similarly as study findings show that men with mental health needs have reported fear and ideas around stigma to influence their attitudes about mental health (Ro et al., 2006). Stigma and fear play a role in African American parent’s openness to submit their children to mental health treatment (Lindsey et al., 2010). This form of generational and cultural influence leaves African Americans vulnerable, feeling shameful, and perpetuates the association of fear concerning receiving help. One study found that African American parents were less likely to seek treatment for their children if they held high levels of stigma regarding the overall process of receiving mental health services (Turner et al., 2015). African American mothers in a qualitative study reported fear as a barrier to seeking the help of mental health professionals for their children (Murry et al., 2011). In that study, 16% reported fear of what others would say if their child were to get help for their emotional or behavioral problems, 56% reported fear of being blamed for their child's emotional and behavioral problems and 22% reported fear of their community looking down on families with emotional or behavioral problems (Murry et al., 2011).

In these studies, the need for mental health service often did not supersede the role of fear and stigma for various subgroups. As a result, stigma has played a role in African American attitudes regarding having mental health needs and help seeking for those needs. This is quite common as according to Pattyn et. al., (2014) individuals with higher levels of perceived public stigma are likely to be influenced by negative stereotypes regarding mental health and mental health services and consequently are less likely to see the importance of seeking treatment. With that, African Americans have grown to live with mental illnesses making effort to normalize the increased difficulties associated. These inherited beliefs have shaped resulting attitudes which have continued to affect many groups of color and impact utilization rates of mental health
services among African Americans in need. Such cultural beliefs have driven these attitudes to present as a barrier to mental health service treatment for African Americans.

**Commonly Reported Sources of Support**

Support measures are a significant component for individuals seeking mental health intervention and treatment within the general population. Research has found positive correlations between formal support, peer-led interventions, tele-mental health services, and faith based mental health programs in connection with motivation and action for engaging in mental health services (Bewley & Morgan, 2011; Caplan & Cordero, 2015; Krider & Parker, 2021). In a qualitative study focused on the mental health needs of prisoners, formal support was utilized as 99% of state prisons included in the sample employed a mental health professional with the majority having at least “one psychologist (83%) and one psychiatrist (81%) and many had additional professionals including at least one counselor (61%), social worker (59%), addiction counselor (33%), master’s student in training (28%), doctoral student in training (25%), or paraprofessional (11%)” (Bewley & Morgan, 2011, p. 354). Peer-led group-based intervention was also found to be a source of support among college aged students. Krider & Parker (2021) found that tele-mental health, which is a virtual version of mental health that is conducted over the phone or through video chats, was supportive for addressing mental health needs. Mental health service providers and patients in behavioral health and criminal justice settings reported that using tele-mental health treatment is more accessible and reduces the challenges (notably, stigma and transportation) related to receiving mental health services (Krider & Parker, 2021). Participants also reported that confidentiality and safety are more controllable with use of tele-mental health contributes to perceived level of support (Krider & Parker, 2021). Faith-based mental health literacy programs have served as supportive. Mental health literacy programs
combined with faith-based teachings were found to be helpful and educational amongst individuals with depression in Latino communities (Caplan & Cordero, 2015).

**Sources of Support among African Americans**

Formal help-seeking has been less popular among members of the African American community when coupled with the priority to keep private information such as that of mental health within the closed systems of family and friends. This attitude is rooted in the saying “what happens in the house, stays in the house”. As a result, African Americans have largely utilized informal methods of support in having their mental health needs met. Informal support has included family members, friends, loved ones and intimate partners (Horwitz & Uttaro, 1998; Lam & Rosenheck, 1999; Pescosolido et al., 1998; Snowden, 1998). In a study assessing methods of help seeking among black individuals, 24% reported exclusively utilizing informal support (Woodward et al., 2011). African Americans have also expressed interest in religious counsel instead of formal help-seeking (Breland-Noble et al., 2011). In a quantitative study examining religiosity and mental health help-seeking, findings show that individuals were also less likely to seek mental health services but relied on informal support (Turner et al., 2019). Overall, the literature shows that such attitudes are impactful as individuals with identified mental health needs may conclude that their mental health condition may not warrant formal support or interventive services at all, thus the choice to rely on informal support as needed.

**The Role of Religion and Help-Seeking**

*Religion and Spirituality Defined*

For many, the church has often been a place of sanctuary and thus, a natural choice in seeking various forms of help. Seeking religious or spiritual counsel has been a common alternative to professional help-seeking in alleviating symptoms commonly associated with
mental health illness. As a result of the impact of the role of religion and spirituality on help-seeking behaviors, religion and spirituality have been defined in the literature.

Throughout most of history, spirituality and religion were interchangeable and often described individuals who attend church and participate in religious events; however, the definitions of religion and spirituality have been evolving in recent decades (Chatters et al., 2008; Pargament, 2009; Roof, 2000). Religion and spirituality are interconnected and extremely similar, but they do have some key differences. Religion differs from spirituality in that it is rigid, structured, formal, and often follows a strict doctrine (Koenig et al., 2001). Formal religiosity is often measured by regularity of church attendance, church membership, and participation in church-related activities (Brown et al., 2015; Chatters et al., 2009).

Contrarily, subjective religiosity is often measured by self-reports and values, rather than active participation. Some measures of subjective religiosity include affiliating oneself with a religion, considering oneself to be religious, considering religion important to oneself, and considering it important to take children to religious services (Brown et al., 2015; Chatters et al., 2008; Chatters et al., 2009). Some researchers have also included “non-organizational religious participation” in their definitions of religiosity and used measures such as “reading religious books or other religious materials, watching religious television programs, listening to religious radio programs on the radio, praying, and asking someone to pray for you” (Chatters et al., 2009, pp. 5-6) to determine a person’s religious status.

Spirituality is a component of religion but can also act as a stand-alone concept. Spirituality can be defined as "a personal affirmation of a transcendent connectedness in the universe" (Young et al., 2000, p. 49). Some researchers describe spirituality as an ever-shifting personalized journey of finding oneself and discovering one’s values and beliefs (Koenig et al.,
Koenig et al. (2001) explains that spirituality begins before religion and extends past it. He describes it as a journey of seeking a higher power that often ends in a person becoming religious or turning away from religion entirely (Koenig et al., 2001). Many researchers agree that spirituality is much more subjective, more individualistic, and less visible than religiosity (Koenig et al., 2001; Marler & Hadaway, 2002; Pargament, 2009; Roof, 2000).

An individual’s spiritual beliefs may be a mixture of different religious practices, a journey of studying one religion at a time, rediscovering lost traditions, or a completely new separate set of values (Roof, 2000). Today, many people who identify as “spiritual” do not consider themselves “religious” (Marler & Hadaway, 2002).

Some researchers believe that this shift away from organized religion came from societal changes and increasing beliefs that people should be able to follow their heart and guide their own decisions rather than following a strict doctrine (Marler & Hadaway, 2002; Pargament, 2009). Researchers also claim that immigration and technology impacted this change because these changes introduced individuals to different cultures, values, and religious systems (Marler & Hadaway, 2002). This caused individuals to question their own beliefs and explore various possibilities in their religious practice. Today, many people see religion as a strict system that limits human potential, while spirituality is seen as a flexible system that allows for individual expression and maximizes human capacity (Pargament, 2009). Given its unique and individualistic nature, spirituality cannot be measured using the same structured measures that are often used to determine a person’s religious status. Many researchers simply ask individuals to self-identify as “spiritual” or “not spiritual” (Marler & Hadaway, 2002).

In conclusion, there are varying definitions of religion and spirituality and therefore both should be observed as two separate constructs. Religion in the literature is broadly viewed as a
traditional, structured, institution-based practice that often follows a strict doctrine and some form of rule system. In contrast, spirituality is a process of self-discovery often shaped by personalized values. Both religion and spirituality often include concepts of faith, the belief in a higher power, and the supernatural. However, spirituality is steadily moving away from the concept of organized religion and becoming a distinct individualistic belief system that varies drastically from person to person.

The Role of Religion and Spirituality in Help-Seeking among the General Population

Aligned with a more philosophical perspective, others have supported the separation of church and state and in doing so, have intentionally held distance between places of worship and secular service providers. In highlighting attitudes supporting the separation of church and professional help, some within the general population have favored exercising religious counsel as an alternative form of professional help-seeking as opposed to opting in for professional mental healthcare service (Breland-Noble et al., 2011). Information in this section will provide information as it relates the role of religion and spirituality and help-seeking patterns for mental health support among various populations.

Historically, the church has been a safe haven and a place for support for those in need and evidence of such can be supported by findings in the literature. In a quantitative study including Americans from diverse religious and cultural backgrounds, findings show that those who identified as Christian or Jewish had higher rates of trust for clergy members, were more likely to “see clergy members as empathetic and were more willing to seek help from clergy members than other participants” (Kane, 2010, pp. 318-319). In another quantitative study focused on females experiencing depression, findings show that higher rates of spirituality are associated with less severe and fewer depressive symptoms (Daaleman & Kaufman, 2006). As
seen in the literature, help-seeking for some has been through refuge offered in a private house of God rather than a public “house of help” also known as formal mental health services. In this informal method of help-seeking, the option for collaboration amongst professional mental health service providers and ordained leaders of the church is less likely which could result in decreased support for the individual.

**The Role of Religion and Spirituality in Help-Seeking among Groups of Color**

As shown, findings have shown that the role of religion and spirituality has had a negative impact on formal help-seeking amongst the general population. As an alternative to formal help seeking, the literature also shows a trend of seeking support within the role of religion and spirituality among African Americans and groups of color.

In a quantitative study examining the relationship between race, ethnicity, age, religiosity, and mental health help-seeking, findings show that individuals living in the South were also less likely to seek mental health services but relied on the church for support (Turner et al., 2019). The participants included 5,008 people (93.91% African Americans; 6.1% Caribbean blacks). The study sample was divided into two subgroups: old (54 or older) and young (53 or younger). The average age was 43. 55.6% of participants were women and 54.7% resided in the southern states. 14.6% of older participants reported holding religious or spiritual beliefs, compared to 33.5% of younger participants. The research questions that guided this study are as follows: “What is the prevalence of African Americans and Caribbean Blacks seeking mental health services? Are there demographic characteristics related to strong versus less strong religious/spiritual beliefs?) Is age (18–53 years and 54 years and older) related to the use of mental health care among African American and Caribbean Black adults?) What factors
differentiate potential age differences in those who seek mental health care and those who do not?” (Turner et al., 2019, p. 906).

The participants that resided in the South reported religious affiliation at much higher rates than those living in other areas of the U.S.; however, their reported “strength of religious beliefs” was no higher than that of other regions (Turner et al., 2019, p. 909). Those living in the South were also less likely to seek mental health services (Turner et al., 2019). A total of 15.23% of participants reported attending at least one 30-minute counseling session at some point in their lives. Fewer older participants reported attending a counseling session than younger participants. “Subjective ratings about the strength of religious/spiritual beliefs (OR = 1.26; 95 CI: 0.99, 1.61), age (OR = 0.62; 95 CI: 0.48, 0.81), and sex (OR = 1.59; 95 CI: 1.25, 2.02) were significantly associated with the odds of seeking mental health care” (Turner et al., 2019, p. 908).

**The Role of Religion and Spirituality in Help-Seeking among Emerging Adults**

In further detailing the role of religion and spirituality as a support for mental health needs, the literature shows that emerging adults are more likely to consider themselves spiritual than religious. In a quantitative study with emerging adults, researchers examined how spirituality affected the relationship between negative life events and depression/anxiety symptoms (Young et al., 2000). The researchers hypothesized that spirituality would act as a protective feature to keep people from developing depression and anxiety symptoms after negative life events. The 303 participants were all enrolled in psychology courses in a single university in the South. Of these, “54% (n = 165) were women, 43% (n = 130) were men, and 3% (n = 8) did not specify their sex, 71% (n = 216) reported their ethnicity as Caucasian, 25% (n = 77) as African American, 1% (n = 4) as Asian, 1% (n = 3) as Hispanic, 1% (n = 3) identified their ethnicity as other and all participants were between 18 and 29 years old” (Young et al., 2000, p. 50). The participants completed a survey that addressed their depressive symptoms,
anxiety symptoms, spirituality, and negative life events. Results show a positive relationship between negative life events and depression and anxiety and a negative correlation between spirituality and depression, but not spirituality and anxiety (Young et al., 2000). The results indicate that a greater level of spirituality weakens depressive symptoms despite negative life events among emerging adults (Young et al., 2000).

Specifically, among African American emerging adults, while limited, there is some evidence of utilizing spiritually guided services as an alternative to seeking formal support for mental health needs. Findings show that instead of seeking the help of a mental health professional, 25% of African American youth preferred to exercise prayer and a relationship with God in coping with mental health problems (Samuel, 2015). As a result of the intimacy established within religious organizations, findings show that the role of spirituality can serve as a protective factor for emerging adults in general and African American Emerging Adults.

A Call for Collaboration between Formal and Religious Informal Support

Beyond empirical literature, rationale for the utilization of faith-based mental health service options can be defined through biblical context that defines the role of God as a counselor. Motivation for help-seeking within the context of the church can be rooted in biblical scripture that pronounces that God leads his children “beside still waters”. For many, this illustrates peace and refuge which could be associated with ongoing mental health needs. While the literature shows that the church has been supportive for groups of color and amongst the general population, utilizing this as the only resource in addressing mental health needs impacts communities. While a religious leader may be well equipped in offering counsel and spiritual aid, specified training and professional skill development is necessary in adequately addressing the mental health diagnosis and symptomatology of a vulnerable population. A lack of
information regarding mental health assessment, mental health illness, individual safety and treatment intervention can lead to improper care and the worsening of the condition. Furthermore, a lack of information can affect perceptions, discourage help-seeking behavior and can lead to misunderstandings about how a collaborative effort can positively affect psychological well-being.

Based on the potential for exposure to a variety of mental health educational information, engaging in multiple points of access to care can be beneficial in receiving holistic treatment in comparison to limiting help-seeking to the closed network of the church. In a study focused on the needs of depressed African American teens, findings show that due to the lack of information about depression and mental illness shared from the church pulpit, African American teens and subsequently, families are less likely to understand how prayer can support the treatment process with mental health professionals (Breland-Noble et al., 2011). While the doors of the church are open for aid and support, the choice to “only see a pastor” increases the level of responsibility and accountability of the religious leader in efforts to provide mental health alleviation. Furthermore, relying solely on religious or spiritual leaders for mental health treatment could result in unmet needs if the support required exceeds the leader’s level of training, skill set and calling. However, in recognizing how the unique role of the church could serve as a pillar to professional service delivery, there is an opportunity for a multidisciplinary team to collaborate in efforts to offer personalized mental healthcare. A collaborative approach between mental health service professionals and religious leaders welcomes a person-centered approach with a capacity to intervene on several developmental domains.

In efforts to respect the individual’s choice and offer spiritual support to psychological needs, some religious and spiritual leaders have adapted models and methods to address mental
health needs as they present. Findings show that church-based health promotion programs have been successful in addressing mental health needs among African American families (Hankerson & Weissman, 2012).

In applying Arnett's theory of emerging adults, theory intersects with individual choice and a willingness to submit and admit a lack of control in a profound way (Arnett, 2006). According to Arnett (2000), there are five key features of emerging adulthood which can be identified in one’s choice to seek informal support. Through informal help-seeking by way of religious or spiritual leaders, emerging adults show a mindfulness of self and a need for self-actualization (Arnett, 2007). This behavioral choice could be associated with a key feature of emerging adulthood, self-focus, and could present in the intentional choice to seek-help. Another key feature that could also be associated with this form of informal help-seeking is that of identity exploration (Arnett, 2000; Arnett, 2007). This feature could be present through informal help seeking in the event that emerging adults have a need for purpose or meaning surrounding the challenges associated with mental health needs. Another key feature that could be surfacing through informal help-seeking is the openness to infinite possibilities. In emerging adults’ openness to infinite possibilities there too is a willingness to submit, an embracing of assistance and direction and an optimism regarding some form of intervention for their mental health needs (Arnett, 2007). In connecting these key features noted in theory, the role of religion and spirituality become vital as an informal support among the target population. In seeking informal support, emerging adults could be proclaiming independence from overbearing parental influence and traditional service delivery options while still claiming a dependent state in relation to the need for spiritual guidance and mental health support.
Emerging Adulthood: A Conceptual Framework

In this research, emerging adult is a term used to describe an age specific population that has been identified through empirical support since the 20th century. From the work of Arnett, emerging adulthood was first proposed as a conception of development spanning from the late teenage years through the one’s twenties with special attentiveness to commonalities present between the ages of 18-25 (Arnett, 2000). Arnett suggests that there are five features of emerging adulthood including identity exploration, instability, self-focus, feeling in-between (age groups) and an openness to infinite possibilities (Arnett, 2015). Arnett associates these features with a distinct period demographically, subjectively and concerning the need for identity exploration early in the life span. Prior to distinction, individuals between the ages of 18-25 were not acknowledged as a distinguished group because society had not recognized the age period with unique and separate association (Arnett, 2000). Arnett notes that many emerging adults identify themselves as being of a unique age. When emerging adults were asked if they feel like an adult or an adolescent, most reported ambiguously, rather than selecting one or the other (Arnett, 2000, p. 471). As a result, emerging adulthood is neither adolescence nor adulthood. With individuals between the age of 18-25 choosing not to self-associate with the adolescent or adult population grew a need to define and explore the lived human experiences that would form this independent group association.

The shift that created the distinct period of emerging adulthood was caused by a variety of changes in the 20th century. First, puberty started to surface at younger ages than before, extending the period of adolescence. Adolescence was also extended due to social changes like an increase in high school attendance (Arnett, 2006). This transition welcomed a norm where late
teens maintained school enrollment, rather than following a more traditional route, beginning a labor career or taking on the family business (Arnett, 2006).

Another consideration supporting the recognition of emerging adulthood takes a legal focus. The adolescence period concludes at age 18 as these individuals are then considered legal adults which invite more freedom, liberties, and a heightened responsibility. Following this legal position, scholars agree that at age 18 the adolescence period ends, and emerging adulthood begins. The work of Arnett supports the naming of this period to be as is as use of the phrase “young adults” implies that these individuals are already adults and have reached full adulthood, whereas “emerging adults” implies that they are approaching adulthood but have not achieved it (Arnett, 2000). Arnett’s work also supports the use of the term emergent as there is a trend amongst the group as evidenced by the prolonging major milestones such as later childbirth, later marriage, later education, and later career beginnings (Arnett, 2006).

