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Something Like a Phenomenon: High Achieving Women of Color and Experiences of Mental Health Resource Utilization

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Something Like a Phenomenon: High Achieving Women of Color and Experiences of
Mental Health Resource Utilization

A dissertation submitted in partial fulfillment
of the requirements for the degree of
Doctor of Philosophy in Counselor Education and Supervision

by

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ABSTRACT

The purpose of this study was to examine, explore, and understand the lived experiences of high-achieving Black and Latina women who had utilized mental health services in the last 18 months. The impact of discrimination and stigma is present today and may manifest itself within communities of color when these individuals attempt to access mental health services. The counseling field and counselor education programs are ethically responsible for integrating social justice counseling into coursework and practice. This informs educators and counselors of barriers that may influence and impact best practices for providing mental health services to communities of color. A qualitative design using the transcendental phenomenological approach was used to describe the meaning and experiences ascribed to utilizing mental health care and any perceived stigma. Nine participants were recruited to participated in individual semi-structured interviews consisting of 12-16 questions. Participants were African American women (AAW) with a minimum of two college degrees and a minimum of at least 2 years working in their chosen fields. Data were analyzed using methods outlined by Moustakas' (1994) data analysis procedures.

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DEDICATION

This dissertation is dedicated to my family, my friends, and colleagues who are like family and to the incredibly powerful women who participated in this study. This journey has been incredibly challenging and exciting. I would not be here without my support system and your encouragement has meant the world to me.

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CHAPTER I: HIGH ACHIEVING WOMEN OF COLOR AND EXPERIENCES OF MENTAL HEALTHCARE UTILIZATION

The American Counseling Association (ACA) outlines core values for all counseling professionals to adhere to provide the best possible care to clients (American Counseling Association, 2014). The mission of the organization is to foster the professional development of counselors, advocate for the profession, and ensure ethical culturally inclusive practices that protect those utilizing counseling services (ACA, 2018). As the United States becomes increasingly diverse, the needs of clients change with the country.

The World Health Organization (WHO) offers an overview of mental health experiences and their relationship to gender. Gender is an important factor in mental health and mental illness (WHO, 2021). The organization reports that depression, the second leading cause of disability globally, is twice as common in women than in men (WHO, 2021). There are differences between genders regarding the age of onset, frequency of psychotic symptoms, course, and social adjustment outcomes of depression (WHO, 2017). The common risk factors for mental disorders that disproportionately impact women include but are not limited to gender-based violence, inequality in income, lower social status and rank, as well as the responsibilities that come with taking care of others (WHO, 2017). Doctors are more likely to give a depression diagnosis to women than men, even when symptoms are similar (WHO, 2017). Women are more likely to be prescribed psychotropic medications, and stereotypes ascribed to gender reinforce social stigmas (WHO, 2017).

As of 2020, the United States' population is a staggering 331,893,745 people (United States Census Bureau, 2020), with African Americans (AA) and Latinx Americans (LA) people representing 31.1% of the whole (United States Census, 2020). Women represent 50.8% of the

total population in the United States. In 2018 African American women (AAW) represented 13.7% of the population, and Latina women (LW) represented 17.8% of the population. By the year 2060 it is projected that women of color (WOC) will be a majority, accounting for 51.5% of all women (Vespa et al., 2020).

A Substance Abuse and Mental Health Services Administration (SAMHSA, 2020) national survey of over 67,000 people from all 50 states, reported that 8.7% of Non-Hispanic AA adults over 18 received mental health services. The same survey reports that co-occurring substance use is more frequent among AA adults with serious mental illness as well as an increasing gap in treatment needed for AAs (SAMHSA, 2020). The Centers for Disease Control and prevention reports that AAW are at a high risk of suicide during high school with a 70% greater likelihood of attempting suicide compared to their White counterparts (CDC, 2019). Two in nine LA people were reported to have a serious mental illness and 39.6 % of LA adults (26-49) received no treatment for serious mental illness (SAMHSA, 2020). There was an increase in major depressive episodes in the LA population ages 18-49 from 2015 to 2018 (SAMHSA, 2020). The demographics in the United States are continually changing and mental health issues continue to impact women and communities of color. Clinicians should prepare to work effectively with an ever-evolving population.

Social justice and culturally responsive counseling are subjects often discussed and researched within the counseling field (Constantine et al., 2007). The ACA acknowledged the importance of social justice and advocacy by adding them to the code of ethics in 2005. Ideally, these topics would be part of the curriculum in all counselor education programs to prepare counselors in training to meet the needs of a diverse society and help those in the profession to acknowledge that oppression is a reality for many marginalized communities (Marsella &

Pederson, 2004; Toporek & McNally, 2006). Social justice is an acknowledgment of the power imbalance that exists in society and creates disadvantages for individuals who are members of marginalized communities (Crether & Ratts, 2008). However, disparities still exist in mental health utilization between women and minorities and White individuals (Davis, 2005). Education and socioeconomic status play a major part in what resources can be accessed. Those who have a higher socioeconomic status are more likely to have more access to mental healthcare (Hatzenbuehler et al., 2013). If we take into consideration how those who make more money have better access to mental healthcare, why then do those with higher education and high socioeconomic statuses who belong to a minoritized group still have higher rates of depression, anxiety, and other mental health issues? What happens in the counseling space when this group utilizes mental health resources? It is important for us to examine the factors that contribute to their mental health resource utilization or the lack thereof.

Currently, there is a lack of research exploring the experiences of educated women of color in professional work roles and how they do or do not access mental health care services; and more specifically, the role of stigma in why someone does not seek mental health care or stops seeking mental health care.

Statement of the Problem

The history of racism and oppression in the United States perpetrated against minoritized people coupled with racist people, policies, and systems increase disparities within the healthcare field for communities of color. One well-known case is the scientific testing done on AA using syphilis in the Tuskegee Experiment in the 1930s (Gray, 1998). Enslaved AAW were used to advance the field of modern gynecology in the late 1850s. The exploitation of AA bodies for scientific purposes has been documented well in scholarly literature. This painful history has

exacerbated disparities in the seeking and treatment of both mental and physical healthcare for women of color. The racism experienced by AAW and LW today is not new and has been pervasive throughout systems in which they are expected to exist. For many years minoritized women were excluded from education, healthcare, and professions that only allowed space for those who identified as White, privileged, male, and affluent. AAW and LW face stereotypes inside and outside of work settings that impact their personal and professional lives. These stereotypes include archetypes that portray AAW as either unattractive mothers who only find worth in taking care of children (also known as the Mammie), an aggressive and angry emasculating woman (aka Sapphire), the strong hard-working woman with endless resilience, or an immoral sexually promiscuous and available woman (aka Jezebel). An AAW stereotypical archetype is the uneducated, poor single woman who does not work but takes advantage of public assistance (aka the welfare queen) (Collins, 2000; West, 2008; Woodard & Mastin, 2005). LW have been perceived as unintelligent, uneducated, and unproductive (Jackson et al., 1995). LW are stereotyped as being promiscuous women who had multiple children at an early age (Ghavami & Peplau, 2013), the nurturing mother who puts her family first always (marianismo), or a fiery, hypersexual woman who embodies sensuality (Faulkner, 2003; Galanti, 2003; Lopez & Chesney-Lind, 2014).