The work of Arnett has been influenced by previous theorists and works. Arnett acknowledges Erik Erikson as the first to propose the idea of “prolonged adolescence” (Arnett, 2000, p.470). Erikson described the time of “prolonged adolescence” as somewhat adolescence and somewhat adulthood, but not entirely either one, a similar argument of Arnett. Other aspects of Erikson’s work is evident in the work of Arnett as Erikson too suggested that youth in industrialized countries are able to explore their identities and roles during their twenties to find their own in society (Arnett, 2000).

Another theoretical contribution was made by Daniel Levinson in 1978 who described the ages of 17 to 33 a “novice phase” (Arnett, 2000, p. 470) where the young person experiences extreme changes and instability as they explore and navigate through the possibilities in their love life, career, and educational journeys. The final contribution that Arnett mentions is that of
Kenneth Keniston, who “conceptualized youth as a period of continued role experimentation between adolescence and young adulthood” (Arnett, 2000, p. 470).

*Four Key Revolutions of Emerging Adulthood*

Arnett suggests that there are “four key revolutions” known as the catalysts that set this transition into motion. These revolutions include the Technology Revolution, the Sexual Revolution, the Women’s Movement, and the Youth Movement (Arnett, 2006).

First, the Technology Revolution is marked by advances in technology that made manufacturing and factory jobs more efficient and reduced the need for workers (Arnett, 2006). This change shifted the focus away from factory jobs and onto the service industry and other skilled labor that emphasize information and require higher education. This shift caused many young adults to continue their education past high school, which postponed life transitions for this age group. This is still prevalent today because most careers (even blue-collar jobs like electricians, construction workers, and mechanics) require a higher level of education due to the new advances in technology. Almost every career requires use of a computer and an understanding of a wide range of information. Today, it is nearly impossible to make a livable wage without at least a bachelor’s degree. Consequently, with young people so busy working toward their degree, they do not have time or funds to start a family (Arnett, 2006).

Next, the Sexual Revolution was sparked by the invention of birth control in 1964. The ability to have intercourse without the concern of pregnancy allowed young people to explore sexual relationships and casual dating with less societal push for marriage. This created a push to postpone life changes like marriage and parenthood so that young adults can discover who they are and have fun experiences before being tied down to a family. Today, many young people
have several sexual partners before marriage or even cohabitate without any plan of getting married or having children, which is a major change from the pre-1960s era (Arnett, 2006).

The Women’s Movement came in the late 1960s and expanded women’s options and made the quick transition into motherhood less desirable. Prior to this shift, a woman’s career choices were highly limited, and they were not typically encouraged to attend college, meaning that becoming a housewife and being supported by a husband was about the best chance they had at that time of living a fulfilling life. Now, women generally have more opportunities when it comes to education and career options. They typically no longer need to find a husband and have children; in fact, for many careers, postponing families can mean more time to spend on a career and more promotions. This shift has put ideas like marriage and family on the backburner and allowed young women to pursue other goals at this age (Arnett, 2006).

Lastly, the Youth Movement began in the late 1960s and brought about beliefs that youth is the best time to be alive and that aging is not something to look forward to. Prior to this movement, adulthood was an achievement that children looked forward to and were proud to come into. Now, however, young adults of later generations judge decisions such as marriage, careers, children, and paying bills as obstacles that should be avoided if possible. Young adults today want to enjoy their youth as long as possible before settling down and “growing up”. We can still see this today in movies, music, and the way some young adults dress (Arnett, 2006).

**Contributing Factors: Connecting Factors, Features & Key Revolutions**

Arnett’s work alludes to the demographic depth of emerging adulthood as it relates to other aspects of the theory. The demographics of the group are wildly varied, and it is nearly impossible to predict specifics such as marital status, parental status, educational level,
employment status, and especially, residential status based on age alone (Arnett, 2000). Aside from the variation, it is the change in demographics that provides further connection between factors and features of emerging adulthood. Changes in demographics amongst emerging adults commonly include later marriage and later pregnancies which have extended the period of emerging adulthood in industrialized societies (Arnett, 2000). Postponing marriage and childbearing can connect to motivations behind the Sexual Revolution, the Women’s Movement and the Youth Movement, three key revolutions that support the cause for the extension prior to reaching adulthood.

Arnett focuses on the aspect of role experimentation as a notable factor of emerging adulthood. He suggests that role experimentation is exercised as emerging adults explore life in the context of love, work, and worldviews. This process can be associated with a key feature of emerging adulthood, identity exploration as it allows emerging adults to address main points associated with identity formation during a critical developmental period (Arnett, 2000).

Arnett explains that frequent residential changes is another feature of emerging adulthood that further distinguishes this group. Living situations greatly range as emerging adults may live with their parents, alone in an apartment, in a dorm room or sorority house, in a shared apartment with roommates, with a romantic partner, or even in their own home. Emerging adults may change residences many times during their twenties, a unique factor that distinguishes them from adolescents or adults but also further solidifies the feature of instability amongst the group. In addition to demographics, subjective perception, and identity exploration, Arnett describes other common factors of emerging adulthood to be experimentation with risky behaviors such as unprotected sex, substance use, and risky driving behaviors (Salvatore, 2017). Aside from these
factors serving to satisfy a desire to experience thrills before committing to a monogamous relationship, they can also be associated with the feature of identity exploration (Arnett, 2000).

**Theoretical Limitations**

The term *emerging adulthood* is not universal across cultures. Recognition of this group in the literature is likely to be found in developed countries that are highly industrialized and technologically advanced. Also, much of the literature focusing on emerging adulthood lack a focus on emerging adults who are not enrolled in college and university settings (Arnett, 2000). Arnett notes that it is important to consider the lack of research studying emerging adults who are not enrolled in college due to practicality and accessibility. For this reason, it is difficult to know much about the “other half” of emerging adults because they are rarely represented in the literature (Arnett, 2000). Lastly, the work of Arnett is not exclusive to the experiences of African American emerging adults, a focus of this research.

**The Health Belief Model**

Health belief is defined as ideas related to health, the “belief that a specific health action will prevent, or cure illness and the desire to recover or avoid illness” (Becker, 1974, p.325). The Health Belief Model (HBM) was created in the 1950s by social psychologists at the U.S. Public Health Services (Becker, 1974). The model was originally developed to address preventative medical care, specifically testing for dangerous diseases like Tuberculosis, but has since been expanded to address dietary changes, safe-sex practices, self-breast exams, mental health services, and many other preventative behaviors (Anagnostopoulos et al., 2013; Asare & Sharma, 2014; Becker, 1974; Orji et al., 2012; Rosenstock, 1974). This was a gradual change that occurred through years of research. After the considerable success of the HBM in assessing prevention behaviors, researchers began to examine existent models that had been used for
illness behavior (or seeking medical attention after symptoms have begun) and found many limitations in these older models (Becker, 1974). This began the expansion into other forms of help-seeking that is still branching out today. Because of the popularity of the HBM, there have been extensive studies that use the HBM to address a wide range of issues that go beyond the original purpose of the model (Castonguay et al., 2016; Orji et al., 2012; Smith, 2009; Watson-Singleton et al., 2017). However, most of these extensions are discipline-specific and cannot be used universally (Orji et al., 2012). These expansions are possible because the six constructs of the HBM apply to all forms of medical care and safe practices (Smith, 2009).

The current version of the HBM consists of six constructs: perceived susceptibility, perceived severity, perceived benefits, perceived barriers, cues to action, and self-efficacy (Orji et al., 2012). The latter two were later additions to the model, with cues to action being added in 1966 (Becker, 1974; Orji et al., 2012) and self-efficacy in 1988 (Rosenstock et al., 1988). These constructs are important in understanding help-seeking behavior because individuals’ perceptions of these constructs create a framework for predicting their help-seeking behavior and designing personalized interventions. First, if individuals perceive higher levels of severity and susceptibility, they are more likely to feel that services are necessary. Additionally, if individuals perceive more benefits than barriers in seeking treatment, they will be more likely to seek services. Cues to action are important to include in this model because they explain the reasons people first make healthy changes in preventing illness, including what events led up to them first seeking treatment. Lastly, a healthy level of self-efficacy provides individuals with the confidence and empowerment to take control of their health by seeking help or practicing preventative behaviors. These constructs all work together to explain why someone would or would not use preventative health measures. The HBM has been found to have high validity and
reliability in predicting help-seeking behaviors in several studies (Anagnostopoulos et al., 2013; Asare & Sharma, 2014; Watson-Singleton et al., 2017). Reliability coefficients range from .61 to .88 and validity coefficients range from .21-.36 (Anagnostopoulos et al., 2013; Asare & Sharma, 2014; Watson-Singleton et al., 2017). The model is adaptable and susceptible to change, as researchers are continuing to expand and amend the original model to reduce its limitations (Orji et al., 2012).

Some strengths of the model include its low cost of implementation, its practical and comprehensive nature, and its ability to be used in primary care settings and other integrative systems (Smith, 2009). Critics of the HBM cite a need for updated systematic reviews as a limitation of the model (Glanz et al., 2008). Another limitation is that many studies that utilize the model only use some of the constructs, but the model works best when all constructs are utilized (Glanz et al., 2008). The model also does not adequately address concurrent variables like gender, age, race, affect, etc. (Smith, 2009). Some critics also claim that the model has low predictive capacity (Orji et al., 2012). It is widely agreed that better operational definitions and universal screening questions are needed for the HBM due to the variability and vagueness of its key concepts (Becker, 1974; Glanz et al., 2008; Orji et al., 2012; Smith, 2009). Lastly, the HBM is only useful if clients have access to appropriate care after overcoming their initial concerns through HBM interventions (Smith, 2009).

**Key Model Constructs:**

1. Perceived susceptibility: How likely am I to become diagnosed with a mental illness?
2. Perceived severity: How serious would a mental illness be in my life?
3. Self-efficacy: How likely am I to control and manage my diagnosis?
4. Perceived benefits: How successful would mental health services be in helping manage/treat my condition(s)?

5. Perceived barriers: What stands in my way of utilizing mental health services?

6. Cues to action: What would persuade me to seek treatment for my mental illness (e.g., advertisement, physician referral)?

7. Social support: Who would assist me in seeking treatment for/management of mental illness (e.g., friends, family, employer, counselor, teacher/professor)

**Quantitative Works Using the Health Belief Model**

Kim & Zane (2016) used specific aspects of the Health Belief Model (HBM) to study the differences regarding mental health seeking among Asian American college students and non-Hispanic white American college students. The study specifically addressed 4 constructs of the HBM: perceived severity of symptoms (operationalized as functioning), perceived susceptibility (operationalized as mental health literacy or problem recognition), perceived benefits of service (specifically, treatment credibility and self-disclosure utility), and perceived barriers (Kim & Zane, 2016). Participants included undergraduate students enrolled in psychology courses at a large, public university on the U.S. west coast. There were 1,005 participants, majority female (71%), with an average age of 19.8 years. “The Asian American participants included Chinese (40.0%), Vietnamese (14.9%), Korean (12.4%), Asian Indian (9.4%), Filipino (8.1%), and Japanese (2.3%) students” (Kim & Zane, 2016, p. 313). A total of “65.3% (39.8% white, 60.2% Asian) reported at least moderate psychological distress, and 15.9% indicated prior use of mental health services” (Kim & Zane, 2016, p. 313).

A cross-sectional online survey was developed and distributed through the university’s Psychology Department participant recruitment website. The students followed a link that took
them to an informed consent document and the survey. The survey took 30-45 minutes to complete. Measures included demographics, psychological distress, attributions of distress, perceived severity, perceived susceptibility, perceived benefits, perceived barriers, and intentions to seek help. The data was analyzed using structural equation modeling. The baseline model was created using multiple-group confirmatory factor analysis. The researchers used a chi-square test to compare results between groups. The researchers also used a multiple indicators multiple causes model to determine mediators of help-seeking intentions (Kim & Zane, 2016).

Findings show that Asian Americans indicated greater psychological distress than white Americans (Kim & Zane, 2016). Asian Americans also reported less prior use of mental health services than white Americans (Kim & Zane, 2016). Asian Americans also attributed greater financial concern and academic concern than white students. “Across both groups, lack of role limitations and better social functioning were negatively related to specific help-seeking intentions, whereas treatment credibility, self-disclosure utility, and general intentions were positively related. Self-disclosure risk and social stigma were negatively related to specific help-seeking intentions for White Americans but not for Asian Americans” (Kim & Zane, 2016, p. 315). Asian Americans had less help-seeking intentions than white students, and they perceived less benefits and greater barriers than white students. Perceived severity, benefits, and barriers were found to be significantly related to help-seeking intentions. There were no racial differences in perceived severity or susceptibility.

Limitations of this study include the use of only 4 of the 7 constructs of the HBM, the interchangeable usage of “mental health literacy” and “susceptibility”, and the absence of non-stigma related barriers. Additionally, the researchers assumed that help-seeking intention was a valid predictor for actual help-seeking, but this is not always the case. The researchers also
assumed that help-seeking is always rational and organized, which is also not always the case. The findings are also limited to college students with access to mental health services. The final limitation is that the study was limited to assessing use of formal mental health services, which may not be the only form of services being used among participants (Kim & Zane, 2016).

Another study based on the concepts of the HBM addressed cue to action, perceived barriers, perceived susceptibility and severity, and perceived effectiveness in participants with mental health needs (Richardson et al., 2013). Methods examined how state level perceptions and public spending toward mental illness in the USA influence an individual’s use of professional care. It was “hypothesized that state perceptions and public spending would affect an individual’s use of mental health services independent of his or her own characteristics and perceptions regarding mental health treatment and related stigma” (Richardson et al., 2013, p. 674). Data was collected from a nationwide system called the Behavioral Risk Factor Surveillance System. This data is collected via a state-wide telephone survey in all 50 U.S. states and territories. The states gather data from a probability sample of citizens. States are required to use a core questionnaire, but can supplement the questionnaire with approved models. Data was gathered from a pool of 216,514 participants in 35 states. A separate data source was used to measure public state mental health funding. Only 21 states had uniform inclusion criteria and were analyzed for this portion of the study. Participants in the study were mostly white (67.8%), and 33.4% had obtained a college degree or technical school certificate. The measures in this study include the current use of mental health services, perceptions of mental health treatment effectiveness, perceived stigma, mental distress, state-level perceptions, and state-level public spending on mental health (Richardson et al., 2013).
Using statistical software, the researchers also conducted a descriptive analysis. Individual-level data was analyzed using logistic regression. The total percent of subjects missing form analyses ranged from 12.7% to 13.7%. State-level data was analyzed using multilevel modeling. “Four models were fitted to estimate the contextual effects of the three state-level variables individually (unadjusted for the others) and together (mutually adjusted) on use of mental health services, adjusting for the individual-level covariates (potential confounders)” (Richard et al., 2013, p. 676). 80% of participants reported usually or always receiving emotional support. 15.3% reported having no healthcare coverage. 10.7% were currently receiving treatment, with the majority (69.3%) reporting having zero days of mental distress in the past thirty days. Among the general population, individuals who reported having more days of distress also more frequently reported receiving treatment. 64.2% of participants believed that treatment could help those with mental illness lead normal lives, and 36.4% believed that there was stigma attached to mental illness. Perceived stigma increased with the number of days of distress. State-level perceived effectiveness of mental illness treatment ranged from 60.3% to 73.7%. State-level perceived stigma ranged from 29.6% to 49%. State-level spending ranged from a low of $14.10 per capita in Arkansas to a high of $289.80 per capita in Maine. All individual-level variables were found to be related to mental health service use. Healthcare coverage, perceived stigma, perceived effectiveness, and low levels of social support all increased the likelihood of receiving services. State-level spending and state-level perceived effectiveness were also found to be related to individual service use. However, state-level stigma was unrelated (Richardson et al., 2013).

One limitation of this study was the cross-sectional design, which prevents longitudinal data and increases potential selection bias. There is a possibility of confounding variables and
unmeasured risk factors. Additionally, over 10% of participants were missing from analyses, and 6% of individuals did not say whether they were receiving treatment, so there is some missing information. There is also a potential for source bias. These results are also not generalizable to the entire U.S. Lastly, state-wide functions are not the only systems impacting mental health service use and therefore may not be the most appropriate measure (Richardson et al., 2013).

There has been literature that further evaluated constructs within the HBM. The purpose of one study was to construct and validate a new scale, the Emotional Benefits and Barriers of Psychological Services Scale (EBBPS) that measured the benefits and barriers of receiving mental health services (Watson-Singleton et al., 2017). The scale was based on the HBM, focusing on the benefits and barriers aspect of the HBM model. There were several different steps involved in this study. First, after developing a 43-item scale, the researchers met with a focus group of 7 women to test the survey and rate its effectiveness. The focus group participants ranged from 29 to 36 years old, were mostly working or middle-class, had at least some college education, and were employed. One woman was divorced; three were married, and three were single. As reported, four of them had never discussed concerns with a mental health professional, and four of them had never discussed concerns with a primary care physician. The participants were given $10 and dinner. After the focus group’s revisions, the scale contained 44 items. Next, two experts in the field (black women who had research or clinical experience working with this population) provided feedback on the updated scale. After the experts’ revisions, the scale contained 42 items (Watson-Singleton et al., 2017).

Once the final scale had been established, the researchers conducted two studies. The first study was exploratory and was analyzed using an exploratory factor analysis (EFA) to test the initial validity of the scale. The sample included 251 black women, between the ages of 18 and
The income of the participants ranged from $24,000 to over $125,000. Half of the participants reported speaking to a mental health professional at some point. Participants were recruited from the psychology subject pool, internet sites, personal networks, and community events in a rural Midwest town. Psychology students received course credit for their participation, and others were entered into a drawing to win $50. Completed surveys were used for data analysis, resulting in 251 participants (Watson-Singleton et al., 2017). Due to a large amount of missing data at random, the researchers used pairwise deletion to maximize available data. EFAs were then conducted using principal axis factoring. Upon further analysis, the researchers decided to maintain only 28 of the 42 scale items. Further EFAs were conducted on the 28 remaining items to ensure their factor structure remained the same.

The two factors that were kept were Life Enhancement (17 questions), which represented the belief that psychological services could enhance or improve life circumstances, and Concerns about Distress (11 questions), which represented the belief that psychological services caused unpleasant emotions and stress (Watson-Singleton et al., 2017). Both factors demonstrated excellent internal consistency. Relationships between demographics and EBBPS subscales were examined using descriptive statistics (specifically, Pearson’s r correlation analyses and Spearman’s rank-order correlation analyses). Number of children was positively correlated with Life Enhancement and negatively correlated with Concerns about Distress. Level of education was inversely correlated with Concerns about Distress. No other demographics were related.

Also examined was the construct validity of the EBBPS scale Watson-Singleton et al., 2017). The sample included 208 black women, ages 18-59. Most participants (157) had at least some college education. As before, the household income ranged from under $24,000 to over $125,000, and most participants were heterosexual (180), single (146), Christian (130), insured
(168), and without children (155). The majority (147) of this sample reported never seeking mental health services. Participants were recruited the same as in the first sample, but this sample included participants from an online marketplace called Mturk. Mturk users completed a 5-item screener, and only participants who identified as black women were allowed to participate. The researchers broke the survey into two shortened versions of the original online survey to ensure that the survey would not take longer than 35 minutes. All participants who were receiving college credit or compensation took the longer version of the study, and participants who were entered into a drawing received the shorter version (20 minutes). The complete survey consisted of demographic questions, the revised survey questions, and the 28-item two-factor EBBPS scale, as well as other scales measuring psychological openness, indifference to stigma, help-seeking propensity, interest in psychological help, intent to seek counseling, ethnic identity and values, level of worry, psychological distress, and measures from the Stereotypical Roles for Black Women Scale (SRBWS). Since there were different versions of the survey, no participants were asked about every single measure (Watson-Singleton et al., 2017).

The analysis findings show that the two-factor model was the most effective model in this study. “Life Enhancement demonstrated modest positive associations with psychological openness and indifference to stigma, and it was strongly associated with general positive attitudes toward psychological help-seeking” (Watson-Singleton et al., 2017, p. 691). Level of education and religiosity were positively related to Life Enhancement. One limitation of this study is that the main outcome was intentions to seek counseling, rather than actual health seeking behavior. Additionally, the participants were limited to individuals with access to the internet and the online survey. The participants also lacked diversity in that it was largely women with some college education. The different data collection methods also create a potential threat
to internal validity. Additionally, the number of women in this study who had previously sought mental health services was substantially higher than the general population, so the results may not be generalizable. Future research is also needed to examine the temporal stability of the EBBPS scale. Lastly, the fit indices for the two-factor model were modest and should require duplication (Watson-Singleton et al., 2017).

Qualitative Works Using the Health Belief Model

The purpose of one study was to analyze help-seeking narratives from people with depression through an HBM-oriented lens in order to construct more effective health communication interventions (Castonguay et al., 2016). The HBM was referenced throughout the analysis process to ensure that the study was relevant to the 7 constructs. The researchers specifically wanted to study the effects of these constructs and their correlation to help-seeking behaviors in mental health settings.

Participants were recruited from an online database. Participants were selected through purposive sampling. The participants were primarily from the United Kingdom, and all lived with depression. The participants had participated in in-depth semi-structured interviews conducted by the Health Experiences Research Group. Interviews lasting between one and six hours took place in the participants’ homes, and the participants had full control over what parts of their interviews were recorded, deleted, or shared for research purposes. All of the narratives came from participants who provided informed consent. After reviewing the original sample of 38 narratives, only 34 were analyzed for this study. 62% of narratives were from women with an average age of 43.8 years and having lived with depression for an average of 11 years (Castonguay et al., 2016).
To analyze the narratives, the researchers applied HBM ideas to the transcripts and pulled out any words or phrases that were related to the HBM through an a priori application of domain characteristics. Then they searched for recurrent patterns in each narrative. The researchers used thematic analysis to code the data. Two researchers independently coded the transcripts using HBM domains and then met to discuss their coding and compare their operational definitions. Once the a priori definitions were established, they recorded the data and then met again to ensure consistency. Team members then engaged in inductive coding. A third researcher was brought in to review the analysis and settle controversies (Castonguay et al., 2016).

To ensure that the study meets “trustworthiness criteria,” the researchers were careful to make sure the study had confirmability, dependability, credibility, and transferability. To establish credibility, the researchers provided empirical support for each of their claims. Credibility was also established through the maximum variation of the sample. To ensure confirmability and dependability, the researchers conducted an external audit on the process and outcome of data analysis. Transferability was ensured by linking findings to research and providing detailed reporting on the processes of this study (Castonguay et al., 2016).

HBM components that were commonly mentioned in the interviews were susceptibility (44%), severity (85%), barriers (91%), self-efficacy (79%) and benefits (88%). Many respondents reported that family history or human nature made them susceptible to depression. Severity was overall described as mental anguish, physiological reactions, and suicidality. Participants reported internal (self-realized) cues to action as well as external (family/friends/etc) cues to action as being critical moments in their decision to seek mental health services. “Stigma was referenced not only with regard to having the illness but also in seeking treatment. Other commonly cited barriers were fear of the treatment experience and difficulty accessing the
medical system. Indeed, uncertainty regarding how to obtain treatment, how one would respond to treatment, and how others would perceive an individual receiving treatment functioned as a broad barrier” (Castonguay et al., 2016, p. 296). There were also barriers to medications that were reported due to preconceptions. The narratives found that benefits often outweigh the barriers. Most participants supported the idea of weighing the benefits and barriers and seeking treatment when the benefits outweigh the barriers. Hope emerged as a strong theme in this section. Participants also recognized the need for self-efficacy when seeking treatment “as indicated by participants’ perceived ability to seek help, perceived ability to control depressive symptoms, or their encouragement toward others to become more efficacious” (Castonguay et al., 2016, p. 297). High levels of efficacy deterred individuals from seeking help, but this was rare. For most, self-efficacy encouraged them to help others develop self-efficacy and seek help as well (Castonguay et al., 2016).

One limitation of this study is that it only included individuals who had successfully sought treatment. Additionally, the participants were largely from the UK, which likely produced different results than studies in other countries. Additionally, only about 8% of the narratives represented ethnic minorities, reducing generalizability. There was also no distinction between different forms of treatment (psychotherapy and medication) in this study. Additionally, the information was gathered from secondary data, and participants could not be contacted for further information or clarification (Castonguay et al., 2016).

Another article utilized the HBM to examine barriers to help-seeking among college students who are at risk for suicide (Czyz et al., 2013). The researchers specifically addressed students’ perceptions based on the 7 constructs of the HBM model and associated these factors with students’ likelihood to receive services. Perceived severity, self-efficacy, and barriers seem
to be the most central constructs in this study based on participant responses. Participants were selected from a larger study. Students were invited to participate in the current study if they “screened positive for elevated suicide risk due to at least 2 of the following risk factors: (a) current suicidal ideation, (b) history of suicide attempt, (c) current depression, and (d) current alcohol abuse” (Czyz et al., 2013, p. 400). They were excluded if they were under 18, studying abroad, or currently receiving treatment. “19,608 students were invited to participate, 4,616 (24%) completed the eligibility screen, 284 (6%) met study eligibility criteria, 226 (80%) completed the 2-month follow-up, and, of those, 182 (81%) did not seek help during the follow-up” (Czyz et al., 2013, p. 400). After excluding responses that were too vague to code, there was a total of 157 (95% of eligible participants) participants in the study. Participants included “106 (67.5%) females and 51 (32.5%) males. Seventy-five (47.8%) freshmen, 46 (29.3%) sophomores, and 36 (22.9%) first-year graduate students participated. The mean age was 20 years (SD 3.07). The racial/ethnic sample composition was Caucasian (68.2%), Asian (15.9%), Multiracial (7.6%), black (3.2%), Hispanic (2.5%), and “other” or not identified (2.6%)” (Czyz et al., 2013, p. 400). 25% of participants were scored as moderately depressed while 11% scored as severely depressed. Additionally, 45% were high risk drinkers, and 48% reported a lifetime history of suicide attempt. A total of 70% reported suicidal ideation for at least several days of the last two weeks (Czyz et al., 2013).

The measures in this study included suicidal ideation, alcohol abuse, depression, suicide attempt history, and barriers to mental health seeking. Participants were invited via email to participate in the study. The emails contained a secure link to the consent form and online survey. After completing an eligibility screen, participants completed a baseline questionnaire. A two-month follow-up was conducted using the same method. Students participating in the
baseline study were entered into a drawing to win up to $1,000, and students who participated in the follow-ups received $10 gift cards and $25 gift cards upon completion (Czyz et al., 2013).

Results were coded by two independent coders who organized the results into themes. Discrepancies in the coding was handled by a third coder. Interrater reliability was high. The researchers then used chi-square analyses and t-tests to further analyze results and look for differences among demographic subgroups. The results were organized into 11 commonly mentioned barriers: “(1) stigma; (2) preference for self-management; (3) no need for treatment due to problems being absent or too minor; (4) no need for treatment due to problems having improved between baseline and follow-up; (5) preference for involving family or friends; (6) lack of time; (7) doubt that professional help seeking would be beneficial; (8) negative past experiences with professional services; (9) pragmatic reasons that get in the way of accessing services, including long wait list, financial issues, and lack of transportation; (10) lack of knowledge about where to go for help; and (11) shyness or discomfort about discussing problems with a mental health professional” (Czyz et al., 2013, p. 401), many of which line up closely to at least one of the constructs of HBM. The most frequently reported reason (66%) for not seeking treatment was that students felt their symptoms were so minor, they did not need it. The second most common barrier was lack of time (26.8%), followed by a preference for managing their problems on their own (18%). Only 12% of students reported stigma or discomfort discussing their mental health concerns as a barrier. Chi-square and t-test analyses found that females (33%) were more likely than males (13.7%) to report lack of time as a barrier. Additionally, Black, multiracial, and other students (52.2%) were more likely to report lack of time as a barrier than White (21.5%) or Asian (20%) students. Mental health and alcohol abuse symptoms at baseline also had an impact on help-seeking behaviors. The analyses found that the heavier someone was
drinking at baseline, the more likely they were to report not needing services due to their problem being so minor or non-existent. Additionally, the less severe the depressive symptoms were at baseline, the more likely participants were to mention that their problems were also minor or non-existent (Czyz et al., 2013).

One limitation of this study is that participants were limited to only students who responded to the email survey, which likely left out other eligible students. Other factors such as the higher number of females in this study or the fact that all students were mostly White and came from a Midwestern University also limit generalizability. Additionally, it is possible that students may have underreported barriers in this study (Czyz et al., 2013).

Another study examined the perceptions of individuals with substance abuse disorder regarding their motivations for treatment (Dillon et al., 2020). The study was designed to address a need for theoretically informed addiction research. This study was guided by 6 of the HBM constructs (susceptibility, severity, benefits, barriers, cues to action, and self-efficacy). The results of this study directly correspond with each of these constructs. The study included in-depth interviews with clients in a year-long residential rehabilitation in Tennessee. The agency has about 500 clients each year, who stay for a year and are required to do chores and work at a community agency during their stay. The participants were recruited through announcements in group meetings. The researchers contacted interested clients to explain the study further and receive informed consent. There were 30 participants total. “18 participants (60%) were male and 12 (40%) were female. The majority of participants (n = 21, 70%) were African American and the other nine participants (30%) were White. Approximately half of the participants (n = 14, 46.7%) were aged 40 to 49 years, seven (23.3%) were aged 50 to 59 years, four (13.3%) were aged 20 to 29 years, another four (13.3%) were aged 30 to 39 years, and one participant (3.3%)
was aged 60 to 69 years. The majority of the participants \( n = 21, 70\% \) reported receiving treatment for cocaine/crack addiction. The other nine participants \( 30\% \) reported receiving treatment for drug, alcohol, methamphetamine, prescription pill, or cough syrup addiction. All participants had completed the active phase of the treatment and were continuing in the program for their long-term recovery (Dillon et al., 2020). The interviews discussed treatment engagement, recovery, and maintaining post-treatment abstinence. The interviews were conducted in a private space in the treatment facility. They were all audio-recorded, transcribed, and uploaded to a web-based analysis application. Two research assistants independently coded the transcripts, looked for patterns, and affirmed that the themes were related to the HBM constructs. The authors developed operational definitions of the constructs and used them when analyzing the transcripts (Dillon et al., 2020).

“Perceived susceptibility was tied to two specific issues including believing that their SUD behaviors were beyond their control and, thus, required formal intervention, and believing that without maximizing their treatment experience, they would be prone to relapse” (Dillon et al., 2020, p. 4). For the construct of severity, respondents reported that the largest motivation to continue in the program is the negative consequences of relapse due to the severity of their addiction. They specifically noted their own health, relationships with family and friends, and being placed in dangerous situations due to the severity of their addiction. “Participants identified three primary benefits that motivated them including opportunities for a better life, reconnecting with family members and close friends, and avoiding legal consequences” (Dillon et al., 2020, p. 5). The only commonly stated barrier mentioned in the study is the length of time required for treatment. Cues to action included decisive moments (turning points and key events), elements of the treatment program (encouragement from staff, job skills, work
requirements, etc.), and faith and spirituality. Self-efficacy was reported several times as a major factor in the program because the program gave them the skills and the motivation to stay sober after completing treatment. They also linked their self-efficacy in remaining sober to their opportunities to observe other clients successfully complete treatment and being able to stay connected to them after leaving (Dillon et al., 2020).

One limitation of this study is the use of a convenience sample from a single facility in Tennessee. Additionally, clients were only eligible if they had completed the first part of treatment and were sober, which means some perspectives may not have been captured in this study. The study also did not include perspectives of staff members and counselors. The study also did not utilize triangulation. Additionally, the study assumes that treatment engagement is directly responsible for client outcomes, which is not necessarily true (Dillon et al., 2020).

In another study, researchers aimed to examine the perspectives of youths aging out of foster care regarding the different systematic factors influencing their use of mental health services (Sakai et al., 2014). The study was based on constructs of HBM: “the threat of mental health problems” (susceptibility and severity), benefits vs. barriers, self-efficacy, and cues to action. The study consisted of 7 focus groups, with 3-5 youths in each group. The focus groups were semi-structured and contained 11 guiding questions to address youth’s perceptions regarding the previously mentioned HBM constructs and their mental health needs (including psychotropic medication and therapy). The focus groups lasted about 60 minutes and were conducted by a trained moderator at the center. The focus groups were audio recorded and transcribed. The youths also completed a 14-item questionnaire for socio demographic purposes. Participants were recruited through purposive sampling from a community center in North Texas that assists youth in transitioning out of foster care. On-site case managers identified eligible
youths and provided a standardized script to the researchers. Eligibility requirements included “a history of mental health service use while in foster care and use of at least 1 mental health service after aging out of foster care” (Sakai et al., 2014, p. 566). Youths were provided transportation and a $25 gift card for participation.

There were 28 participants ranging in age from 18-27 years. “More than half were male, approximately half were African American, and youth had spent, on average, 8 years (range, 3-17) in foster care. Most youth were high school graduates or had obtained a general equivalency diploma. Approximately two-thirds were unemployed at the time of interviews, and approximately 1 of 5 had moved more than 10 times since leaving foster care. Two-thirds of youth were insured, predominantly by Medicaid, and more than one-third were currently receiving Social Security payments for disability. Private office and community-based centers were the most common locations for mental health services after leaving foster care” (Sakai et al., 2014, p. 567). Analysis of the study was conducted using a grounded-theory approach called “coding consensus co-occurrence and comparison”. Transcripts were independently reviewed by 3 authors and coded to characterize key phrases and themes. The authors then met to develop a codebook and coded all remaining transcripts according to the codebook. Coding issues were resolved through consensus. Data was stored onto a web-based software program that allows for more detailed analysis. Several categories emerged from this process. The major themes that emerged in the analysis include “contextual experiences in foster care, need for mental health services, benefits to treatment, transition skills and supports, and barriers to access” (Sakai et al., 2014, p. 567). Contextual experiences in foster care were related to two domains including “limited engagement in mental health decisions, and insufficient preparation for independence” (Sakai et al., 2014, p. 567). Youth described being pushed to receive mental health services in
the foster care system even if they did not believe they needed it, which made them less open to receiving services after aging out of the system (related to the constructs of severity and self-efficacy). Youth also described feeling insufficiently prepared and lacking self-efficacy because CPS took care of everything for them while they were in foster care and then expected them to be able to take care of themselves when they turned 18. “The need for mental health services was characterized by the youth’s considering the symptoms to be indicative of a serious and ongoing mental health problem or the result of past experiences, and the youth’s difficulty coping, necessitating mental health services versus their ability to rely on themselves to address the problem” (Sakai et al., 2014, p. 568).

The reported benefits of treatment were related to medication and therapy. Many youths stated that medication was helpful, while others reported feeling that medication was unnecessary. Other youths reported that therapy was more helpful than medication. “Youth reported limited self-efficacy in accessing needed mental health services at the time of aging out of foster care. Self-efficacy was challenged by limited knowledge about mental health diagnoses and potential treatment options, and a lack of skills to navigate the mental health system at the time of aging out of foster care” (Sakai et al., 2014, p. 570). Barriers included health insurance barriers, logistical barriers, and barriers to establishing a relationship with mental health providers. “Themes regarding insurance included eligibility related discontinuation of Medicaid coverage, and barriers to access despite eligibility for insurance coverage” (Sakai et al., 2014, p. 570). Logistical barriers included a long wait time between appointments (regardless of urgency), prolonged clinic wait times, and transportation issues. Barriers to establishing a relationship with mental health providers were often related to moving around a lot or changes in insurance coverage. One limitation of this study is that all youths were from a single center in

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North Texas, so the results are not generalizable to the public. Participants also were all volunteers who had engaged in mental health services and had access to community center resources, which could have impacted the results. Additionally, the study questions were derived from the HBM, which is limited in its ability to predict certain aspects of access and utilization of services (Sakai et al., 2014).

The Benefits of Using a Mixed-Method Approach to Examine Utilization of Mental Health Services among African American Emerging Adults

There are three reasons why a mixed-method approach is the best methodology to examine mental health utilization among African American emerging adults. First, quantitative measures provide greater context as it relates to an observation of a phenomenon (Doyle et al., 2009) which is the underutilization of formal mental health services. Quantitative measures used in the current study provide explanation of rates of utilization as it relates to individual willingness and intention of seeking formal help for mental health needs. In this approach, the quantitative data confirms that underutilization of formal mental health services continues amongst African American Emerging adults and further supports the phenomenon in occurrence.