AAW and LW are at a higher risk of developing mental illness due to risk factors like poor health, double minority status (i.e., double stigma), and the strain of having multiple roles. In Latin American countries, violence is one of the top five causes of death and is the principal cause in countries like Brazil, Colombia, Venezuela, El Salvador, and Mexico (Buvinic et al., 1999; Hernandez, 2002). People from those countries immigrate to the United States looking for a better life but instead often face further struggles due to living in neighborhoods with higher

levels of poverty and violence (Crowley et al., 2006). Many people in the LA community face obstacles when attempting to access health services (including mental health) such as language barriers, economic barriers (i.e., financial accessibility), and stigma (Fortuna et al., 2009; Perez & Fortuna, 2007).

One identified gap in the literature is the experience of AAW and LW who have achieved high levels of education and achieved professional career goals, and what their experiences are when they seek mental health services. A literature review resulted in articles that explore minority women, stigma, and gaps in treatment. However, high achieving women who seemingly have resources available to them do not appear to have been studied. These women are often pillars of strength in their families and communities, but their experiences of seeking and receiving mental health services are not well known. Of particular interest is their perception of stigma, despite having post-secondary education, graduate degrees, and higher incomes.

Rationale and Significance

Understanding the experiences of this population of women will fill a gap in the literature pertaining to work, stigma, racism, and mental health utilization. The data gathered from the study contributes to further understanding of how high-achieving women of color experience the counseling space and what barriers are still in place that impedes their access and use of those resources. Information gathered provided some insight into how women of color continue to be impacted by systems of oppression. Thus counselors, educators, supervisors, employees, and health insurance entities can be better informed about the needs of working educated women of color.

The core values of the ACA lists integrity, proactive leadership, social justice & empowerment, and diversity, equity, and inclusion. The “Bumper Sticker” goes on to state that

“Everyone counts, Everyone has opportunity, and Everyone is welcome” (ACA, 2020). If these core values are meant to be integrated into practice and training, it will require the profession to look at disparities in service. No longer is it acceptable to talk about how important these core values are, it is imperative that action be taken to demonstrate the commitment to these core values. Forming a task force is not enough, nor is it sufficient to continually report the lack of knowledge without attempting to fill the gaps for counselors. These disparities will need to be noted and explored to advance the vision of diversity, equity, and inclusion. Furthermore, the information from this study contributes to the field and hopefully manifests best practices for counselor educators and supervisors. This study contributes to the ACA’s vision of social justice counseling (ACA ethics code, 2014).

Purpose of Study

The purpose of this study was to examine the lived experiences of high achieving women of color (HAWOC) who perceived stigma while utilizing, accessing, or attempting to access mental health services and what contributed to a positive or negative experience. This study also attempted to understand what, if any, role stigma played in delaying or terminating mental health services. These services include mental health counseling, mental health consultations, telehealth counseling services, inpatient treatment, and any kind of mental health assessment.

This research was conducted using a transcendental phenomenological design that has been made popular by qualitative researchers and Moustakas (1994). The transcendental philosophy emphasizes understanding individual experiences while setting aside preconceived notions and bias (Moustakas, 1994). For this study, each person’s experience was the primary source for knowledge and meaning making. Thus, the researcher utilized online communities and counseling professionals to recruit HAWOC who participated in individual semi-structured

interviews. The study explored experiences of 9 participants, as this is within the recommended number stated by Creswell et al. (2007).

Research Questions

In phenomenological research, it is common to have several broad research questions focused on a specific population of individuals (Creswell, 2007). The following research questions informed this study:

1. What are the lived experiences of high-achieving women of color utilizing mental health care services?
2. What factors contributed to either the cessation of or the continuation of services?
3. In what way if any did stigma impact the start or cessation of services?

Researcher Position in the Study

As an AAW who has worked in professional and managerial positions in the past, I needed to assess my own bias and assumptions as the study progresses. My experience seeking mental health services both with and without insurance had both positive and negative aspects. While I had some success utilizing therapy through insurance, there were a limited number of sessions allowed and I struggled to find the right counselor. My counselor was a White woman and while she was very kind and knowledgeable, we never discussed identity, race, or how those things impacted me and my mental health. I eventually ceased counseling because of the lack of identity discussions and the number of sessions were limited. I was hesitant to disclose that I was utilizing therapy at my workplace due to the negative attitudes and comments I had observed from those in positions of power. Before I decided to pursue this study, I had to acknowledge that my experiences might have been negative but that may not be the case for all AAW and LW.

I journaled my thoughts and reactions after each interview and include those in my report of the research.

Definition of Terms

Certain terms are referenced throughout this research. Following is a list of terms that are used frequently and their definitions in relation to this study.

High Achieving Women of Color (HAWOC): Individuals who 1.) Identify as being biological female 2.) identify with being Black/AA descent and/or Hispanic/Latina and 3.) currently work or formerly worked for at least 2 years in a white-collar occupation and 4.) utilized or attempted to utilize mental health services during their time in that occupation. 5.) possess a graduate degree and are employed in a high-status occupation.

Stigma: a collection of negative attitudes, beliefs, thoughts, and behaviors that influences the individual, or the public, to fear, reject, avoid, be prejudiced, and discriminate against people with mental disorders. Stigma is manifest in language, disrespect in interpersonal relationships, and behaviors (Gary, 2005)

Double Stigma: the increased stigma that occurs as a result of belonging to stigmatized groups (ethnic minority and those with mental illness) (Gary, 2005)

Coping: The constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as stressful or exceeding the individual's resources (Lazarus & Folkman, 1984).

CHAPTER II: REVIEW OF LITERATURE

The following chapter outlines literature that establishes the relationship between what is known and what still needs to be addressed regarding Black and LW. There is a plethora of research that addresses mental health issues and women, mental health and Black/Brown communities, and the history of mistrust that exists between those communities and the medical and mental health professions. The studies outlined below help us to understand where this study fits into the current literature.

Mental Health

Mental healthcare includes emotional, psychological, and social well-being and is important at every stage of life (MentalHealth.gov, 2020). Despite empirical evidence that some interventions are effective, many people either do not seek mental health services, or discontinue services (American Psychiatric Association, 2000; Corrigan, 2004; Proctor, 2002). The reasons for this are many and varied. Reasons can include external barriers like geographic location, financial constraints, and availability of service providers. Internal factors include attitude towards help seeking behaviors, internal and external stigma, and cultural views of mental illness (Corrigan, 2000: 2004). People with lived experiences of mental illness often report feeling devalued, dismissed, and dehumanized by health professionals (Hamilton et al., 2016). People with lived experiences of mental illness also report feeling stigmatized by the public (stereotypes, prejudice, and discrimination) as well as internalizing that public stigma which results in negative beliefs about the self (Corrigan & Kleinlein, 2005). Mental illness-related stigma, including that which exists in the healthcare system and among healthcare providers, has been identified as a major barrier to access treatment and recovery, as well as poorer quality physical care for persons with mental illnesses (Knaak, et al., 2017). The United States mental

health care system has historically ignored the experience of mental health disorders among minorities with respect to prevention, treatment methods, and overall research (Hunn & Craig, 2009). The United States has a history of prejudice and discrimination against African Americans (AA), Latinx Americans (LA), and other minority groups. That prejudice and discrimination continue to be seen today. Minority group members with mental illness experience discriminatory practices in multiple spheres of society including policy, research, clinical settings, and at work (Anderson, 2013; Corrigan 2004b; Williams, 2009). The overlap of stigmatized identities results in double stigma and self-stigma (Corrigan, 2004b; Gary, 2005; Link et al., 2001). AAW and LW report higher levels of stress, poverty, and marginalization when compared to their White peers (Araugo, 2006; Benjamin, 2013; Dolezsar et al., 2014; Mathunjwa-Dlamini et al., 2011). Within the AA and LA populations are subgroups that need to be considered regarding their mental healthcare needs. This includes AAW and LW who are working in professional fields.

Mental Health, African Americans, and Latinx Populations

The mental health care system in the United States consistently overlooks the experience of minorities with mental health disorders with respect to prevention, treatment methods, and overall research (Hunn & Craig, 2009). There has been an increased focus on factors that may contribute to low rates of utilization of mental health services by AA, specifically African American Men (AAM) (Williams & Cabrera-Nguyen, 2016). AAM are underrepresented in mental health utilization and uncovering the factors that contribute to low utilization is crucial. Further, examining how untreated mental health symptoms are responsible for adverse personal and social consequences experienced by AAM could contribute to best practices (Williams & Cabrera-Nguyen, 2016). AAM do not access or utilize mental health services as frequently as

their peers (Evans et al., 2016). The psychological distress experienced by AAM including discrimination, racism, poverty, poor education, and exposure to crime may contribute to the underutilization of mental health services (Plowden et al., 2016). As a result of issues involving masculinity, AAM are less likely to acknowledge mental health concerns or seek treatment when it is needed (Hack et al., 2017). It is imperative that practitioners consider how these statistics impact the women in the lives of AAM. Nelson et al.'s (2016) qualitative study found that AAW still conceptualizes being a strong black woman (SBW) through specific characteristics including independence, high achievement, and taking care of family. Included in these families are AAM who bring with them their own mental health issues and struggles. AAW make meaning from their roles in the family and community and mental health clinicians need to consider this when trying to understand the complexity of that meaning making (Nelson et al., 2016).

The health and mental health of AA and LA populations are impacted by their living arrangements. Substandard housing, constant worry regarding personal safety, increased crime rates, noise, pollution, and lack of resources all work together to discourage healthy community environments (Amutah, et al., 2016). Additional evidence suggests that repeated exposure to violence, crime, and lack of resources contribute to the onset of psychological disorders including depression, anxiety, anger, stress, and Post Traumatic Stress Disorder (Perry, et al., 2015). Certain minority groups, including AA and LA patients, are less likely to be involved in their care (Eliacin et al., 2016). Research suggests that many individuals in minority populations are less likely to be proactive about their mental healthcare due to a lack of awareness about how visit preparation may help, having a history of negative patient-provider relationships, and beliefs involving the healthcare visit such as not wanting to undermine the authority of mental health professionals (Eliacin et al., 2016). Campbell (2017) noted that to better understand

disparities in mental health and service utilization, it is imperative to take a closer look at the experiences of AA and LA populations including personal experiences with the specific disorder, a history of help-seeking behaviors, and patterns of service use. Prevalence rates reveal that AA seeking mental health services present more depression symptoms than people in any other racial/ethnic background (Carrington, 2002; Dwight-Johnson et al., 2001). Social confrontations with racism, sexism, and poverty have resulted in an increased risk of depression and other mental health concerns among AAW (Schulz et al., 2006).

AA tend to be overrepresented when evaluating high-needs populations. Though AAs represent about 12% of the population, their presence in prisons, mental hospitals and homeless populations represent a majority in those settings (Snowden, 2001). NIMH's Consortium on Psychiatric Epidemiology Studies (CPES) funded four studies to examine the prevalence of mental disorders among minorities. The studies compared White, AA, LA, and Asian ethnic groups (Heeringa et al., 2004, McGuire & Miranda, 2008). Although there are more minorities who live in poverty in the United States, and poverty and poor health are positively correlated with mental health disorders, minorities reported lower rates of lifetime mental illness versus their White counterparts (Heeringa et al., 2004; McGuire & Miranda, 2008). However, this does not result in equal treatment when seeking mental healthcare services. According to the Institute of Medicine's Unequal Treatment Report (2004) a disparity is "a difference in healthcare quality due to differences in health care needs or preferences of the patient" (McGuire & Miranda, 2008, pg. 395; Smedley et al., 2003). Research has demonstrated that social determinants such as lower levels of education, lower socioeconomic status, inadequate and unsafe housing, racism, and living in close proximity to environmental hazards disproportionately impact minority populations and thus contribute to their poorer health outcomes (Betancourt & Maina, 2004).

One example of the impact of social determinants is the fact that three of the five largest landfills in the country are in AA and LA communities. Studies have found that foreign born populations have healthier profiles than their US born counterparts (Alamilla, 2020). For example, United States-born LA s have increased rates of depression and substance abuse compared with their foreign-born counterparts, a phenomenon termed the immigrant paradox (Alegria et al., 2007). Anxiety sensitivity, or the fearfulness of anxious and bodily symptoms, has been suggested as a potential mechanism that explains the relationship between stress and depression (Naragon-Gainey & Watson, 2018), and it is estimated that LA individuals may report higher anxiety sensitivity (Piña & Silverman, 2004; Weems et al., 2002) as well as generally higher sensitivity to somatic sensations (Varela et al., 2007) than non-Hispanic White individuals. Researchers found that acculturation was related to depression and was mediated by acculturative stress for the LA population. Researchers found that the association between U.S.-culture acquisition and participant depressive symptoms was mediated by the pressure to be competent in English and pressure against acculturation from the heritage culture. Plainly stated, the association between heritage-culture retention and participant depressive symptoms was mediated by all components of acculturative stress (Castillo et al., 2015).