In conclusion, the phenomenon of underutilization of formal mental health services has previously been documented in the literature but the rationale for the approach in this current study serves to confirm a continual trend of underutilization among emerging adults, support how the trend continues through the identification of barriers, identity causes of mental distress, sources of support, the role of mental health stigma and religious and spiritual support, all of which enriches African American literature and minority studies.

Secondly, qualitative methods provide greater context that address how or why a phenomenon is in observation (Doyle et al., 2009). In this study, qualitative methods will explore motivations that discourage and encourage formal participation in utilizing mental health
services among African American emerging adults. Furthermore, qualitative methods in this study will provide an explanation of what alternative sources of support are being utilized to meet mental health needs. Finally, the combined use of standardized measures and narratives can provide a more comprehensive understanding regarding the relationship between how African American emerging adults feel about mental health services and their use of formal services and sources of support. Rationale for this approach is further supported by the literature that states “studying utilization data itself is not enough to change the trajectory of the issue of underutilization because quantitative data alone does not accurately address the why the observation is happening” (Becker, 1974, p. 4). Approaching the study from a mixed perspective provides context to further understand service barriers, explains motivations connected to professional help-seeking and narrates a part of the Black help-seeking experience that is under-reported.
CHAPTER III. METHODOLOGY

Six Primary Objectives

This research has six primary objectives:

1. Through quantitative methods, this study will determine if minority status, age, gender and school affiliation are predictive of individual willingness to seek help for mental health needs among African American emerging adults between the ages of 18 and 29.

2. Through quantitative methods, this study will determine if minority status, age, gender and school affiliation are predictive of help-seeking behavior for mental health needs among African American emerging adults between the ages of 18 and 29.

3. Through qualitative methods, this study will identify factors that cause African American emerging adults between the ages of 18 and 29 years to experience mental distress.

4. Through qualitative methods, this study will examine the factors that encourage African American emerging adults, between the ages of 18 and 29 years to use professional mental health service.

5. Through qualitative methods, this study will examine the factors that discourage African American emerging adults, between the ages of 18 and 29 years to use professional mental health services.

6. Through qualitative methods, this study will examine the sources of support African American emerging adults between the ages of 18 and 29 use when they experience mental distress.
Research Questions

To accomplish the overall research objectives, this study will address the following six fundamental questions.

Research Question 1. Are minority status, age, gender and school minority status predictive factors for willingness to seek help for mental health needs among African American emerging adults between the ages of 18 and 29.

Research Question 2. Are minority status, age, gender and school minority status predictive factors of help-seeking behavior for mental health needs among African American emerging adults between the ages of 18 and 29.

Research Question 3. What causes African American emerging adults to experience mental distress?

Research Question 4. What factors encourage African American emerging adults to seek mental health services?

Research Question 5. What factors discourage African American emerging adults from seeking mental health services?

Research Question 6. What sources of support do African American emerging adults rely on following an experience of mental distress?

Hypotheses

As related to the above research questions, the researcher offers the following hypotheses:

H(1): Minority status is not a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

H(a) 1: Minority status is a predictive factor for willingness to seek help for mental health needs among African American emerging adults.
H(2): Age is not a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

H(a) 2: Age is a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

H(3): Gender is not a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

H(a) 3: Gender is a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

H(4): School minority status is not a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

H(a) 4: School minority status is a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

H(5): Minority status is not a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

H(a) 5: Minority status is a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

H(6): Age is not a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

H(a) 6: Age is a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.
H(7): Gender is not a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

H(a) 7: Gender is a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

H (8): School minority status is not a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

H(a) 8: School minority status is a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

Conceptual H(1): African American emerging adults will be less willing to seek help for mental health needs than non-minority emerging adults based on the factors of race, age, school, and gender.

Operational H(1): Willingness-To-Seek-Help global scores will be lower for minority, African American emerging adults than for non-minority emerging adults indicating less willingness to seek help for mental health needs.

Conceptual H(2): African American emerging adults will show less intention to seek help for mental health needs than non-minority emerging adults.

Operational H(2): General Help-Seeking global scores will be lower for African American emerging adults than for non-minority emerging adults indicating less intention to seek help for mental health needs.
Mixed Method Design

Mixed methods research is defined as research in which the investigator collects and analyzes data, integrates the findings, and draws inferences using both qualitative and quantitative approaches or methods in a single study (Tashakkori & Creswell, 2007). One advantage of conducting mixed methods research is that it provides a more comprehensive picture of the research problem than either quantitative or qualitative methods can produce alone (Doyle et al., 2009). Conducting mixed methods research can serve several purposes including that of triangulation, complementarity, development, initiation, or expansion (Onwuegbuzie & Collins, 2007). One disadvantage of conducting a mixed method design is that the research has to apply to two or more designs concurrently or sequentially. Therefore, it can be time consuming to collect, analyze, and interpret data with validity (Doyle et al., 2009).

This proposed study utilized a concurrent design with nested samples for both the quantitative and qualitative components of the study. A concurrent design speaks directly to time orientation in mixed method research and in using a concurrent sampling design, “data stemming from the sample selected for one phase do not inform the data stemming from the sample selected for the other phase and both samples are integrated and interpreted at a later stage” (Collins et al., 2007, p. 276). With a concurrent design, data collection for the quantitative and qualitative components “occur within the same time frame being that one does not inform the other” (Collins et al., 2007, p. 276). Using a concurrent sampling design allowed the researcher more flexibility in collecting the samples while offering convenient engagement options for participants as completion of survey and Zoom interviews could be completed at the time participant choosing.
The relationship of the qualitative and quantitative sample is nested. A nested relationship implies that the “sample members selected for one component of the investigation represent a subset of those participants chosen for the other phase of the study” (Collins et al., 2007, p. 277). In this study, qualitative data was generated from participants that expressed interest in further participation after engagement with quantitative data collection. The relationship between the quantitative and qualitative sample is also described as nested as the qualitative sample members consisted of a subset, African American emerging adults who showed evidence of prior mental health service utilization. A nested relationship between the samples highlights an advantage. Being that participants from the quantitative phase also participated in the qualitative phase of the study, there was less of a need to recruit participants for the qualitative phase.

**Quantitative Sampling Scheme**

The quantitative component utilized a cluster sampling scheme. A cluster sampling scheme “selects intact groups representing clusters of individuals rather than choosing individuals one at a time and involves multiple stages prior to data collection” (Collins et al., 2007, p.272). In this study, clusters of participants are identified as emerging adults intact by enrollment at Louisiana State University (LSU), The University of Southern Mississippi (USM), Texas State University (TSU), and Southern University (SU).

**Qualitative Sampling Scheme**

The qualitative component utilized a criterion sampling scheme involving participants because “they represent one or more criteria” (Onwuegbuzie & Collins, 2007, p. 286). A strength of this sampling scheme is that it involved a specific inclusion criteria. Inclusion criteria was
based on belongingness to the target population of African American emerging adults and verbal disclosure of their participation in formal mental health service or treatment within the past twelve months. Such inclusion provided valuable feedback as participants not only represented a subset of the sample from the quantitative component of the study, but they were also representative of African American emerging adults who showed evidence of prior mental health service utilization. As mentioned, mental health service utilization is defined as formal help seeking behavior displayed in the past twelve months (SAMHSA, 2015). African American emerging adults who have not shown evidence of formal help-seeking behavior in the past twelve months were excluded from the qualitative phase of research. With the criterion-sampling scheme being non-random, a limitation is that application extends itself to participant selection bias in order to enhance the desired results of the study findings (Collins et al., 2007).

Participants

For both components of the study, participants consisted of college attending emerging adults ranging between the ages of 18 and 29 as defined by the work of Arnett. Recruitment targeted emerging adult college students and therefore nontraditional undergraduate students were excluded from participation. Study participants were recruited through LSU, USM, TSU, and SU faculty members. Participants were administered an electronic version of the two quantitative instruments. Monetary incentives of a $30.00 e-Visa card were offered to participants of the qualitative phase. With use of a correlational design with 1-tailed hypotheses for the quantitative portion of the study, a “minimum sample size of 64 participants is required to make statistical generalizations” (Onwuegbuzie & Collins, 2007, p. 288). Following recommendation, quantitative data was collected on 120 emerging adults (n=120).
For the qualitative component of the study, African American emerging adults between the ages of 18 and 29 completed interviews in a phenomenological design. This design choice requires a small sample size in comparison to an ethological design or a grounded theory approach (Creswell, 1998). Because the relationship of the samples is nested, participants in the qualitative phase were of subset representation of quantitative phase. Participants from the quantitative component who were interested in further participation were recruited for participation in the qualitative component if they met the criteria detailed above. With use of a phenomenological design, a minimum sample of 6 interviews is required to make statistical generalizations (Morse, 1994). Following recommendation, qualitative data was collected on 6 emerging adults (n=6).

Procedure

Following IRB approval, quantitative data was collected electronically via Qualtrics. With the course instructors’ consent, a Qualtrics survey link was provided to students in various academic departments via email. Departments included Social Work, Child and Family Studies, Chemistry, Education, Psychology and Coastal Reliance. Before starting the questionnaire, students were introduced to the purpose of the research study followed by a request for informed consent. Study participants were asked to complete a short online demographics form followed by the questionnaire consisting of 27 items.

For the qualitative component, the researcher screened each participant before the interview to ensure that all inclusion criteria was met. An email invitation, accompanied by an informed consent form, which explained the participant’s right to refuse to participate or withdraw at any time during the study, was sent to the participants. Following participate interest, the researcher conducted a fifteen-minute initial interview via telephone to ensure that
the participant understood the research and participation responsibilities. In this, the researchers provided an overview of the study, verified participant qualifications, clarified the interview process, verified that the candidate would have no difficulty articulating their experiences as it related to mental health service utilization and help-seeking, and arranged an interview time and date. Interviews were held via Zoom ensuring environments that were safe and conducive to conducting an interview. Interviews were conducted by a researcher and a graduate assistant serving as an interviewer. Before beginning interviews, participants were provided a summary of the research purpose and asked to reply with verbal consent again before starting. With consent, recording of the interviews began. Researchers informed the participant that there was a set of questions to refer to as a guide, but that conversational participation was welcomed. On average, interviews lasted about thirty minutes with each participant. After all interview questions from the instrument were addressed, all participants were given the opportunity to provide additional related information in the event that they had not expressed a prioritized point. Notes were taken during each interview and the conversation was thoroughly documented and transcribed. With participant permission, interviews were recovered and saved so that transcriptions could be verified for accuracy.

**Measures**

In the quantitative phase, participants engaged with two standardized instruments. For one, the Willingness-To-Seek-Help Questionnaire (See Appendix A) consists of 25 items that evaluates one’s openness to seeking out professional psychological help (Cohen, 1999). Items from this likert response instrument require survey participants to indicate the extent to which they identify with a statement provided. Examples from the Willingness-To-Seek-Help Questionnaire include a) If I am ever depressed, I will seek out the appropriate person to tell
about it. b) If, in the course of medical treatment for a physical ailment, I were to experience serious anxiety, I would ask the doctor to treat the anxiety. c) Becoming addicted to drugs is the kind of situation that would cause me to place my fate in the hands of an expert.

A reliability analysis procedure using SPSS yielded a Cronbach’s alpha value of .85 (Cohen, 1999). In reporting discriminant validity, a correlation of .02 indicates that the scale can discriminate between attributes such as social desirability and the actual measure at hand, willingness to seek help (Cohen, 1999). In reporting convergent validity, willingness to seek help was found to correlate to gender as expected (Cohen, 1999). Correlations between other expected variables were not found justifying the need for continued research (Cohen, 1999). With use of the Willingness-To-Seek-Help Questionnaire, a higher global score (38-75) indicates more willingness to seek help and a lower global score (0-37) indicates less willingness to seek help for mental health needs (Cohen, 1999).

Secondly, the General Help-Seeking Questionnaire (See Appendix B) consists of 2 items and was developed to assess intentions to seek help from different sources and for different problems (Rickwood et al., 2005). Items from this likert response instrument require the survey participant to response with their level of likeliness to engage with various people (i.e. formal and informal persons) concerning a personal or emotional problem, or suicidal thoughts. Examples from General Help-Seeking questionnaire include a) If you were having a personal or emotional problem, how likely is it that you would seek help from the following people? b) If you were experiencing suicidal thoughts, how likely is it that you would seek help from the following people?

A reliability analysis procedure using SPSS yielded a Cronbach’s alpha value of .85 (Rickwood et al., 2005). In reporting validity, a positive and significant correlation between
intentions to seek mental health care for personal-emotional problems and actually seeking counseling is evident (Rickwood et al., 2005). With use of the General Help-Seeking Questionnaire, a higher global score (70-140) indicates greater intention to seek help and a lower global score (20-70) indicates a less intention to seek help for mental health needs (Rickwood et al., 2005). This instrument has yielded findings that are supportive of the body of research but still requires additional testing in other specified research areas, an aim of this research. To address the consistency standard of validation, both quantitative instruments and scoring information is provided in the appendix. Providing such enhances the ability to replicate this study which adds to the measure of reliability.

Prior to qualitative data collection, interview protocol was established as it related to instrumentation. Interview protocol consisted of 3 phases. Utilizing the interview protocol refinement (IPR) framework, phase one of protocol focused on ensuring alignment between interview questions and research questions (Castillo-Montoya, 2016). For example, questions regarding the root of help-seeking were formulated while evident repetition of wording or constructs in questions were excluded. Phase 2 ensured question development was conversational (Castillo-Montoya, 2016). For example, instead of using research-oriented language, questions were formed in terms that were more likely to be used in casual conversation. Phase 3 consisted of obtaining feedback (Castillo-Montoya, 2016). An example of such included requesting review and feedback of individual questions and using that information to edit the interview questionnaire and create interviewer instructions. See Appendix C to view the full qualitative instrument. In this study, Race (nominal) is defined as identifying as minority or non-minority. Age (continuous) is defined as individuals between the ages of 18-29 years of age. School Affiliation (nominal) is defined by the university of enrollment at the time of survey
complete and options for affiliation include LSU, USM, TSU and SU. School Minority Status is defined by the rate of minorities currently enrolled at a university. For universities with minority student enrollment below 60% (LSU and USM), low minority status was referenced. For universities with a non-minority student enrollment above 60% (SU and TSU), high minority status was referenced. Gender (nominal) is defined as individuals self-identifying as male or female in terms of their gender identity.

**Analysis**

For the quantitative analysis, variables analyzed included the Willingness-To-Seek-Help global scores, General Help-Seeking global scores, Gender Identity, School Minority Status, Age as it relates to emerging adult status and self-reported minority status labeled as Race. Levels of measurement and dummy coding for each independent variable are as follows: Race (nominal) (dummy coding: 0=Non-minority, 1-Minority), Age (continuous), School Affiliation (nominal) (dummy coding: 0=SU, 1=LSU, 2=TSU, 3=USM) Gender (nominal) (dummy coding: 0=Female, 1=Male) School Minority Status (nominal) (dummy coding: 0= High Minority Status, 1=Low Minority Status)

For quantitative analysis, a linear regression model was applied. A linear regression model can be a helpful technique used to predict or explain an observed phenomenon (Sperandei, 2013), which in this study is the underutilization of mental health services among African American emerging adults. In running this technique with SPSS software, the researcher screened the data, checked the assumptions, fit the model, estimated the parameter, and interpreted the result relative to the initial research questions (Tabachnick & Fidell, 2007). There were three tables of interest reported on including the Model Summary, the ANOVA Table, and the Coefficients Table. From these tables, R and R Square (Model Summary), the F-ratio
(ANOVA table), unstandardized coefficients, t-value and the p-value (coefficients table) were reported.

From the Model Summary table, R was reported as it measures the quality of the prediction of the dependent variable. The R value ranges from 0-1 with a stronger relationship indicated the closer the result is to 1 (Tabachnick & Fidell, 2007). Results from the R Square column were reported as it indicates the proportion (percentage) of variance in the dependent variable that can be explained by independent variables (Tabachnick & Fidell, 2007). From the ANOVA Table, the F-ratio was reported as it tests if the overall regression model was a good fit for the data (Tabachnick & Fidell, 2007). From the Coefficients Table, the unstandardized coefficients indicated the amount of change in the dependent variable associated with an independent variable when all other independent variables were held constant (Tabachnick & Fidell, 2007). The Coefficients Table was also of focus as it showed statistical significance of each of the independent variables (Tabachnick & Fidell, 2007).

Before analysis, there were 8 assumptions to be checked to ensure that the data met criteria for a proper multiple linear regression analysis. Assumptions included ensuring that the dependent variables were measured on a continuous scale, ensuring that the independent variables were measured on a continuous scale, verifying independence of observations, ensuring a linear relationship between both the dependent variables and independent variables and the dependent variable and the independent variables collectively (Tabachnick & Fidell, 2007). Dummy coding was used on several independent variables including race, gender identity, school minority status and school affiliation. More assumptions included checking for homoscedasticity, multicollinearity, outliers and normal distribution among residuals.
(Tabachnick & Fidell, 2007). All assumptions have been met and supporting tables and graphs are provided.

For the qualitative analysis, phrases used by interviewees were the primary data of focus (unit of analysis). As part of the qualitative interview process, participants self-reported demographic variables and whether they displayed help-seeking behavior in the last 12 months. Following data collection, two coders ensured reliability and trustworthiness. According to Lietz & Zayas (2010), there are four areas that should be considered to ensure a level of trustworthiness within the qualitative component of a study. Areas for consideration are credibility, transferability, auditability, and confirmability (Lietz & Zayas, 2010). To increase credibility in this research, researchers used triangulation, member checking and included thick description. To increase transferability in this work, the researcher used thick descriptions to create an opportunity for findings to be applicable to other settings (Lietz & Zayas, 2010). While generalizability is not the goal, the researcher does intend for qualitative findings to be applicable to “various practices, settings, theories or future research (Lietz & Zayas, 2010, pg., 195). To address audibility and consistency in this research, the researcher incorporated the use of process notes increasing dependability and allowing another researcher to follow or critique the work (Lietz & Zayas, 2010; Lincoln & Guba, 1985). To address confirmability and truth value, the researcher used triangulation, member checking, and “clearly linked data findings” through use of tables (Lietz & Zayas, 2010, pg., 197; Lincoln & Guba, 1985). Attention in these areas shows due diligence in the researcher’s efforts to accurately report participants’ perceptions and perspectives (Lietz & Zayas, 2010) as it relates to underutilization of formal mental health services.
Next, the two research questions will be addressed as follows:

Research Question 1. Are minority status, age, gender and school affiliation predictive factors for willingness to seek help for mental health needs among African American emerging adults between the ages of 18 and 29.

Research Question 2. Are minority status, age, gender, and school affiliation predictive factors for help-seeking behavior for mental health needs among African American emerging adults between the ages of 18 and 29.

Quantitative Analysis

Using a linear regression model, Research Question 1 and Research Question 2 assessed emerging adult’s willingness and help-seeking intention of formal mental health services along the dimensions of minority status, age, gender and school affiliation using SPSS software.

Next, the four research questions will be addressed as follows:

Research Question 3. What causes African American emerging adults to experience mental distress?

Research Question 4. What factors encourage African American emerging adults to seek mental health services?

Research Question 5. What factors discourage African American emerging adults from seeking mental health services?

Research Question 6. What sources of support do African American emerging adults rely on following an experience of mental distress?

Qualitative Analysis

Following the Interview Protocol, a thematic analysis revealed (1) the factors that cause distress among African American emerging adults; (2) the factors that encourage African
American emerging adults to use mental health services; (3) the factors that discourage African American emerging adults from using mental health services; (4) the sources of support on which African American emerging adults rely during times of distress.

**Development of Coding Systems: Coding Interview Data**

To identify themes from the collective interviews, all interview content was analyzed using a coding system that aligns with the concepts of the Health Belief model. Words, phrases and frequency of words and phrases served as the units of analysis and key points in coding development. Specifically, interviews were transcribed verbatim and coded according to the number of times a particular word or phrase was used and as it relates to constructs of the Health Belief Model. Inter-rater reliability was considered and as a result, two researchers independently code all interviews. Resulting themes were determined to include perceived susceptibility, perceived severity, self-efficacy, perceived benefits, perceived barriers, cues to action, social support, spiritual reliance and causes of distress.
CHAPTER IV. RESULTS

A total of 120 emerging adults submitted responses to two quantitative instruments including the Willingness-To-Seek-Help Questionnaire and the General Help-Seeking Questionnaire. The qualitative component of the study included a total of six female African American emerging adults between the ages of 18 and 29. Participants were enrolled at four total universities including USM, TSU, SU and LSU. From these universities, participants were recruited from The Office of Student Affairs and select educational departments. Departments of recruitment include Social Work, Child and Family Studies, Chemistry, Education, Psychology and Coastal Reliance. A linear regression model was applied in this study and the quantitative findings are provided in tables. In addition, each qualitative theme is reported separately in a table and illustrative quotes from participants are provided.

Assumptions Testing

Assumption #1: Dependent variables are measured on a continuous scale.
Willingness-To-Seek-Help Scores and General Help-Seeking Score (interval and continuous)

Assumption #2: Independent variables are measured on a continuous scale.
Race (nominal) (dummy coding: 0=Non-minority, 1-Minority), Age (continuous), School Affiliation (nominal)(dummy coding: 0=SU, 1=LSU, 2=TSU, 3=USM) Gender (nominal) (dummy coding: 0=Female, 1=Male) School Minority Status (nominal) (dummy coding: 0=High Minority Status, 1=Low Minority Status)

Assumption #3: There is no multicollinearity in the data.
Analysis of collinearity statistics show this assumption has been met, as VIF scores were well below 10, and tolerance scores above 0.2.

Assumption #4: The relationship between the continuous variable and the DVs is linear.
Scatter plots show that this assumption had been met.

**Assumption #5: The values of the residuals are independent.**

The Durbin-Watson statistic, a measure of serial correlation, showed that this assumption had been met, as the obtained value was close to 2 (Durbin-Watson =1.520; 1.441).

**Assumption #6: Homoscedasticity**

The plot of standardized residuals vs standardized predicted values showed no obvious signs of funneling, suggesting the assumption of homoscedasticity has been met.

**Assumption #7: Normality**

The P-P plot for the model suggested that the assumption of normality of the residuals may have been violated to some extent. However, as only extreme deviations from normality are likely to have a significant impact on the findings, the overall results are likely valid.

**Assumption #8: There are no influential cases biasing your model.**

Cook’s Distance values were under 1, suggesting individual cases were not influencing the model.

**Multicollinearity**

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>95.0% Confidence Interval for B</th>
<th>Collinearity Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Constant)</td>
<td>45.581</td>
<td>-</td>
<td>37.948</td>
<td>.920</td>
</tr>
<tr>
<td>SchoolMinStatus</td>
<td>-2.012</td>
<td>-.052</td>
<td>-7.546</td>
<td>.926</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>-3.658</td>
<td>-.077</td>
<td>-10.485</td>
<td>.926</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>-13.987</td>
<td>-.509</td>
<td>-18.381</td>
<td>.741</td>
</tr>
<tr>
<td>Age</td>
<td>1.190</td>
<td>.259</td>
<td>1.887</td>
<td>.821</td>
</tr>
</tbody>
</table>

*a. Dependent Variable: WSH Score*
Table 4.2 Coefficients

<table>
<thead>
<tr>
<th>Model</th>
<th>B</th>
<th>Std. Error</th>
<th>Beta</th>
<th>t</th>
<th>Sig.</th>
<th>95.0% Confidence Interval for B Lower Bound</th>
<th>Upper Bound</th>
<th>Collinearity Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Constant)</td>
<td>52.062</td>
<td>8.567</td>
<td></td>
<td>6.077</td>
<td>&lt;.001</td>
<td>35.094</td>
<td>69.030</td>
<td></td>
</tr>
<tr>
<td>School Min Status</td>
<td>15.376</td>
<td>6.212</td>
<td>.215</td>
<td>2.475</td>
<td>.015</td>
<td>3.073</td>
<td>27.679</td>
<td>.920</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>-15.181</td>
<td>7.662</td>
<td>-.171</td>
<td>1.981</td>
<td>.050</td>
<td>-30.357</td>
<td>-.005</td>
<td>.926</td>
</tr>
<tr>
<td>Age</td>
<td>2.617</td>
<td>.782</td>
<td>.307</td>
<td>3.346</td>
<td>.001</td>
<td>1.068</td>
<td>4.167</td>
<td>.821</td>
</tr>
</tbody>
</table>

a. Dependent Variable: GHS Score

Table 4.1 and 4.2 show collinearity statistics. With variance inflation factor (VIF) values at 1, there are no problematic correlation between the independent variables of Age, Gender Identity, School Affiliation and Race as it relates to Willingness-To-Seek-Help score and General Help-Seeking score. With VIF scores well below 10 and tolerance scores above 0.2, the assumption of multicollinearity is met. It can be concluded that the independent variables are not highly correlated to each other and such they do provide unique or independent information in the regression model.

**Linear Relationship**

![Figure 4.1 Scatter Plot of Willingness-To-Seek-Help by Age](image)

Figure 4.1 Scatter Plot of Willingness-To-Seek-Help Scores by Age
Figure 4.1 shows that the assumption of a linear relationship between Willingness-To-Seek-Help scores and Age is met.

![Scatter Plot of General Help-Seeking by Age](image)

Figure 4.2 Scatter Plot of General Help-Seeking Scores by Age

Figure 4.2 shows that the assumption of a linear relationship between General Help-Seeking scores and Age is met.

*Reporting Means*

<table>
<thead>
<tr>
<th>WSH Score * Gender Identity</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>45.30</td>
<td>114</td>
<td>13.733</td>
</tr>
<tr>
<td>Male</td>
<td>33.50</td>
<td>8</td>
<td>9.690</td>
</tr>
<tr>
<td>Total</td>
<td>44.71</td>
<td>120</td>
<td>13.773</td>
</tr>
</tbody>
</table>
Tables 4.3, 4.4, 4.5 and 4.6 report mean scores of the dependent variable (Willingness-To-Seek-Help Score) for each group. Findings show that the mean scores for willingness were lower for minorities and schools with higher minority status (SU and TSU) in comparison to non-minorities and schools where the students are majority non-minority (schools with a lower
minority status; USM and LSU). Findings also show that mean scores are higher among females in comparison to males.

**Table 4.7 Mean Scores**

<table>
<thead>
<tr>
<th>Gender Identity</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>81.2807</td>
<td>114</td>
<td>25.56114</td>
</tr>
<tr>
<td>Male</td>
<td>58.6667</td>
<td>6</td>
<td>8.68716</td>
</tr>
<tr>
<td>Total</td>
<td>80.1500</td>
<td>120</td>
<td>25.45771</td>
</tr>
</tbody>
</table>

**Table 4.8 Mean Scores**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Minority</td>
<td>91.9286</td>
<td>56</td>
<td>23.14685</td>
</tr>
<tr>
<td>Minority</td>
<td>69.8438</td>
<td>64</td>
<td>22.91753</td>
</tr>
<tr>
<td>Total</td>
<td>80.1500</td>
<td>120</td>
<td>25.45771</td>
</tr>
</tbody>
</table>

**Table 4.9 Mean Scores**

<table>
<thead>
<tr>
<th>School Affiliation</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU</td>
<td>20.0000</td>
<td>2</td>
<td>0.0000</td>
</tr>
<tr>
<td>LSU</td>
<td>80.7895</td>
<td>38</td>
<td>20.10937</td>
</tr>
<tr>
<td>TSU</td>
<td>71.2000</td>
<td>15</td>
<td>23.92906</td>
</tr>
<tr>
<td>USM</td>
<td>83.6923</td>
<td>65</td>
<td>26.47990</td>
</tr>
<tr>
<td>Total</td>
<td>80.1500</td>
<td>120</td>
<td>25.45771</td>
</tr>
</tbody>
</table>
Tables 4.7, 4.8, 4.9 and 4.10 report mean scores of the dependent variable (General Help-Seeking Score) for each group. Findings show that the mean scores for general help-seeking were much lower for minorities and schools with higher minority status (SU and TSU) in comparison to non-minorities and schools where the students are majority non-minority (schools with a lower minority status; USM and LSU). Findings also show that mean scores are higher among females in comparison to males.

<table>
<thead>
<tr>
<th>School Minority Status</th>
<th>Mean</th>
<th>N</th>
<th>Std. Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Help Seeking Score</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Minority Status</td>
<td>65.1765</td>
<td>17</td>
<td>26.10969</td>
</tr>
<tr>
<td>Low Minority Status</td>
<td>82.214</td>
<td>103</td>
<td>24.26169</td>
</tr>
<tr>
<td>Total</td>
<td>80.1500</td>
<td>120</td>
<td>26.45771</td>
</tr>
</tbody>
</table>

Table 4.11 General Help-Seeking Score Descriptives

<table>
<thead>
<tr>
<th>Descriptives</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHScore</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SU</td>
<td>2</td>
<td>20.0000</td>
<td>.0000</td>
<td>.0000</td>
<td>20.0000</td>
<td>20.0000</td>
<td>20.000</td>
<td>20.000</td>
</tr>
<tr>
<td>LSU</td>
<td>38</td>
<td>80.7806</td>
<td>20.10937</td>
<td>3.26217</td>
<td>74.1797</td>
<td>87.3993</td>
<td>51.00</td>
<td>117.00</td>
</tr>
<tr>
<td>TSU</td>
<td>15</td>
<td>71.2000</td>
<td>23.92986</td>
<td>6.17846</td>
<td>57.9485</td>
<td>84.4515</td>
<td>20.00</td>
<td>120.00</td>
</tr>
<tr>
<td>USM</td>
<td>65</td>
<td>83.6923</td>
<td>26.47890</td>
<td>3.28443</td>
<td>77.1309</td>
<td>90.2537</td>
<td>33.00</td>
<td>140.00</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>80.1500</td>
<td>25.45771</td>
<td>2.32396</td>
<td>75.5483</td>
<td>84.7517</td>
<td>20.00</td>
<td>140.00</td>
</tr>
</tbody>
</table>
Table 4.12 General Help-Seeking Score ANOVA

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>9268.738</td>
<td>3</td>
<td>3089.579</td>
<td>5.282</td>
<td>.002</td>
</tr>
<tr>
<td>Within Groups</td>
<td>67854.562</td>
<td>116</td>
<td>584.953</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>77123.300</td>
<td>119</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.11 and 4.12 show descriptives and results from a One-way ANOVA. Findings show the means, standard deviation and significance value for the dependent variable, General Help-Seeking Score.

Table 4.13 Willing-To-Seek-Help Score Descriptives

<table>
<thead>
<tr>
<th>WSH Score</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>SU</td>
<td>2</td>
<td>34.50</td>
<td>9.192</td>
<td>6.500</td>
<td>-48.09</td>
<td>117.09</td>
<td>28</td>
<td>41</td>
</tr>
<tr>
<td>LSU</td>
<td>38</td>
<td>42.66</td>
<td>6.995</td>
<td>1.135</td>
<td>40.39</td>
<td>44.98</td>
<td>27</td>
<td>54</td>
</tr>
<tr>
<td>TSU</td>
<td>15</td>
<td>42.33</td>
<td>8.666</td>
<td>2.237</td>
<td>37.53</td>
<td>47.13</td>
<td>26</td>
<td>60</td>
</tr>
<tr>
<td>USM</td>
<td>65</td>
<td>46.78</td>
<td>17.187</td>
<td>2.132</td>
<td>42.50</td>
<td>51.01</td>
<td>10</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td>120</td>
<td>44.71</td>
<td>13.773</td>
<td>1.257</td>
<td>42.22</td>
<td>47.20</td>
<td>10</td>
<td>72</td>
</tr>
</tbody>
</table>

Table 4.14 Willing-To-Seek-Help Score ANOVA

<table>
<thead>
<tr>
<th>WSH Score</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>720.686</td>
<td>3</td>
<td>240.229</td>
<td>1.275</td>
<td>.286</td>
</tr>
<tr>
<td>Within Groups</td>
<td>21852.105</td>
<td>116</td>
<td>188.380</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>22572.792</td>
<td>119</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.13 and 4.14 show descriptives and results from a One-way ANOVA. Findings show the means, standard deviation, and significance value for the dependent variable, Willingness-To-Seek-Help Score.
Independence of Observations

Table 4.15 Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>Std. Error of the Estimate</th>
<th>Durbin-Watson</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.663a</td>
<td>.440</td>
<td>.421</td>
<td>10.489</td>
<td>1.441</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Age, Gender Identity, SchoolMinStatus, Race/Ethnicity
b. Dependent Variable: WSH Score

The value of 1.441 informs that the assumption of independent observations has been met.

Table 4.16 Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>R</th>
<th>R Square</th>
<th>Adjusted R Square</th>
<th>Std. Error of the Estimate</th>
<th>Durbin-Watson</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.446a</td>
<td>.199</td>
<td>.171</td>
<td>23.31511</td>
<td>1.520</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Age, Gender Identity, SchoolMinStatus, Race/Ethnicity
b. Dependent Variable: GHS Score

The value of 1.520 informs that the assumption of independent observations has been met.

Homoscedasticity

Figure 4.3 Willingness-To-Seek-Help Score Plot
Figures 4.3 and 4.4 plot the standardized values that the model would predict against the standardized residuals obtained. As the predicted values increase (along the X-axis), the variation in the residuals resembles a random array of dots instead of a cone shape. As a result, the assumption of independent observations has been met.

**Normality**
Figures 4.5 and 4.6 show P-P plots of each dependent variable model. Based on plots, it is suggested that the assumption of normality of the residuals may have been violated to some extent. However, as only extreme deviations from normality are likely to have a significant impact on the findings, the overall results are likely valid.

**No Significant Outliers**

Cook’s Distance values were all under 1, suggesting individual cases were not unduly influencing the model.

**Results**

<table>
<thead>
<tr>
<th>Model Summaryb</th>
<th>Model Summaryb</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Model</td>
<td>R</td>
</tr>
<tr>
<td>1</td>
<td>.663a</td>
</tr>
</tbody>
</table>

a. Predictors: (Constant), Age, Gender Identity, SchoolMinStatus, Race/Ethnicity
b. Dependent Variable: WSH Score

In Table 17, the Model Summary shows a value for Pearson’s $R$, which is one measure of the quality of the prediction of the dependent variables, which in this study are Willingness-To-
Seek-Help and General Help-Seeking. A value of 1 indicates the most strength. The Pearson’s $R$ value (highlighted in purple) of 0.663 indicates a moderate positive correlation (level of prediction) in strength. The $R$ Square in a multiple regression represents explained variance that can be contributed to all the predictors in a progression. The $R$ Square value (highlighted in blue) of 0.440 (.440 x 100= 44.0) shows that 44% of the variance in the dependent variable, Willingness-To-Seek-Help can be accounted for by the independent variables of Age, Gender Identity, School Minority Status and Race.

Table 4.18 Model Summary

<table>
<thead>
<tr>
<th>Model</th>
<th>$R$</th>
<th>$R$ Square</th>
<th>Adjusted $R$ Square</th>
<th>Std. Error of the Estimate</th>
<th>Durbin-Watson</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.446a</td>
<td>.199</td>
<td>.171</td>
<td>23.31511</td>
<td>1.520</td>
</tr>
</tbody>
</table>

In Table 18, the Model Summary shows a Pearson’s $R$ value (highlighted in purple) of 0.446 indicates a moderate positive correlation (level of prediction) in strength. With values indicating a positive relationship it is observed that increase in one value results in increase in another. The $R$ Square value (highlighted in blue) of 0.199 (.199 x 100= 19.9) shows that 19.9% of the variance in the dependent variable, General Help-Seeking can be accounted for by the independent variables of Age, Gender Identity, School Minority Status and Race.

Table 4.19 ANOVA

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>$F$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Regression</td>
<td>4</td>
<td>2506.498</td>
<td>22.784</td>
<td>&lt;.001b</td>
</tr>
<tr>
<td></td>
<td>Residual</td>
<td>116</td>
<td>110.012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>22787.339</td>
<td>120</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: WSH Score
b. Predictors: (Constant), Age, Gender Identity, SchoolMinStatus, Race/Ethnicity
In Table 19, the F-ratio in the ANOVA table tests whether the overall regression model is a good fit for the data. The ANOVA table shows that the independent variables of Age, Gender Identity, School Minority Status and Race statistically significantly predict the dependent variable of Willingness To Seek Help, $F(4, 116) = 22.784, p < .0005$ (i.e., the regression model is a good fit of the data).