Mental Health and Women

Good mental health is essential to overall well-being, however 1 in 5 women in the United States experienced a mental health condition in 2019 (U.S. Department of Health and Human Services, Office of Women's Health, 2019). Many mental health diagnoses affect women at a greater rate than men or affect women in different ways. Those diagnoses include depression and bipolar disorder (U.S. Department of Health and Human Services, Office of Women's Health, 2019). Women are twice as likely to have symptoms of depression compared

to men (NIMH, 2020).

There are a variety of factors that contribute to an increased risk of depression among women including living below the federal poverty line (Brody et al., 2018), a family history of depression, a change in hormones (progesterone and estrogen) during the menstrual cycle, pregnancy, and menopause (Brody, et al., 2018; U.S. Department of Health and Human Services, Office of Women's Health, 2019). Women who experience prolonged physical and emotional pain from chronic illness, health issues, accidents, and trauma such as sexual abuse are also at a higher risk of depression (Trivedi, 2004). Additionally, depression is linked to many health issues for women including higher rates of heart disease and obesity (Lichtman et al., 2008; Pratt & Brody, 2014), which can compound medical issues and the need to seek healthcare.

Women are also more than twice as likely as men to have an anxiety disorder in their lifetime (NIMH, 2015). Panic disorders are twice as common among women than men, and women with generalized anxiety disorder have a higher risk of depression and other anxiety disorders when compared to men (Vesga-Lopez et al., 2008; National Library of Medicine: Panic Disorders, 2013). Bipolar I disorder may be diagnosed later in life for women. This can result in increased stress for women who do not know why they may be experiencing manic and depressive episodes (Arnold, 2003). Bipolar II disorder is more common than Bipolar I, and it affects more women than men. Women with bipolar II experience depressive episodes more often than women with bipolar I (Arnold, 2003). Women with bipolar disorder of either type are more likely than men with bipolar disorder to have other physical and mental health conditions, including problems with alcohol use, depression caused by bipolar disorder, thyroid disease, obesity caused by medicines that treat bipolar disorder, and migraine headaches (Freeman et al., 2002). Women who have bipolar disorder are at risk for experiencing a depressive episode after

giving birth, and those same women who experience a depressive or manic episode after giving birth are more likely to have episodes after other pregnancies. Women with bipolar disorder are at high risk of developing postpartum psychosis (Pacchiarotti et al., 2016).

Women are more likely to struggle with the negative perception of body image and eating disorders. Although every 1 in 50 people may have body dysmorphic disorder (BDD), the condition is more common in women and usually starts in adolescent years (Body Dysmorphic Disorder Foundation, n.d.). Anorexia affects more girls and women than boys and men and is a serious health problem that can increase the risk of early death. Anorexia is also more common among girls and younger women than older women. On average, girls develop anorexia at 16 or 17 (National Collaborating Centre for Mental Health, 2004). Teen girls between 13 and 19 and young women in their early 20s are most at risk, but eating disorders are happening more often in older women. In one recent study, 13% of American women over 50 had signs of an eating disorder (Gagne, et al, 2012).

Women experience higher diagnosis rates of certain personality disorders. Women are more likely than men to have a borderline personality disorder (BPD) diagnosis. BPD is a serious mental illness that causes unpredictable or unstable moods and affects a woman's self-image, work-life, and sense of identity among other things. BPD affects 1 in 100 adults, mostly young women and co-occurs with other mental health conditions like anxiety, eating disorders, and substance use disorders (NIMH, 2020: BPD, 2016). The disparity in BPD between men and women could be due to implicit bias, which is yet another burden women carry within the health care system.

The experience of a variety of mental health issues within the female population indicates that many of these women are likely to seek mental healthcare services at some point. Therefore,

it is important to understand how women have been treated within mental healthcare settings historically and currently.

A History of Hysteria

Hysteria is the first mental disorder attributed to women, and Freud considered hysteria an exclusively female disease (Tasca et al. 2012). The first to use the term Hysteria was Hippocrates in the 5th century BC, and he believed (similarly to Plato) that the issues for women start in the uterus. According to the Greek physician the uterus is restless and due to a subpar sex life, women needed to expel poison and stagnant humors (Tasca 2012; Sterpellone, 2002). In the Middle Ages the Roman Empire had fallen and physicians had inherited a medical culture. Doctors had taken refuge in an area between Egypt and Iraq, and with them they brought knowledge of classic science, and this contributed to the spread of theories about the uterus being the source of madness. From the Middle East to Europe the messages about Hysteria spread. Hypnosis and smelling salts continued to be common treatment for hysteria. Treating the uterus became known as best treatment in the “scientific” vision in informed circles. For thousands of years women were thought to have mental disorders that stemmed from three general theories of the etiology of mental illness: supernatural, somatogenic, and psychogenic. Supernatural theories attribute mental illness to possession by evil or demonic spirits, displeasure of gods, eclipses, planetary gravitation, curses, and sin (Tasca et al., 2012; Farreras, 2019). Somatogenic theories identify disturbances in physical functioning resulting from either illness, genetic inheritance, or brain damage or imbalance. Psychogenic theories focus on traumatic or stressful experiences, maladaptive learned associations and cognitions, or distorted perceptions (Farreras, 2019). Further, mental disorders in women resulted in scientific bias. Women were unfavorably perceived as being sinful, a view believed to be particularly true if they did not procreate. These

perspectives resulted in women being misdiagnosed, misunderstood, and treated for disorders such as Hysteria (Tasca, 2012). The treatment for hysteria in ancient Egypt included forcing the uterus to return to its natural position. If the uterus was too high, the woman was treated by placing acrid substances near the hysteric woman's mouth, while scented substances were placed near the vagina. The treatments were reversed if the uterus was too low (Sigherst, 1951; Cosmacini, 1997; Tasca, 2012). Although these treatments seemed strange and outlandish by today's standards, the Egyptians were not the only people to treat the "woman's disease" in hard-to-understand ways. What must also be considered is the idea that women were inferior to men. This belief was widely accepted and many women like Hidegard of Bingen and Trotula de Ruggier (both considered to be some of the earliest female doctors) were discredited by influential men at the time. It was not until the 18th century that the idea of hysteria started to be associated with the brain instead of the uterus. This meant that hysteria could be found in both sexes. It was not until the father of psychoanalysis, Sigmund Freud, confessed to having hysteria himself did attitudes about it being a woman's disease change (Loughran, 2008; Tasca et al; 2012). This history demonstrates that there is evidence that women have often been misunderstood. Due to the anatomical and physiological differences between the sexes, the medical community would look to the uterus for lack of a better source of illness or psychosis (Tasca, et al., 2012). Beliefs about women and their inferiority would manifest itself throughout history and in modern medicine as stigma, underutilization, and the marginalization of women, and more specifically, women of color.