Table 4.20 ANOVA

<table>
<thead>
<tr>
<th>Model</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regression</td>
<td>15665.038</td>
<td>4</td>
<td>3916.259</td>
<td>7.204</td>
<td>&lt;.001*</td>
</tr>
<tr>
<td>Residual</td>
<td>63056.962</td>
<td>116</td>
<td>543.595</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>78722.000</td>
<td>120</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. Dependent Variable: GHSscore
b. Predictors: (Constant), Age, Gender Identity, SchoolMinStatus, Race/Ethnicity

In Table 20, the F-ratio in the ANOVA table tests whether the overall regression model is a good fit for the data. The ANOVA table shows that the independent variables of Age, Gender Identity, School Minority Status and Race statistically significantly predict the dependent variable of General Help-Seeking, $F(4, 116) = 7.204, p < .0005$ (i.e., the regression model is a good fit of the data).

Table 4.21 Coefficients

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>95.0% Confidence Interval for B</th>
<th>Collinearity Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td>t</td>
</tr>
<tr>
<td>(Constant)</td>
<td>45.581</td>
<td>3.854</td>
<td></td>
<td>11.827</td>
</tr>
<tr>
<td>SchoolMinStatus</td>
<td>-2.012</td>
<td>2.794</td>
<td>-0.052</td>
<td>-0.720</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>-3.658</td>
<td>3.447</td>
<td>-0.077</td>
<td>-1.061</td>
</tr>
<tr>
<td>Age</td>
<td>1.190</td>
<td>.352</td>
<td>.259</td>
<td>3.381</td>
</tr>
</tbody>
</table>

a. Dependent Variable: WSH Score

Table 21 shows the extent to which the individual predictor variables contribute to the model. In this study, Race and Age (as highlighted) did contribute to the model. As a result,
hypotheses 1 and 2 are rejected as Race and Age are predictive of Willingness-To-Seek-Help. In both cases, the alternative hypothesis is accepted as findings show statistical significance. Table 5 shows that School Minority Status (p=.473) and Gender (p=.291) did not significantly contribute to the model. For hypotheses 3 and 4 there is failure to reject.

X H(1): Minority status is not a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

✓ H(a) 1: Minority status is a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

X H(2): Age is not a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

✓ H(a) 2: Age is a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

✓ H(3): Gender is not a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

X H(a) 3: Gender is a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

✓ H(4): School minority status is not a predictive factor for willingness to seek help for mental health needs among African American emerging adults.

X H(a) 4: School minority status is a predictive factor for willingness to seek help for mental health needs among African American emerging adults.
Table 4.22 Coefficients

<table>
<thead>
<tr>
<th>Model</th>
<th>Unstandardized Coefficients</th>
<th>Standardized Coefficients</th>
<th>t</th>
<th>Sig.</th>
<th>95.0% Confidence Interval for B</th>
<th>Collinearity Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B</td>
<td>Std. Error</td>
<td>Beta</td>
<td></td>
<td>Lower Bound</td>
<td>Upper Bound</td>
</tr>
<tr>
<td>1 (Constant)</td>
<td>52.062</td>
<td>8.567</td>
<td>6.077</td>
<td>&lt;.001</td>
<td>35.094</td>
<td>69.030</td>
</tr>
<tr>
<td>SchoolMinStatus</td>
<td>15.376</td>
<td>6.212</td>
<td>.215</td>
<td>2.475</td>
<td>3.073</td>
<td>27.679</td>
</tr>
<tr>
<td>Gender Identity</td>
<td>-15.181</td>
<td>7.662</td>
<td>-.171</td>
<td>-</td>
<td>-1.981</td>
<td>.050</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>-1.614</td>
<td>4.931</td>
<td>-.032</td>
<td>-</td>
<td>-3.27</td>
<td>.744</td>
</tr>
<tr>
<td>Age</td>
<td>2.617</td>
<td>.782</td>
<td>.307</td>
<td>3.346</td>
<td>1.068</td>
<td>4.167</td>
</tr>
</tbody>
</table>

a. Dependent Variable: GHS Score

Table 22 shows the extent to which the individual predictor variables contribute to the model. In this study, Age, School Minority Status, and Gender did contribute to the model. As a result, hypotheses 6, and 8 are rejected as Age, Gender and School Affiliation are predictive of General Help-Seeking. For hypotheses 6, 7 and 8, the alternative is accepted as findings show statistical significance. Table 6 shows that Race (p=.744) did not significantly contribute to the model. For hypothesis 5, there is failure to reject.

✔ H(5): Minority status is not a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

✗ H(a) 5: Minority status is a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

✗ H(6): Age is not a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

✔ H(a) 6: Age is a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.
X H(7): Gender is not a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

✓ H(a) 7: Gender is a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

X H(8): School minority status is not a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

✓ H(a) 8: School minority status is a predictive factor for help-seeking intentions for mental health needs among African American emerging adults.

Table 4.23 Joint Display Causes of Distress

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score</td>
<td>Causes of Distress: When you are stressed what are some of the causes?</td>
<td>“Money”</td>
</tr>
<tr>
<td>High GHS Score</td>
<td></td>
<td>“Future career success”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“School responsibilities”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Covid-19 &amp; university related policy”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Romantic relationships”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Family pressure”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Health threats”</td>
</tr>
</tbody>
</table>

Table 23 reports findings associated with research question 3: What causes African American emerging adults to experience mental distress?
Table 4.24 Joint Display of Self-Efficacy

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score</td>
<td>Self-Efficacy: How likely am I to control and manage my diagnosis?</td>
<td>“I guess within my own culture and my extended family too, that’s like, ‘oh you can handle this yourself, like you don’t need to seek out somebody else to help you with that.’”</td>
</tr>
<tr>
<td>High GHS Score</td>
<td></td>
<td>“I feel like the symptoms are not as drastic or they’re manageable. I’ll be like more functional to be able to face whatever my challenge is. And like be able to like engage through whatever the struggle is.”</td>
</tr>
</tbody>
</table>

Table 24 reports findings associated with research question 5: What factors discourage African American emerging adults from seeking mental health services?

Table 4.25 Joint Display of Cues To Action

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score</td>
<td>Cues to Action: What would persuade me to seek treatment for my mental illness?</td>
<td>“Probably for it to get so bad that I can’t function… the depression just got so bad that I wasn’t leaving the bed.”</td>
</tr>
<tr>
<td>High GHS Score</td>
<td></td>
<td>“When I felt that it started to affect other people around me. When people started to worry about me, um, I didn’t like that. I didn’t like feeling that people had to constantly check up on me so that was definitely a motivating factor.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I want to improve. Like, I want my condition to improve.”</td>
</tr>
</tbody>
</table>

Table 25 reports findings associated with research question 4: What factors encourage African American emerging adults to seek mental health services?
Table 4.26 Joint Display of Perceived Benefits

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score</td>
<td><strong>Perceived Benefits:</strong></td>
<td>“My experience with mental health over the years have taught me how to be better about taking care of myself.”</td>
</tr>
<tr>
<td>High GHS Score</td>
<td><strong>How successful would mental health services be in helping treat my illness?</strong></td>
<td>“Therapy can be really helpful if you’re going through those difficult emotions. And there’s a level of anonymity in it that’s really nice… And I really like group therapy. Like that’s what’s been the most helpful for me, is like not being alone in it.”</td>
</tr>
</tbody>
</table>

Table 26 reports findings associated with research question 4: What factors encourage African American emerging adults to seek mental health services?

Table 4.27 Joint Display of Perceived Barriers

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score</td>
<td><strong>Perceived Barriers:</strong></td>
<td>“I had a really hard time sticking with a therapist. I think that part of that was just that I didn’t want to go to therapy, and the other part was feeling like I didn’t have a therapist that I necessarily felt entirely comfortable with.”</td>
</tr>
<tr>
<td>High GHS Score</td>
<td><strong>What stands in my way of utilizing formal mental health services?</strong></td>
<td>“I feel like my main issues that ever came up were economic issues, such as like therapists being like out of network or not taking like my insurance.”</td>
</tr>
</tbody>
</table>
|                      |                                      | “I feel like it’s just a little more difficult to get in partly because a lot of them are so booked all the time, and it’s the booking, the whole process of getting booked, like you can’t just call and say ‘hey I need to talk to someone now, like while it’s on my mind.’ It’s kinda like I have to make an appointment to do this. Will I still have time? Will
Table 27 reports findings associated with research question 5: What factors discourage African American emerging adults from seeking mental health services?

Table 4.28 Joint Display of Perceived Severity

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score High GHS Score</td>
<td>Perceived Severity: How serious would a mental illness be in my life?</td>
<td>“And the depression just got so bad that I wasn’t leaving my bed. Like, period... But it just got so bad that I had to [seek mental health services].”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I felt forced to be there, and so I really didn’t like that, and I felt like what led me there maybe wasn’t that bad and I didn’t think that I needed help to begin with but I went.”</td>
</tr>
</tbody>
</table>

Table 28 reports findings associated with research question 4: What factors encourage African American emerging adults to seek mental health services?

Table 4.29 Joint Display of Perceived Susceptibility

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score High GHS Score</td>
<td>Perceived Susceptibility: How likely am I to become diagnosed with a mental illness?</td>
<td>“It doesn’t matter what your background like these things are affecting everybody. It’s just not talked about by everybody.”</td>
</tr>
</tbody>
</table>
“Hey, we all have bad days, even I have bad days sometimes.”

Table 29 reports findings associated with research question 4: What factors encourage African American emerging adults from seeking mental health services?

Table 4.30 Joint Display of Spiritual Reliance

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score</td>
<td>Spiritual Reliance:</td>
<td>“Sometimes I rather just pray because some of my issues are not big enough for professional help”.</td>
</tr>
<tr>
<td>High GHS Score</td>
<td></td>
<td>“I consider myself to be spiritual and not religious but I still like to talk with my counselor regularly”.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I believe in a spiritual higher power and that power wants me to be mentally healthy because that is related to my well-being”.</td>
</tr>
</tbody>
</table>

Table 30 reports findings associated with research question 6: What sources of support do African American emerging adults rely on following an experience of mental distress?
Table 4.31 Joint Display Fear of Stigma

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score</td>
<td>Fear of Stigma:</td>
<td>“I don’t want my parents to <strong>think any less of me.</strong>”</td>
</tr>
<tr>
<td></td>
<td>Negative ideas about individual character linked to a mental health need</td>
<td>“Getting help makes me feel like I am <strong>part of the problem</strong> in society”.</td>
</tr>
<tr>
<td>High GHS Score</td>
<td></td>
<td>“Mental illness is like a sign that <strong>I am a bad person</strong> because this only happens to <strong>bad people</strong>”.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Even though I have had (mental health) help, <strong>I am embarrassed</strong> about telling people that I still need help”.</td>
</tr>
</tbody>
</table>

Table 31 reports findings associated with research question 5: What factors discourage African American emerging adults from seeking mental health services?

Table 4.32 Joint Display of Social Support

<table>
<thead>
<tr>
<th>Standardized Scores</th>
<th>Theme</th>
<th>Qualitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>High WSH Score</td>
<td>Social Support:</td>
<td>“Mother”</td>
</tr>
<tr>
<td></td>
<td>Who is there to offer support through my mental illness?</td>
<td>“Family”</td>
</tr>
<tr>
<td>High GHS Score</td>
<td></td>
<td>“Friends”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Boyfriend”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“My counselor”</td>
</tr>
</tbody>
</table>

Table 32 reports findings associated with research question 6: What sources of support do African American emerging adults rely on following an experience of mental distress?
Summary

In conclusion, findings show that in predicting Willingness-To-Seek-Help scores, Race and Age are significant supporting that minority emerging adults are in fact less willing to seek professional help for mental health needs compared to non-minority emerging adults. Quantitative findings show that not only are Race and Age predictive factors for willingness to seek help but, findings show that compared to non-minority emerging adults, Willingness-To-Seek-Help scores are lower for minorities as indicated by the mean item scores for each group. In predicting General Help-Seeking scores Age, School Minority Status, and Gender are significant. In this, support is provided in the claim that help-seeking intentions can be predicted based on age, percentage of minorities enrolled at a university and gender identity. Findings also show that mean scores for General Help-Seeking are higher among females in comparison to males.

Resulting qualitative themes include perceived susceptibility, perceived severity, self-efficacy, perceived benefits, perceived barriers, cues to action and social support. In reporting main findings following the response to generate more qualitative research for an underreported population, overall causes of distress reported include the need for money, anticipation around future career success, consuming school responsibilities, Covid-19 & university related policy, pressured romantic relationships, family pressure to succeed and continual health threats. Findings show that common sources of support identified by minorities mostly spun from informal relationships just as reported in the existing literature. Additionally, findings show that awareness of stigma and personal belief contribute to the phenomenon of underutilization and impact one’s decision to seek formal help for mental health needs which aligns with existing literature.
CHAPTER V. DISCUSSION

Practice Implications: Strategies to Combat Underutilization

When examining how the underutilization of formal mental health services has impacted African American emerging adults, findings suggest that there are practice and policy responses that could increase formal service engagement. To combat common barriers to underutilization, to be addressed should be the lack of holistic approaches to mental health services (Dillon et al., 2020), the need for increased professional community involvement (Oedegaard et al., 2020), the lack of cultural competence training for professionals (Ofonenedu et al., 2017), practitioners should encourage social engagement from peers and family (Castonguay et al., 2017) and the use of personal narratives should be used to combat self-stigma and maximize self-worth. Further attention in these areas would increase formal mental health service utilization among African American emerging adults being that a lack thereof has led to barriers, limitations, and underutilization.

Integrated and Holistic Approaches

One barrier to action is a lack of focus on holistic approaches for mental health awareness and intervention (Dillon et al., 2020). Holistic approaches involve mental health professionals connecting the mind, body, and spirit for balance and healing (Lutton and Swank, 2018). Aside from aiding the individual, promoting holistic interventions develops mental health literature in rural regions which is needed to empower distant communities (Crowe et al., 2019). An inability to access educational information regarding treatment options often leads to dependence solely on medication (Crowe et al., 2019).

A lack of integrated systems can inhibit feelings of support and safety, as well as the obtainment and dissemination of mental health skills (Greig et al., 2021). Integrating services
with outside professionals, such as primary care physicians, emergency rooms, schools, pastors, religious leaders or community care centers, would facilitate treatment of the whole person rather than the parts (Lutton & Swank, 2018). Examining trauma-informed leadership in academic institutions has revealed that promoting an integral approach among at-risk communities assembles comprehensive support networks without advocating for one particular system, or area of need, over another (Greig et al., 2021). This level of collaboration between educational and interventional practices can be beneficial leading to increased referral and retention rates as individuals are able to more easily access resources related to mental health treatment (Dillon et al., 2020). An inability to locate a provider and obtain resources within medical and educational communities resulted in a hindered ability to make informed decisions for mental health and therefore implementing an integrated approach was deemed necessary in efforts to establish healthy college campus communities (Nobiling & Maykrantz, 2017). As a result, there should be emphasis on the importance of building collaborative partnerships with physicians, faith-based organizations, and other mental health providers as this creates a multifaceted solution (Crowe et al., 2019).

**Expand Treatment Availability and Support**

Professionals are encouraged to increase information integration, expand availability and enhance community support (Oedegaard et al., 2020). This practice is suggested because understanding the benefits and risks of various treatment options, such as medication usage, group therapy, intensive outpatient services, or individual counseling, are critical factors in the decision to engage with formal mental health support. Increased information integration on various treatment options help individuals achieve self-efficacy and decrease the stigma associated with treatment (Oedegaard et al., 2020).
In posing another solution to the issue of underutilization of formal mental health services, professionals are encouraged to expand the availability of treatment options to the greater community (Oedegaard et al., 2020). For some African American emerging adults enrolled in university, accessing professional mental health services comes with the challenges of inconsistent transportation, inconvenient hours of formal service operation, demanding personal work schedules, and financial obligations. A suggestion for application by Ofonedu et al. (2017), includes offering extended clinic times, such as after-hours or weekend appointments. This suggestion for practice combats common barriers to action associated with external factors by accommodating inflexible personal and work schedules of college-aged students. Additionally, providing appointment reminders and collaborating with outside agencies, such as transportation services and staffing agencies are frequently identified engagement practice elements associated with effective engagement outcomes (Ofonedu et al., 2017).

For individuals lacking access to formal mental health psychoeducation, it is imperative that practices create accessible means of seeking and receiving mental health services (Platell et al., 2020). To increase participation in mental health services mental health practitioners should increase access to education about mental health disorders within schools and local agencies where individuals frequently visit (Platell et al., 2020). Overall, these implications ensure more informed submission to services, increase formal service accessibility, address common barriers to action and ultimately decrease the underutilization of formal mental health services.

**Rescripting Personal Narratives to Address Self-Stigma**

It is vital to recognize that one can create self-stigma and addressing this is of equal importance in reducing the impact of public stigma on the issue of underutilization (Dickstein et al., 2010; Green-Shortridge et al., 2007). Proposed strategies include engagement in Cognitive
Behavioral Therapy, psychoeducation, or acceptance and commitment therapy (Dickstein et al., 2010) which are all treatment modalities that often include the use of personal narratives. Use of narratives in treatment are associated with self-efficacy, an influential factor in the perceived ability to seek help, perceived ability to control depressive symptoms, responsiveness, and motivation for change (Castonguay et al., 2016). Addressing underutilization with the use of therapies and narratives better equips clients to address their own negative thinking related to mental health, enhances transferable life skills, develops self-efficacy and empowers individuals seeking to reach a healthy mental state (Castonguay et al., 2016; Dillon et al., 2019).

**An Educational Approach**

An educational approach is a common intervention used to reduce stigma as it has been found to some extent to increase positive attitudes related to mental health. But while education alone has shown some progress in some short-term studies (Dickstein et al., 2010; Greene-Shortridge et al., 2007) ultimately, it has been found to be unsuccessful at changing poor attitudes toward mental illness in longitudinal research (Corrigan et al., 2001; Dondanville et al., 2018; Mezuk et al., 2021). In the efforts to promote formal mental health utilization, the educational approach has been most useful in providing information regarding the benefits of professional service engagement (Bjørnsen et al., 2019). While educational interventions alone have not proven to be effective in reducing stigma, it is important to note that through education, individuals have reported gaining a greater understanding of how poor mental health can be negatively impactful and others have reported how educational efforts have led to an increase in knowledge regarding mental illnesses (Atkins et al., 2010). As a result, it is believed that the overall impact of education as a practice implication for reducing stigma is significant and thus, it is encouraged for future application.
Social Implications: Strategies to Combat Stigma

As a result of human interconnectedness, societal factors have the potential to shape cultural ideology through the policy, macro systems and media agendas. Through the use of media, mental health has been portrayed as dangerous, criminal, and unpredictable (Corrigan et al., 2002; Mezuk et al., 2021; Srivastava et al., 2018; Stuart, 2006; Yu et al., 2022) resulting in the creation of negative social beliefs, demeaning social scripts, and biased treatment of individuals with a mental health diagnosis. Such realities drive the need for effective strategies and interventions to combat stigma from a social perspective. Research on stigma has focused largely on understanding the nature of stigma and evaluating the extent to which stigma affects the utilization of mental health care. The need for intervention strategies aimed at reducing stigma is widely recognized (Britt et al., 2008; Dickstein, 2010; Greene-Shortridge et al., 2007), yet few specific interventions have been explored and not all methods have been beneficial in the efforts to reduce stigma. Of interventions used, common strategies for combating mental health stigma include making personal contact, protesting, and combining use of moral persuasion, education and socialization (Corrigan et al., 2002; Corrigan & Penn, 2015; Yu et al., 2021).

Personal Contact

Beyond interventions mentioned, research suggests that contact strategies have the greatest effect on modifying attitudes (Alexander & Link, 2003; Corrigan et al., 2001; Corrigan et al., 2002). Contact strategies have been found to reduce stigma and improve attitudes toward mental illness in several studies and yield greater results than education or protesting alone (Corrigan et al., 2001; Corrigan et al., 2002; Dondanville et al., 2018; Mezuk et al., 2021). Making personal contact has included individuals sharing stories and personal experiences regarding their mental diagnoses and psychological state. Direct interaction with individuals
living with a mental illness and exposure to their life and daily living stories addresses stigma likely as it evokes empathy and understanding. Studies have found that when education and scientific articles were paired with firsthand accounts of mental illness, individuals demonstrated less stigmatized attitudes toward mental illness and treatment (Corrigan et al., 2001; Mezuk et al., 2021). Specifically, Dondanville et al. (2018) found that contact strategies that aim to “put a face” on individuals with PTSD by sharing personal stories and supportive comments with the public are a common strategy that successfully combat stigma in society.

**Protesting**

Stigma towards mental health is becoming a very well-known issue, and efforts to reduce such stigma are on the rise (Corrigan & Penn, 2015). One approach to reducing mental health stigma is protesting, which is the act of spreading awareness about issues and confronting individuals and organizations who are spreading harmful messages that increase mental health stigma, in an effort to promote inclusiveness and sensitivity (Corrigan & Penn, 2015). Wahl (1995) suggests that protest strategies are helpful in reducing stigma from media outlets, which in turn may reduce the stereotypes held by the public because these stereotypes are not as prominent in the media. This approach is viewed as aggressive and effective as consumers demand changes to media portrayals of issues such as mental health (Wahl, 1995).

Protesting is found to be effective in reducing covert examples of stigma in the media, but there is little evidence that this strategy is effective in genuinely changing people’s minds and increasing their own personal understanding of mental health issues (Corrigan & Penn, 2015). So, while commonly used, protesting has been found unsuccessful in reducing stigma on a long-term basis as findings show that these interventions only temporarily reduce negative thinking (Corrigan & Penn, 2015). Mental health advocates have used protesting and lobbying as
a method to decrease mental health stigma and increase mental health awareness nationally but there is a lack of supporting evidence that efforts effectively change negative attitudes towards mental health at the macro level. On the contrary, such efforts have been thought to encourage individuals to suppress their feelings, which can create negative feelings toward a specific group or mental illness (Corrigan et al., 2001; Dickstein et al., 2010; Greene-Shortridge et al., 2007). As seen, protesting has limitations. But since there is substantial evidence that protesting is effective when it is aimed at media outlets, rather than individuals (Corrigan & Penn, 2015; Wahl, 1995) it should be exercised as a macro level solution in efforts to reduce the negative impacts associated with mental health stigma.

**Moral Persuasion, Education and Socialization**

The underutilization of formal mental health treatment could be addressed by informing society and individuals of their role in perpetuating mental health stigma. *Humans are interconnected*. Therefore, promoting socialization and spreading awareness of the harms associated with mental health stigma could normalize the help seeking of formal treatment on a national scale. Findings show that the concept of interconnectedness, or the awareness that all people influence each other, prompts the public to hold themselves accountable for the recovery of individuals with disorders (Yu et al., 2021). Furthermore, highlighting interconnectedness is effective in reducing stigma and improving intergroup relations (Yu et al., 2021). Such findings imply that social and ecological factors, as well as focusing on individuals’ strengths and personal experiences rather than illness and mental health diagnoses, play a role in mental health acceptance (Yu et al., 2021). From these findings, it is clear that the issue of poor mental health stigma must be addressed from a social perspective to increase utilization of formal mental health treatment.
Culturally Sensitive Practices to Addressing Stigma

Tailored to African American studies, it is vital to address the issue of underutilization of formal mental health services from a cultural perspective. Aligned with other research, findings show that stigma associated with mental health continues to be one of the most pervasive barriers to treatment, which develops negative attitudes about mental health treatment and deters individuals’ willingness to engage in mental health services (Conner et al., 2009). Mental health stigma and self-concealment of struggles were significantly connected to African American college students’ hesitation to participate in professional mental health treatment (Masdua et al., 2012). Implications relate to the need to focus on the stigmatizing attitudes associated with African Americans’ dispositional tendencies to conceal personal information from others in formal outreach programs. Suggested is to increase the access of mental health services on college campuses (Masdua et al., 2012). Outreach services can begin to disintegrate these barriers by providing basic information regarding the services provided by professionals to develop a trusting therapeutic environment, as cultural factors play a significant role in the hesitation among African American students (Masdua et al., 2012).

Additionally, barriers to action related to stigma and a lack of cultural awareness among professionals can lead to the development of negative attitudes toward formal mental health treatment (Conner et al., 2009). Furthermore, African American culture often encourages help-seeking from family, close friends, and community members for emotional and psychological assistance (Masdua et al., 2012). Considering how negative help-seeking attitudes and internalized stigma limits the access of formal mental health services, psycho-educational interventions must be developed and implemented within community and clinical settings to decrease the stigmas associated with mental health in African Americans (Planey et al., 2019).
Goals for decreasing social stigmas include increasing public awareness through health promotion campaigns and public education in community and educational centers (Conner et al., 2009). On the micro level, clinicians can set treatment goals for individuals to develop a personal narrative related to their mental health and determine their own outcomes outside of socially stigmatized beliefs (Conner et al., 2009).

**Race Conscious Interventions**

Extensive mental and physical health disparities exist among racial and ethnic groups, with numerous studies suggesting the significant, culturally specific stressors minorities face in response to trauma (Myers et al., 2015). Across cultural groups, African Americans were more likely to endure post-disaster PTSD and depression in comparison to Whites (Davidson et al., 2013). Structural racism exists at the root in the differences of trauma symptoms, such as access to health care, food and housing insecurities, and the low socioeconomic status (Kim et al., 2021). Cultural competency in professionals is critical when treating trauma among minority populations, as interventions designed for predominantly non-minorities may not produce the same results for African Americans and other minorities.

One direction that professionals must consider when delivering race conscious interventions is offering solution-focused and time conscious interventions. Often, minority individuals face structural barriers to accessing treatment, including financial restrictions and social stigma (Ghafoori & Fern Khoo, 2020). Findings show positive mental health outcomes for people of color using Present Centered Therapy (PCT) (Ghafoori & Fern Khoo, 2020). PCT has been effective as a form of supportive therapy that explores socio-cultural impacts while providing adaptive responses related to trauma (Belscher et al., 2017). Furthermore, solution-focused and brief interventions convey respect for multicultural differences, focusing on innate
strengths and the use of resources already present in the individual’s life (Corcoran, 2000). Offering therapeutic support in brief sessions can increase motivation to seek treatment, as well as concrete solutions (Ghafoori & Fern Khoo, 2020).

**Policy Implications**

The underutilization of formal mental health services can be addressed through policy efforts. Methods include giving further attention to application of ethical standards as it relates to the CSWE code of ethics, increasing healthcare policy advocacy efforts (Awad et al., 2021, Hitchcock et al., 2021, Reed, 2021) and ensuring that there is consistency among the application of ethical guidelines for diverse populations (Cassidy et al., 2019).

**Attention to Ethical Standards and The Code of Ethics**

As a means of increasing participation in formal mental health treatment, professionals must ensure that their practices abide by mental health guidelines and psychological ethics, meaning serviced participants and clients understand their rights and treatment plan before consenting to services (Workers, N. A., 2008). Social workers should provide clients with an opportunity to ask questions (Workers, N. A., 2008). Guidelines have included discussing topics that could be sensitive in nature; however, the willingness to engage in specialized topics has been found to increase trust in the therapeutic process, thus leading to increased possibilities for successful outcomes (Oedegaard et al., 2020).

Per the Council on Social Work Education (CSWE), mental health professionals have an ethical responsibility to provide informed consent prior to engaging in services with individuals, which is found within the National Association of Social Workers (NASW) Code of Ethics (NASW, 2008, preamble). One example of these ethical mandates, NASW code 1.03, states that, “social workers should use clear and understandable language to inform clients of the purpose of
the services, risks related to the services, limits to services because of the requirements of a third-party payer, relevant costs, reasonable alternatives, clients’ right to refuse or withdraw consent, and the time frame covered by the consent (NASW, 2008, preamble).

Core competencies acknowledged by the CSWE, state that social workers are to commit to behavioral practices that foster a multicultural society or embrace cultural differences (CSWE, 1973). In alignment with CSWE standards, social workers show appreciation for ethnic representation by encouraging diversity and supporting individual differences through service and the professional practice of cultural competence. Of the four practice behaviors associated with diversity in practice, the worker’s ability to recognize the extent to which a culture’s structures and values may oppress, marginalize, alienate, create or enhance privilege and power (NASW, 1999) is detrimental for minorities seeking professional help for mental health issues. Interventions included address this in aims to meet a person where they are and offer specific services to meet their mental health needs. Cultural diversity is valued as it shapes the human experience and empowers the individual to become resilient. Understanding that the person in the environment is multidimensional, workers aim to meet varying needs while educating, advocating and validating the whole person. The dimensions of diversity are understood as the intersectionality of multiple factors including age, class, color, culture, disability, ethnicity, gender, gender identity and expression, immigration status, political ideology, race, religion, sex, and sexual orientation (NASW, 1999). As shown through specified intervention responses, support is offered for diverse groups without penalization due to cultural difference.

**Healthcare Policy and Social Work Advocacy**

In considering the decline of mental health among African Americans and minority populations, advocating for mezzo and macro level change is crucial in efforts to repair society.
One of the main functions of social work is to engage in advocacy efforts for disadvantaged individuals (Reed, 2021). The NASW Code of Ethics (2008) reiterates on three separate codes that social workers are ethically obligated to engage in social and political actions to ensure equality is present in the delivery of basic human needs. A means of advocacy includes encouraging policy that promotes the use of non-traditional formal support, such as teletherapy on college campuses and at community mental health centers. Advocating for continued use of formal virtual therapeutic services provides opportunities to access professional mental health support for rural communities, as well as those lacking reliable means of transportation (Novacek et al., 2020).

Another means of advocacy involves the improvement of public health policies to increase accessibility. There has been unequal access to public health funding, which impacts the availability of community mental health centers in urban and rural regions (Reed, 2021). Health care discrimination is associated with decreased mental health for all ethnic groups; however, African Americans consistent display the most severe effects from discrimination (Gee et al., 2006). These disparities can be addressed through macro interventions, which involve systematic strategies and processes in which professionals can engage to bring about systemic-level changes related to macroaggressions (Awad et al., 2021). Mental health professionals are called to engage in committees as a means of bringing awareness to the implications of decreased mental health support for African Americans, such as serving on educational boards at universities as advocates for African American emerging adults (Awad et al., 2021). It should be noted that students in college have unique needs during the pandemic, with the transition to online learning, relocation from student housing, and loss of socialization with peers (Hitchcock et al., 2021). Advocating for increased funding for mental health centers and interventions can
alleviate some of the burden college students face in the aftermath of a pandemic (Hitchcock et al., 2021). Using these means of professional advocacy as it relates to healthcare policy could improve access, increase mental health utilization rates and promote efforts to end systematic inequalities contributing to disparities in care (Reed, 2021).

**Recognizing the Impact of COVID-19 on Mental Health**

The COVID-19 pandemic has had a considerable impact on the mental health of many individuals in the US and across the world (Ambrosetti, 2021; Gillard et al., 2021; Shim & Starks, 2021). Individuals have reported increased stress levels due to lockdown restrictions, isolation, and the personal loss associated with the COVID-19 virus (Ambrosetti, 2021; Gillard et al., 2021). Gillard et al. (2021) found that individuals reported an increase in anxiety and depression following the public restriction of access to necessary and leisure activities such as shopping, working, and dining in restaurants. For many, mental health symptoms worsened because they were unable to use their regularly practiced coping skills such as going to the gym, socializing, or just getting out of the house (Gillard et al., 2021).

**The Impact of COVID-19 on Emerging Adults Mental Health**

Emerging adults enrolled in college have been disproportionately impacted by the COVID-19 pandemic. Emerging adults have reported significant disruption to everyday life, making it difficult to socialize and use healthy coping mechanisms (Lopez-Castro et al., 2021). For many college-attending emerging adults managing classroom responsibilities following the outbreak of Covid-19 has been more difficult (Lopez-Castro et al., 2021) as they were forced to stay home and attend classes remotely regardless of if they were prepared for the challenges associated with online learning. Viner (2021) found that school closures were associated with
increased health concerns for children and emerging adults, including increased anxiety and depression symptoms, and increased suicide rates. Furthermore, treatment seeking, and psychiatric hospitalizations dropped dramatically, indicating that prevention, treatment and mental health problems were less prioritized (Viner, 2021) in response to efforts to understand the nature of the virus. Lopez-Castro et al. (2021) found that during “campus lockdowns” college students experienced grief due to the loss of loved ones and some experienced high rates of mental health problems such as anxiety, depression, stress, and PTSD.

*The Impact of COVID-19 on the Mental Health Status of People of Color*

Findings indicate that the negative impacts on mental health that have been associated with the COVID-19 pandemic did not impact everyone equally (Cosgrove & Herrawi, 2021; Gillard et al., 2021; Shim & Starks, 2021). People of color and people of low socioeconomic backgrounds have been disproportionately impacted by the pandemic. Gillard et al. (2021) found that participants from minority communities had increased stress levels due to fear that was associated with the higher rates of COVID-19 among people of color. Participants also reported that in these communities, socialization and community is of utmost importance, and losing that connection was more difficult for people of color than those in the majority population. Some participants also reported that the increased media coverage of Black Lives Matter protests and police brutality intensified their stress during this time (Gillard et al., 2021; Shim & Starks, 2021).

In addition to the impact on mental and physical health, COVID-19 disproportionately created other systemic problems for poor black communities, including food insecurity, housing insecurity, and lower wages (Dubowitz et al., 2021; Vasquez Reyes, 2020). Since the COVID-19 pandemic, food insecurity in two low-income, predominantly African American communities
increased by 80%, while SNAP benefits remained roughly the same (Dubowitz et al., 2021). This spike exceeded the average food insecurity spikes during this time significantly. Consequently, pre-existing conditions such as diabetes, heart disease, and obesity are more prevalent in these areas, increasing the risk of experiencing adverse effects on COVID-19. Vasquez Reyes (2020) states that African Americans were already more likely to be homeless or impoverished prior to the pandemic and after onset of the virus, they are less likely to receive assistance than White Americans. Furthermore, Versey (2021) claims that African Americans disproportionately rent rather than own, making them more susceptible to evictions and housing insecurity. During the pandemic, many people lost income and were threatened with eviction or homelessness (Versey, 2021). Additionally, the low-income jobs that are largely dominated by people of color caused African Americans to risk exposure because they were often considered “essential.” This likely contributed to the disproportionately high rates of COVID-19 among African Americans as well as the major impact of African American mental health (Vasquez Reyes, 2020).

Cosgrove and Herrawi (2021) report that marginalized communities are at a higher risk of physical harm and emotional stress because of the COVID-19 pandemic because therapists and psychologists have been attempting to solve a social, systemic issue with individual solutions like therapy instead of with macro solutions. The researchers argue that many of the heightened risk factors among people of color and people from marginalized communities are the result of longstanding systemic racism and a lack of social justice. It is believed that the only way to solve this problem is to tackle the root of the situation and make changes to policies and promote social justice, but instead, psychologists consistently over diagnoses and encourage individual treatment (Cosgrove & Herrawi, 2021). Findings indicate that people of color are at a much higher disadvantage during the pandemic because they experience more risk factors and
are not given adequate services to assist with the negative impact of COVID-19. Shim and Starks (2021) refer to this phenomenon as a “syndemic,” which describes the complex interactions between the COVID-19 pandemic, systemic racism, and mental health inequities. Individuals with pre-existing mental health conditions as well as individuals from marginalized communities are at a higher risk of contracting COVID-19, being hospitalized because of COVID-19, and/or dying from COVID-19 (Shim & Starks, 2021). Shim and Starks (2021) believe that the combination of racial minority, pre-existing mental health conditions, and the COVID-19 pandemic have led to devastating health consequences and need to be addressed through a critical race lens.

The Impact of Covid-19 and Formal Treatment Experiences

In considering the impact of Covid-19 on mental health treatment experiences, Gillard et al. (2021) found that individuals reported inadequacy in formal treatment as their appointments had been cut drastically. Collectively, treatment experiences have plummeted as clients have felt that problematic symptoms have been ignored or that Covid restrictions and mandates have been used as an excuse to prematurely discharge and conclude services (Gillard et al., 2021).