Women of Color and Mental Health

Women of color (WOC) experience not only sexism but also ethnic discrimination (Anderson & Fitch, 2017; Arellano-Morales et al., 2015; Benjamins, 2013). AAW are vulnerable to experiencing the mental and physical challenges of depression and are subject to misdiagnosis, underdiagnosis, and overall mistreatment (Carrington, 2002). Although there have been efforts to remove barriers and close the gap in services, barriers to access persist for minority women within the healthcare and mental healthcare fields. When accounting for socioeconomic status, increased rates of depression among low-income AAW have been identified, including the finding that these women often have increased levels of stress, leading to depression among as well as other mental health disorders (Nadeem et al., 2008). Yet, the aspects of the overall experience of being a WOC needs further exploration and consideration. While it is evident that low-income AAW are at high risk for mental health concerns such as depression, little is known regarding culturally competent treatment and prevention methods (Nadeem et al., 2008). LW may experience both ethnic discrimination and sexism. Some studies cite that 50% to 75% of LA individuals experience ethnic discrimination at least once in their lifetime (Arellano-Morales et al., 2015; Pew Research Center, 2016). LW, particularly adolescents, engage in more suicide behaviors than other groups (Romero et al., 2014). Specifically, Latina high school students, when compared with non-Hispanic White and LA male high school students, had higher rates of suicidal thoughts (21% vs. 18.4% and 2.6%, respectively) and suicide attempts (13.5% vs. 7.9% and 6.9%, respectively; Suicide Prevention Resource Center, 2013). A similar pattern emerged for adults, given that the prevalence rate of suicide attempts for LW was 6.1% compared with 2.7% for LA men (Fortuna et al., 2007). Although ethnic and sex discrimination have been the most studied, LA individuals also experience differential treatment based on nativity/generation

level, documentation status, phenotype, and social class, to name a few, all of which can contribute to mental health problems. For instance, a darker skin color (e.g., LA individuals who identify their race as Black) has been associated with greater mental health problems (Araújo & Borrell, 2006), particularly among LW (Adames et al., 2016; Telzer & Vazquez-Garcia, 2009). Pregnant AAW receive a lower quality of prenatal care and have worse peripartum outcomes compared to their White counterparts (Huggins et al., 2020). It is well established that inadequate obstetrical care leads to a stark increase in morbidity and mortality in AA mothers and their infants (New York City Department of Health and Mental Hygiene, 2008-2012). Rates of depression and anxiety during pregnancy are thought to be equal across racial groups, with some data showing an increased risk among Black and LW. Despite this, AA and LW are less likely to begin treatment for postpartum depression compared to their White counterparts (Kozhimannil et al., 2011). If treatment is started, there is often a longer delay of care after delivery to diagnosis compared to White women, which is a critical time in the process. AA and LW are also less likely to have follow-up or to receive continuing care after pregnancy (Huggins et al., 2020).

The Lack of Black and Brown Counselors

When researching the number of counselors in the United States, the U.S. Bureau of Labor Statistics (2021) reports that there are a total of approximately 774,270 counselors. This number combines marriage and family, educational guidance and career, rehabilitation, substance abuse, behavioral disorders, and mental health counseling. The National Center for Education Statistics reports that 65,527 Black women conferred their master's degree from 2018-2019, with 4,206 of those women getting degrees in social sciences and psychology, making them eligible to become licensed counselors (2020). In 2015 the American Psychological Association reported that 86% of those in the psychology field are White and 4% identify as

Black (Hamp et al., 2016). According to a report posted on the American Counseling Association, 10.3% of counselors identify as Hispanic or Latino. Considering that 13% of the U.S. population identifies as Black and 18% identify as Hispanic, there simply are not enough counselors with these identities to meet the growing needs of these Black and Brown Communities.

Stigma and Mental Health

Research about people with mental illness (PWMI) has been growing over the last 50 years. Beginning with Erving Goffman's (1963) influential essay *Stigma: Notes on the Management of Spoiled Identity*, research on stigma has continued to grow each year, with a large amount of stigma research occurring in the last decade (Bos et al., 2013). Across disciplines, but especially within the field of psychology, researchers have been primarily concerned with examining mental illness stigma at the individual level (Link & Phelan, 2001). A large amount of research demonstrates that PWMI experience discrimination in nearly every domain of their lives, including employment (Farina & Felner, 1973; Link, 1987; Stuart, 2006), housing (Corrigan et al., 2003; Farina et al., 1974), and medical care (Thorncroft et al., 2007). Experiences of stigma are associated with increased symptom severity (e.g., Boyd et al., 2014), decreased treatment seeking (e.g., Corrigan, 2004) and treatment non-adherence (Sirey et al., 2001). The most common forms of prejudice toward PWMI are fear, pity, and anger (Corrigan, 2005; Corrigan et al., 2004). Prejudice is strongly connected to stereotypes. For example, the stereotype of dangerousness may lead to feelings of fear and the stereotype of incompetence may lead to feelings of pity. Prejudice toward PWMI may also be expressed or experienced as anxiety, leading to awkward interactions (Hebl et al., 2000) and/or serve as a sign to the behavioral aspect of stigma, discrimination. Discriminatory behaviors can be subtle to overt, but

which result in the “differential and disadvantaged treatment of the stigmatized” (Fox et al., 2019; Pescosolido & Martin, 2015, pg. 192). There are four common types of discrimination directed towards PWMI described in the literature: withholding help, avoidance, segregation, and coercion (Corrigan & Rüsch, 2002; Corrigan & Watson, 2002). Stereotypes, prejudice, and discrimination lead to a range of outcomes that affect both people living with and without mental illness. Individuals who endorse stigmatizing attitudes toward PWMI are less likely to support insurance parity (i.e., covering mental illness at the same level as other medical conditions) and increased government funding for mental health treatment (Barry & McGinty, 2014). Depression is a stigmatized condition (Barney et al., 2006; Halter, 2004). and persons who are depressed report more stigma associated with depression than do those who are not depressed (Alvidrez & Azocar, 1999; Pyne et al., 2004). Today, individuals with mental illness are often inappropriately placed in jails and prisons, a practice that has extended over more than two centuries (Buchanan & Leese, 2001; Corrigan et al., 2004a).