Similarly, Ambrosetti et al. (2021) found that during “lockdown periods”, psychiatric hospitalization decreased, and upon the removal of such restrictions, psychiatric conditions worsened, and hospitalization increased. Suicidal behaviors were specifically exacerbated by the removal of restrictions (Ambrosetti et al., 2021) showing that despite underutilization of formal outpatient services people have struggled with acclimating in a time of crisis and could benefit from a formal treatment experience to cope with high stress levels. In all, such findings indicate that formal mental health help-seeking is less prioritized and mental health care may be less accessible during lockdown periods.
Solutions To Addressing the Impact of COVID-19 on Mental Health

Since COVID-19 has contributed to mental health problems and has created barriers to receiving treatment, it is imperative for practitioners to adapt their practices to increase the ease of access to treatment (Ambrosetti et al., 2021). Ambrosetti et al. (2021) recommends that these barriers can be reduced by increasing access to in-home care, implementing quarantine procedures in inpatient care, utilizing telehealth, and using video chat services to meet the client where they are. Some of these suggestions are already in practice as telehealth has been rapidly growing as a widely accepted form of mental health treatment internationally (Gillard et al., 2021). A major concern voiced is the lack of privacy that is associated with telehealth. As a result, Gillard et al. (2021) recommends that privacy should be heavily emphasized by practitioners and for individuals without access to privacy face to face formal treatment should be prioritized.

Among the varying experiences related to decreased mental health as a result of Covid related circumstance, one universal factor was that change was inevitable. Findings indicate that mental health professionals must address the disparities that exist in mental health services following the COVID-19 pandemic, especially among marginalized African American and minority emerging adult populations. Solutions can be found in developing and delivering race conscious interventions that build upon cultural strengths and resiliency to assist individuals in processing and healing from psychological distress (Novacek et al., 2020). Another solution to addressing the impact of Covid-19 on mental health could be through advocacy. Found to be helpful are advocacy initiatives focused on increasing mental health de-stigmatization among African American and minority communities (Reed, 2021). Lastly, to address the impact of
Covid-19 on mental health professionals must increase their understanding of varying psychosocial needs in response to trauma (Hitchcock et al., 2021).

**Addressing African American Emerging Adult Psychosocial Needs Following Covid-19**

One unique characteristic of the COVID-19 pandemic on emerging adults is the lingering impact of the traumatic event (Hitchcock et al., 2021). Disaster management theory posits that individuals follow patterns of psychosocial responses to disaster, similar to stages of grief (Zunin & Myers, 2000). Unlike most traumatic events, COVID-19 has not fully transitioned out of a period of impact, highlighted by intense feelings of confusion, disbelief, anxiety, and intense desires for protection of the self and others (Hitchcock et al., 2021). Considering this lingering phase of uncertainty, professionals must address mental health concerns across the physical, mental, and cultural facets of need. Based on the theory of ecological systems proposed by Bronfenbrenner (Teater, 2014), humans interact with their physical, social, and cultural environment simultaneously, which would call for professionals to meet the needs of the psychosocial system rather than solely focusing on the individual parts.

To address psychosocial needs, professionals must gather a comprehensive history of cumulative burdens for the at-risk individuals (Myers et al., 2015). Understanding prior trauma impacts can guide professionals in approaches to implement when assessing the mental health impacts of COVID-19 among African American emerging adults. Mental health professionals are encouraged to engage in collaborative efforts with external social providers, such as food and housing assistance agencies, to address fears and insecurities produced by COVID-19 (Myers et al., 2015).
Research also addresses the need for mental health professionals to obtain disaster-oriented training to understand the impacts. Laborde and associates (2013) explored the outcomes of developing and implementing mental health preparedness training for professionals serving Black communities and concluded that trainers felt better equipped to address psychosocial concerns for African American individuals following disaster than they did prior to completing the training. Likewise, Laurenzi and colleagues (2021) study exploring psychosocial interventions for young adults who tested positive for HIV amid COVID-19 shared the positive outcomes coordinating interventions with professionals outside of the mental health field, and the use of digitally based interventions within low-income settings to reach at-risk populations.

**Limitations**

There were six identified limitations of this study. There was an imbalance in gender representation. Males are underrepresented in the data ($n=6$) and females are overrepresented ($n=110$). Secondly, there was an overrepresentation in the variable, school affiliation, as there was a greater response from participants enrolled in LSU ($n=38$) and USM ($n=65$). Also, from USM, TSU, and LSU participants were recruited from select educational departments. Departments of recruitment include Social Work, Child and Family Studies, Chemistry, Education, Psychology and Coastal Reliance. With many participants yielding from such departments, those students may be more likely to support formal help-seeking for mental health needs and may be more willing to seek help for mental health needs as doing so would be likely aligned with their personal and professional values. Fourth, neither instrument, the Willingness-To-Seek-Help Instrument and the General Help-Seeking instrument were specifically created with sensitivity to participants of people of color. Data is made available due to self-report including responses that contribute to Willingness-To-Seek-Help scores, General Help-Seeking
scores, minority status and evidence of formal help-seeking within the past twelve months. Due
to Covid-19 safety policies, formal help-seeking was limited for a period due to distancing
requests and occupancy restrictions on many college campuses.

**Future Research**

Qualitative findings show that even when individuals choose to seek formal help, there is
hesitancy to comply and commit to mental health treatment due to racial differences between the
provider and the participant. As a result, future research should assess the impact of mental
health treatment of people of color by mental health professionals of color. These findings
support the literature that shows that there is a lack of diverse mental health professionals and
therefore, people of color have opted out of treatment options due to fear of being stigmatized by
White professionals (Suite et al., 2007). Qualitative findings show that even when individuals
choose to seek formal help, there is fear of being misunderstood due to cultural differences
between the provider and participant. As a result, future research should assess minority
willingness to seek help when the treatment professional is also a person of color. Based on such
findings, future research should assess the impact of formal mental health utilization and
treatment outcomes of minorities as it relates to case assignment to a mental health professional
of color as diversity in healthcare fields makes a difference. Diversity integration within
organizations requires systematic, multimodal responses that are well integrated into overarching
strategic responses that will transform the entire organization (Griggs & Louw, 1995). This type
of change at the structural level, shows evidence of true institutional transformation which could
make a difference in the decision to seek formal help by minorities. Following findings reporting
the impact of stigma, future conversations will require attention to methods that can be utilized to
not only reduce embedded bias, but also to reduce negative stigma and the poor reputation
associated with a perceived legacy of discrimination within healthcare settings. Social workers have the skill, practice, expertise, passion and intellect to be at the forefront of this conversation.

Based on findings related to fear of stigma and feelings that mental illness associates an individual with being “part of the problem” in society, future research is needed to more fully understand the impact of social and political factors on the mental health of African American emerging adults. It is important to view these issues through a critical race lens and pay attention to racial, cultural, and economic factors when studying this population. According to Umberson (2017) and supported by the findings of this work, future research should estimate racial differences in the life course. Studies should identify populations at a high risk of loss and document the consequences of loss for these populations and how these consequences vary across geographic locations (Umberson, 2017). Future researchers should work to develop coping-based interventions that can help African Americans combat the negative psychological and physiological effects of racial discrimination (Hope et al., 2015). Future researchers could also benefit from engaging African American emerging adults in interventions that encourage their participation in social and civic engagement (Hope et al., 2015). Further educational efforts should be considered as stigma and stereotypes surrounding mental illness are still common issues despite use of current approaches and awareness efforts (Mezuk et al., 2021). Quantitative findings in this work support the trend of low willingness to seek-help and low rates of help-seeking among emerging adults warranting the need for more creative and innovative educational approaches to combat stigma and increase formal utilization rates. To address the issue, future research should narrow down what type of educational approach is most impactful on reducing stigma, providing information on mental health and increasing interest in formal mental health treatment.
Conclusion

The current study assessed willingness to seek-help and general help-seeking and provide context in further understanding mental health service barriers, explain motivations connected to professional help-seeking and narrate a perspective of the black help-seeking experience that is under-reported. The literature shows evidence of existing mental health illnesses that continue to be untreated among emerging adults and findings of this study support such. Despite the continual conversations regarding mental health, efforts to increase awareness of mental illness and offer formal services, findings of this research show that internal and external barriers continue to impact overall willingness to seek help and general help-seeking intention for formal mental health treatment among minority emerging adults.

Just as reported in existing literature that minority emerging adults are less likely to seek formal help than non-minorities, findings of this research show that the phenomenon of underutilization among minority emerging adults continues in some areas in the south. Race and age were in fact, predictive factors of lower Willingness-To-Seek-Help scores. Age, Gender and School Affiliation were predictive of General Help-Seeking scores among African American emerging adults. In making connections between constructs of the Health Belief Model and qualitative findings, there is evidence that perceived susceptibility, perceived severity, self-efficacy, perceived benefits, perceived barriers, cues to action and social support influence the formal help-seeking experience of African American emerging adults.

Qualitative findings also revealed how stigma and spiritual reliance are influencing factors in the role of formal help-seeking. Common informal supports and alternatives to formal help-seeking include consulting peers, friends or family members, praying, submitting to a “higher power” or practicing self-reliance all of which provide greater understanding to not only
why formal mental health service utilization rates tend to be lower for minorities but how other options equate to meaningful support. Findings of this research, provide causes of distress which gives insight into what type of support should be offered to emerging adults enrolled in the university during a time of a pandemic or other times of distress.

In connecting these findings, the Theory of Emerging Adulthood, general help-seeking intentions and willingness to seek-help, it is suggested help-seeking follows meeting four conditions and all must be met before one seeks formal help. The four conditions include admitting a need for help that extends beyond self-help, readiness for self-disclosure, readiness to relinquish control over one’s life to some degree and willingness to change (Keith-Lucas, 1994). When these pre-conditions are met, only then is an individual willing to seek help for their needs. Findings of this research support the combination of concepts as emerging adults who sought formal help within the last 12 months reported a need for greater support, a desire to adhere to treatment for the perceived benefit of regaining life control, and an openness to learn healthier coping strategies in preparation for future life possibilities. Qualitative results from this study align with the combination of concepts as emerging adult participants referenced some pre-conditions met in their formal help-seeking experience. Aligned with psychological characteristics of emerging adulthood, these findings report that self-focus and the need to be financially and mentally stable in life did positively impact formal help-seeking.

While the process of receiving formal mental health services is more widely discussed, overall, these findings show that many minority emerging adults still hold reservations. As a result, practice, policy and social implications are suggested to further understand, treat, and prevent mental health illness in emerging adults especially those of diverse backgrounds being that the impact of stigma, lack of access, and limited mental health resources persist.
APPENDIX A. WILLINGNESS-TO-SEEK-HELP QUESTIONNAIRE

1. If I were afraid of heights, I would try to conceal this from my friends.
2. No conflict in our marriage could be so severe that my partner and I could not solve it on our own.
3. Were a problem to develop in my sex life, I would either need to solve it alone or to live with it, because I would not be able to discuss it with anyone.
4. If, for whatever reason, I were to have prolonged difficulty walking, I would do whatever possible to avoid asking help from anyone.
5. When something breaks down in my home, I usually persist in trying to fix it myself, even when it is difficult and I am wasting time and money.
6. If I were suddenly afraid to go out in the street, I believe I could overcome without help from anyone else.
7. If a serious problem were to arise in my marriage, I would be willing to talk about it with a professional, or with a friend or relative, but in any case I would not keep it to myself.
8. Sexual problems are a difficult topic to talk about, but if I were to have such a problem I would use the services of an expert.
9. If I ever have difficulty seeing, I will try to arrange my life so no one will notice.
10. If I were to lose control and hurt my child in a moment of anger, I would need to make sure that no one would know about it.
11. Discovering unexpectedly that my spouse was hitting my child too hard would lead me to seek out someone who could intervene as quickly as possible.
12. Were my spouse to suggest that we go to a family therapist, I would take the position that we are able to solve our own problems.
13. I believe that a time of mourning for a loved one would be a time when I would need other people.
14. If both my legs were to be broken in an accident, I would prefer to stay home for a few months rather than be pushed around in a wheelchair.
15. Some problems are so distressing that they cannot be managed alone.
16. If I were to develop an irrational fear of the dark and I were concerned that it might affect my child, I would seek out a person who could help me overcome my fear.
17. At the funeral of a loved one, I would do all I could do appear strong and not show any weakness.
18. If I had a chronic illness, such as diabetes, I would seek out persons who could offer me guidance in addition to the medical treatment.
19. If a member of my family were to become mentally ill, I would hope for contact with an expert who could advise me in how I might be of help.
20. If I thought I had a problem of excessive drinking, I could discuss it with persons who might be able to help me.
21. Problems of sexual dysfunction would cause me to seek outside help.
22. During a period of bereavement for a loved one, I would allow friends and relatives to take over some of the tasks for which I am usually responsible.
23. Becoming addicted to drugs is the kind of situation that would cause me to place my fate in the hands of an expert.
24. If, in the course of medical treatment for a physical ailment, I were to experience serious anxiety, I would ask the doctor to treat the anxiety.
25. If I am ever depressed, I will seek out the appropriate person to tell about it.

NOTE: The response format for all questions was:
“3” identify completely with statement
“2” identify with statement
“1” do not identify with statement
“0” do not identify with statement at all

Scoring was reversed on items 1, 2, 3, 4, 5, 6, 10, 19, 25; these were phrased as indicators of unwillingness to seek help.
## APPENDIX B. GENERAL HELP- SEEKING QUESTIONNAIRE

**Question 1 = Personal or emotional problems**

1. If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely  
3 = Unlikely  
5 = Likely  
7 = Extremely Likely

<table>
<thead>
<tr>
<th>Help Source</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de-facto)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>b. Friend (not related to you)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>c. Parent</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>d. Other relative/family member</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>e. Mental health professional (e.g. psychologist, social worker, counselor)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>f. Phone helpline (e.g. Lifeline)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>g. Doctor/GP</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>i. I would not seek help from anyone</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>j. I would seek help from another not listed above (please list in the</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>space provided, (e.g., work colleague. If no, leave blank)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>
### Question 2 = Suicidal ideation

2. If you were experiencing suicidal thoughts, how likely is it that you would seek help from the following people?
   Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

<table>
<thead>
<tr>
<th>1 = Extremely Unlikely</th>
<th>3 = Unlikely</th>
<th>5 = Likely</th>
<th>7 = Extremely Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de’ facto)</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Friend (not related to you)</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Parent</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. Other relative/family member</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. Mental health professional (e.g. psychologist, social worker, counselor)</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>f. Phone helpline (e.g. Lifeline)</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>g. Doctor/GP</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>i. I would not seek help from anyone</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>j. I would seek help from another not listed above (please list in the space provided, e.g., work colleague. If no, leave blank)</td>
<td>1 2 3 4 5 6 7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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APPENDIX C. QUALITATIVE INSTRUMENT

1. Everyone has a bad day. When you are discontent/overwhelmed, how do you feel and who makes up your support system?

2. When you feel distressed for any reason, what do you do to feel better? Possible responses: Look for self-help, family, religion, spiritual, alternative medicine, traditional healers, medical practitioners other allied health, other. Explain:

3. As it relates to the question above, do you find these actions helpful in alleviating your stress? If so, how?

4. What issues, if any, have you encountered when attempting to seek professional help for mental health needs?

5. What would motivate you to seek mental health treatment if you ever needed services? OR What motivated you to seek mental health treatment when you needed services?

6. Some people do not seek mental health treatment because they feel ashamed, or they think that strong people should be able to handle their own problems. Have any of these thoughts or feelings motivated you to not seek mental health treatment or support? Please explain.

7. In your opinion, what would increase your willingness to seek mental health treatment?

8. In your opinion, what steps need to be taken to remove stigma in seeking mental health services among college students?
APPENDIX D. IRB APPROVAL

ACTION ON EXEMPTION APPROVAL REQUEST

TO: Tamecia Curry
Social Work

FROM: Dennis Landin
Chair, Institutional Review Board

DATE: October 31, 2019

RE: IRB# E11925

TITLE: The Relationship Between Willingness to Seek Help and Help Seeking Behaviors


Review Date: 10/30/2019

Approved X Disapproved

Approval Date: 10/31/2019 Approval Expiration Date: 10/30/2022

Exemption Category/Paragraph: 2a

Signed Consent Waived?: Yes

Re-review frequency: Three years

LSU Proposal Number (if applicable):

By: Dennis Landin, Chairman

PRINCIPAL INVESTIGATOR: PLEASE READ THE FOLLOWING –
Continuing approval is CONDITIONAL on:
1. Adherence to the approved protocol, familiarity with, and adherence to the ethical standards of the Belmont Report, and LSU's Assurance of Compliance with DHHS regulations for the protection of human subjects*.
2. Prior approval of a change in protocol, including revision of the consent documents or an increase in the number of subjects over that approved.
3. Obtaining renewed approval (or submittal of a termination report), prior to the approval expiration date, upon request by the IRB office (irrespective of when the project actually begins); notification of project termination.
4. Retention of documentation of informed consent and study records for at least 3 years after the study ends.
5. Continuing attention to the physical and psychological well-being and informed consent of the individual participants, including notification of new information that might affect consent.
6. A prompt report to the IRB of any adverse event affecting a participant potentially arising from the study.
8. SPECIAL NOTE: When emailing more than one recipient, make sure you use bcc. Approvals will automatically be closed by the IRB on the expiration date unless the PI requests a continuation.

* All investigators and support staff have access to copies of the Belmont Report, LSU's Assurance with DHHS, DHHS (45 CFR 46) and FDA regulations governing use of human subjects, and other relevant documents in print in this office or on our World Wide Web site at http://www.lsu.edu/irb
REFERENCES


social support on service use for recurrent episodes of mental health distress among primary care patients. *The Journal of Behavioral Health Services & Research, 45*(1), 90-104. [https://doi.org/10.1007/s11414-016-9545-4](https://doi.org/10.1007/s11414-016-9545-4)


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VITA

Tamecia M. Curry received a BSW and MSW from the University of Southern Mississippi. She is currently an instructor at The University of Southern Mississippi. She has worked as a school-based clinician for Hattiesburg High School and a Pine Belt wraparound facilitator serving families and at-risk youth in need of mental health service intervention. As a Southern Regional Education Board Fellow, she has traveled the nation to participate in initiatives focused on the enhancement of teaching, mentoring, diversity, equity, and inclusion. Upon completion of her doctoral degree, she will continue mental health research and service within academia.