Internalized stigma can also have a detrimental effect on well-being (Picco et al., 2016). PWMI can internalize the stigma that is prevalent within society. In this sense, they come to believe and act as if the stigma is a real and legitimate phenomenon (Corrigan, 2004b; Corrigan et al., 2003). A major barrier to psychiatric treatment, internalized stigma exacerbates several health-related issues due to its known ability to obstruct symptom relief and recovery and heighten existing problems such as low self-esteem (Pearl et al., 2017). Discrimination faced at the micro, meso, and societal level can lead to marginalization (Brinkley-Rubinstein, 2015). Keene et al. (2017) highlighted how concealed stigma and isolation can contribute to emotional distress and is a likely contributor to symptoms of anxiety and depression.

AAW/LW and Stigma

Researchers have examined the stigma experienced by women, the stigma that is experienced by minorities, the stigma experienced when disclosing mental illness while in the workforce, and how minority women utilize mental health care resources (Caltaux, 2013; Corrigan, 1998, 2000; Corrigan & Watson, 2002; Corrigan & Mathews, 2003; Goffmen, 1963; Phelan et al., 2008; Rusch et al., 2005). Stigma is a term that is used to convey prejudice or negative stereotyping. It can emit poorly justified and often false information about people that helps to create discriminatory acts against them (Corrigan et al., 2001). Numerous types of stigmatizations and stereotypical labeling of minority groups have endured for centuries (Corrigan et al., 2003; Harris et al., 1996; Jones, 2002; Johnson & Cameron, 2001). Researchers and clinicians, including mental health professionals, have historically attempted to document the inferiority of certain ethnic minority groups in the name of justifying prejudice and discrimination (Anderson & Nickerson, 2005; Helms et al., 2005; Smedley, & Smedley, 2005; Yee et al., 1993). Various researchers have focused on intelligence, physical ability, pain tolerance, emotional regulation, and other traits and characteristics, all attempting to target the inferiority of non-majority ethnic groups (Anderson & Nickerson, 2005; International HapMap Consortium, 2003; International Human Genome Sequencing Consortium, 2001).

Women constantly face stereotypes in our culture. Gender stereotypes include being described as passive, emotional, excitable, illogical, lacking self-confidence, and lacking leadership skills (Broverman, et al., 1972). When women exhibit traits that are traditionally used to describe men they are often seen as less desirable (Heilman, 2001). Considering the attributes needed to pursue degrees and thrive in professional settings, women must worry about how they are perceived while still maintaining credibility. AA and LW are particularly vulnerable to

double or layered stigma. The societal pressure that results from the intersectionality of being a woman and a minority with a mental health illness means that the implications for mental health service providers is vast. Latina and AAW are more likely than white women to endorse stigma concerns (Avidrez & Azocar, 1999; Cooper-Patrick et al., 1997).

Medical Mistrust

AA are likely to be distrustful of medical professionals due to a long history of marginalization and discrimination, including medical experimentation and confinement to psychiatric hospitals (Snowden, 2001). Many medical advancements were developed by using AA people as test subjects explicitly against their will or without full informed consent to the research being done (Huggins et al., 2020). For example, the history of reproductive medicine began with the surgical developments of Dr. Marion J. Sims (aka the Father of Gynecology) who practiced his gynecological procedures on enslaved AAW. Those AAW were often experimented on without anesthesia and were forced to help Dr. Sims by forcibly holding down other AAW during experimental procedures (Washington, 2008). AAW 's ability to reproduce was also tightly controlled throughout history (Huggins et al., 2020). Enslaved AAW were forced to have more children during slavery and restricted procreation was later used to control the AA population. This restriction was based on the belief that AA women could not control their fertility and were this was the source of certain societal problems (Huggins et al., 2020). Involuntary sterilization, a levonorgestrel-releasing implant, and the medroxyprogesterone acetate shot, were largely tested on women of color with the intention of limiting fertility of AAW (Roberts, 1999; Washington, 2008).

Recent research has found that AAW, LW, and Indigenous women are more likely to experience mistreatment by a provider compared to White women (Vedam et al., 2019).

Mistreatment includes being shouted at, providers ignoring requests for help, violations of privacy, coercion of treatment (cesarean delivery or episiotomy), and dismissal of pain (Vedam et al., 2019). These experiences (especially during pregnancy) are associated with pain and suffering, reminders of prior trauma, posttraumatic stress symptoms, sleep disturbances, poor self-rated health, fear of having another child, negative body image, and feelings of dehumanization. Thus, it makes sense that these women would be mistrustful of the medical system. These encounters and outcomes can have a destructive impact on a woman's physical and mental health (Reed et al., 2017; Schroll et al., 2013; Swahnberg et al., 2007). The United States Public Health Service's infamous four-decades-old Tuskegee Syphilis Study serves as a powerful example of the deleterious effects of prejudice and discrimination (Gray, 1998). This one study helps to emphasize the harm that health professionals, in collusion with the federal government, can perpetuate upon ethnic minority individuals in the name of the advancement of science and protection of the public (Gary, 2005; Jones, 2002; U.S. Department of Health and Human Services, 1999). Ethnic minorities who have symptoms or histories of mental disorders experience vastly different access and outcomes than their more socially accepted White counterparts (Pescosolido, Gardner, & Lubell, 1998; Poussaint & Anderson, 2000; Rogler, Cortes, & Malgady, 1991).

Coping, Health Seeking, and Mental Illness in the African American Community

AA tend to cope with stress by using a plethora of strategies including facing and overcoming problems as an act of heroic striving or "John Henryism" (Adams, et al., 1999; Snowden, 2001). John Henryism and "cool pose" are terms used to describe the efforts made by AA to either work excessively hard in overcoming adversity or to develop a certain level of mental toughness to cope with daily life stressors (Mosley et al., 2017). These coping strategies

were developed in response to not fitting into the dominant culture. The AA community places expectations on its members which perpetuates the idea that AA cannot be depressed because they are able to deal with anything (Campbell & Mowbray, 2016). These expectations include the pressure to keep personal matters private, not discussing struggles with strangers, and keeping social distance from those who are perceived as having any mental illness (Abdullah & Brown, 2011; Rao et al., 2007).

A study by Samuel (2015) explored the attitudes of AAs toward mental illness. Study participants reported minimal tolerance of mental illness by the AA community and the thought of having a mental illness indicates signs of weakness or laziness, which would result in internalizing one's experiences as opposed to seeking help (Samuel, 2015). The AA community has associated mental health treatment with personal inadequacy which further contributes to low utilization of mental health services (Samuel, 2015). It is reported that only 15.7% of AAs who have been diagnosed with a mood disorder seek help (Avent, Cashwell, & Brown-Jeffy, 2015). Greater stigma around needing mental healthcare, such as what has been observed in the AA population, reduces AAs' openness to seek treatment (Hopkins & Shook, 2017). Burkett (2017) stated that to gain an accurate understanding of the low utilization of mental health services in the AA population requires an increased focus on the social and cultural experiences of the AA population including the effects of trauma, feelings of medical mistrust, and the environment. Independence is a major component of masculinity within the AA culture for many years and impacts why someone may or may not seek help, although it is highly recommended that one receives outside social supports to maintain psychological well-being (Plowden et al., 2016). A study in 2015 examined how AAM cope with stress. Results of the study revealed that most men who were interviewed identified the temporary use of drugs and alcohol as a means of coping

with stress, which was further validated by AAW sampled in the study who maintained that these behaviors were commonly exhibited by AAs. These coping tools are used in large part because of a lack of teaching during their earlier years in how to cope with stress using more positive outlets (Ellis et al., 2015). AAs of faith often look to their community faith leaders for guidance and support during times of emotional distress due to a level of trust in spiritual leaders not afforded to others (Crenshaw, 2015). In coping with everyday stressors, many AAs meet with religious leaders to assist with coping with mental health issues (Okunroumu et al., 2016). The AA church fosters an environment in which communication between congregants and church leaders is frequent, which may also influence beliefs about outside mental health services (Bilkins et al., 2016). Bilkins et al. (2016) cite culture as being a major influence in the attitudes and beliefs held about mental illness and suggest how church leaders' attitudes may also be influenced by their own history or experiences with racial discrimination which may encourage or discourage church members from seeing outside help.

Coping, Help Seeking and Mental Illness in the Latinx American Community

The Pew Research Center reported that in 2017 there were nearly 60 million Latinos in the United States (Pew Research Center, 2019). That is approximately 18% of the population. The 2017 article by Chang & Biegel, explored factors affecting mental health service utilization and dropout rates among LA with mental health issues. The findings revealed that LA with older age, health insurance, a perceived need for mental health services, a mental health need perceived by others are more likely to use mental health services. Further, for LA who were younger, did not have health insurance, and had lower levels of family support were more likely to discontinue using mental health services (Chang & Biegel, 2017). LA mental health care utilization is half that of non-Hispanic Whites (Substance Abuse and Mental Health Services

Administration, 2015). Language barriers, lack of insurance, and a shortage of culturally competent providers, cultural and religious values play a significant role in mental health care disparities (Gonzales et al., 2011).

Per the behavioral model of health, help seeking attitudes is a function of predisposing and enabling individual characteristics coupled with contextual characteristics (Benuto et al., 2020) While there are not as many research studies on the help seeking behaviors of LA (when compared to AA and Asian Americans) Davis and Liang (2015) found support for the theory that the cultural value machismo (high levels of masculinity) among LA is associated with less positive attitudes towards help seeking. Further Mendoza et al. (2015) argued that attitudes towards help seeking among LA is impacted by family values of protecting one's family and family name by not sharing conflicts with those outside of the family.

In a 2019 study Caplan found evidence that among LA baith based communities, mental illness and depression were culturally viewed and perceived to be a spiritual problem rather than an illness. This indicates that LA (particularly Spanish speaking) has a low perception of need for mental health services no matter the severity. Religion and using religion as a coping mechanism coupled with familismo (necessity of family and community support) is considered sufficient to treat mental illness (Caplan, 2019; Moreno & Cardemil, 2013).

Mental Health and Stigma in the Workforce

From a business standpoint, mental illness poses a serious challenge for organizations. Existing research has shown that mental illness contributes to both direct (e.g., health care) and indirect (e.g., lost productivity) costs that costs companies billions of dollars per year (Greenberg et al., 2015). This is due to increased absenteeism, presenteeism (Koopman et al., 2002), and health-care resource utilization among employees. The World Health Organization reported that

neuropsychiatric disorders are now the leading reasons for why people in the United States need disability assistance (WHO, 2017). The rate of individuals experiencing mental illness is increasing (Weissman et al., 2017), indicating the economic impact of mental illness on organizations will continue to escalate. Although we know PWMI have knowledge, skills, and abilities that contribute to organizational effectiveness, the societal stigma faced by individuals with mental illness contributes to structural discrimination in workplace settings, such that individuals with mental illness have reduced access to quality jobs and are less likely to be perceived as promotable (Corrigan et al., 2004; Follmer & Jones, 2017). Examining mental illness as a workplace issue is a timely and important topic, given that many businesses are unprepared to support those with mental illness in a way that is reflected in their policies, procedures, and leadership, and culture (Fairclough et al., 2013). For instance, approximately 25% of organizational leaders reported a lack of confidence in their ability to effectively support employees with depression, while only 13% reported they were “very confident” in their ability (Shann et al. 2014). Another issue that arises for PWMI who work is the idea that because some mental illness is invisible it is thought of as less legitimate (Follmer & Jones, 2017). In a study of absenteeism, employees from both Canada and China rated depression as a less legitimate reason to be absent from work than bad weather, poor transportation, or illness of a family member (Johns & Xie, 1998).

The economic impact of mental illness is large and worth noting. Considering all diagnoses, the U.S. spent \$225 billion on mental health in 2019 between private insurers and public Medicaid programs for low-income Americans (businessinsider.com, 2020). Untreated mental health conditions can result in unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, and suicide, and poor quality of life. The economic

cost of untreated mental illness is more than 100 billion dollars each year in the United States (National Alliance on Mental Illness, 2020).

More research is needed around how occupational status contributes to or impacts health disparities (Williams et al., 2010). Higher-status occupations (“white collar”) are generally associated with better health and well-being (Schieman & Reid, 2009; Schulz et al., 2000), but this protection may not extend to women and minorities. Women who work in high-status careers face characteristically White, male-dominated, highly competitive, and disproportionately stressful occupational environments (National Academy of Sciences, 2007; Frank et al., 1998; Frank et al., 1999). While high-status occupations have been associated with stress for women, limited attention has been dedicated to how occupational experiences may differentially affect the well-being of AA or LW (Hall et al., 2012) or how this relationship may influence racial disparities in health. As professionals, AA and LW must cope with the stress of being a racial and gender minority, in addition to the demands faced by all employees and the occupational stressors associated with the job. As minority women move up the social ladder and obtain high-status professional positions, mobility may have both positive and negative implications for their health (Forman, 2003; Jackson & Stewart, 2003). Stress from “racial stereotyping, exclusion from office networks, harassment, or assumptions of inferior cognitive ability” (Hall et al., 2012, p. 211) is a particularly frequent occurrence for minorities, especially women (Peterson et al., 2004; Schulz et al., 2000; Shrier et al., 2007). Consequently, minority high achieving women who work in predominantly White work environments are more likely to express higher levels of psychological distress (Jackson & Stewart, 2003). It is important for research to identify and characterize mental health risks at all socioeconomic status levels (Jackson & Stewart, 2003) because even those with higher SES

levels may experience occupational stress (Jackson et al., 2010; Williams et al., 2010). Perceived racial discrimination, acute discrimination, and the racial composition of the workplace may be more visible and influential in professional careers because women and minorities are numerical and racial minorities (Jackson et al., 1995). Professional working women reported more discrimination than non-professional working women and those with lower levels of education, which is consistent with other studies that have found that middle-class AAs are more likely to report perceiving discrimination (Peterson et al., 2004) and unfair treatment (Schulz et al., 2000) than low-SES AAs. In the workplace, discrimination can limit the economic opportunities of PWMI. Additionally, these mechanisms prevent people without diagnoses of mental illness from seeking mental health support to avoid gaining the label of mental illness (Corrigan, 2004).

High Achieving Women of Color

Black feminist thought scholar Patricia Hill Collins (1986) described the marginalized and isolated status of AAW in various professional and academic settings as the “outsider-within” (p. S14). Collins (1999) asserted, “outsider-within identities are situational identities that are attached to specific histories of social injustice—they are not a decontextualized identity category divorced from historical social inequalities that can be assumed by anyone at will” (p. 86). Howard-Hamilton (2003) relied on the term coined by Collins and noted that AAW in higher education and high-status occupations

have been invited into places where the dominant group has assembled, but they remain outsiders because they are still invisible and have no voice when dialogue commences. A sense of belonging can never exist because there is no personal or cultural fit between the experiences of AAW and the dominant group. (p. 21)

Dating back to the Black Power movement, AAs began to utilize strength within the community, exposing a positive change in self-esteem development, after making advancements and social strides never accomplished before (Cross, 1991). As more social and professional

doors opened for AA men and women, these changes allowed for a significant expansion of black identity, venturing into higher social status, professionalism, and financial stability, each sustained by the transformations of black identity (Cross, 1991). As black identity began to expand, and black people were able to live beyond pre-determined identities dictated by historically constraining factors (e.g. slavery, Jim crow, segregation), the experiences of oppression did not vanish (Cross, 1991). Not only are men, and more specifically women, challenged by the encounters of racism and sexism, but in addition there are hardships of vocational development as well (Richie et al., 1997). Therefore, AA women are triumphantly progressing in society, attaining social and professional status, ultimately advancing identity and experience, while still being psychologically strained by ever present encounters with interlocking systems of oppression. The construct of the strong black woman schema (SBW) is a response to the stigma of the aforementioned images, ultimately portraying a woman who can complete all tasks and withstand all challenges, with seemingly no psychological challenge or maintenance. The foundation of being strong in the AA community has a positive and consistent connotation yet bares a lot of pressure to uphold that archetype, with many disadvantages for the AAW that are challenged by the task of living within those socially constructed parameters (Walker- Barnes, 2009) There are specific characteristics of the SBW and they are as follows: 1. Embody and display multiple forms of strength 2. Possess self -ethnic pride, in spite of intersectional oppression 3. Embrace being every woman and 4. Be anchored by religion and spirituality (Abrams et al., 2014). Donovan & West (2015) revealed that AAW are experiencing high levels of identified stress symptoms, yet low expression of distress, resulting in the idea that SBW have a high tolerance for stress. As a result of the SBW persona, AAW have been triumphant in overcoming adversities, yet their coping mechanisms have been in the form of

stoicism, silence, and selflessness, ultimately an unconscious self-suppression of their symptoms (Beauboeuf-Lafontant, 2008; Donavan & West, 2015). One would think that having high education attainment (EA) would in turn mean better employment opportunities and less employment stress. However, Assari Bazargan (2019) found that in the United States, race and ethnicity limit the health gains that follow high EA. While EA helps individuals avoid environmental risk factors, such as occupational stress, this is more valid for non-Hispanic Whites than AAs and LA people. The result is additional physical and mental health risks in highly educated AAs and Hispanics. Plainly, AA and LW with high education and high-status jobs are not immune from mental illness and stress. All this information coupled with the help seeking attitudes and coping strategies employed by AA and LA populations are reasons to explore how HAWOC experience stigma, work, and mental health resource utilization. To date there is a lack of research that describes the experiences of HAWOC and their experiences of stigma while utilizing (or attempting to utilize) mental health care services.

CHAPTER III: METHODOLOGY

This chapter describes the chosen methodology for this research study as well as the rationale for the chosen methodology. This chapter will also outline the participants, criteria, data analysis, and trustworthiness. The intersection of HAWOC and their utilization of mental health resources directly impacts how those women work, how long they work, and the overall health of the individual and the company (Comas-Diaz & Greene, 1995). To fully understand WOC's experience using these services, qualitative research is appropriate considering that an understanding of those experiences is sought after as opposed to exploring to what extent the services were used.

Transcendental Phenomenological Design

There are many research articles that outline what qualitative research is and how to conduct it in the most reliable and valid way (Cope, 2014; Duffy et al., 2016; Georgiadou, 2016; Humphreys, 2006; Kettunen & Tynjälä, 2018; Reisetter et al., 2004). One way to conceptualize the work of qualitative researchers is a focus on how a group experiences or sees the question or problem (Creswell & Poth, 2017). Qualitative research may lead to a better understanding of certain populations, as well as influence practitioners and how they treat clients (Bloor, 2016). For the scope of this project, the purpose of qualitative research is to tell of shared experiences using a specific approach to inquiry.

Moustakas (1994) posits that “meaning is at the heart of perceiving, remembering, judging, feeling, and thinking” (p. 68). There are many qualitative research methods, but a phenomenological design is the chosen method for this research study. More specifically a transcendental phenomenological approach within a constructivist framework is the best fit for this study. Moustakas's transcendental phenomenology is less focused on the interpretation of

the phenomenon (as it is in hermeneutical phenomenology) and more on the description of a shared experience. Moustakas's transcendental phenomenological methods are intended for researchers who want to find the common threads in all of the participant experiences and report the "essence" of those experiences (Moustakas, 1994). This is appropriate for a study, such as this one, that seeks to understand the unique experiences that each woman has while attempting to use resources for mental health. Each woman of color has unique experiences of this process. However, the existing literature does not currently have a plethora of information about these unique experiences.

Theoretical Frameworks

The intention of this research study was to understand the participants' point of view and to better understand their experiences in their individual context, ideally resulting in an improvement in service delivery to these clients. A transformative framework was chosen for this research to contribute to a knowledge base in which their needs and voices can be seen and heard. "...Issues facing marginalized groups are of paramount importance to study- issues such as oppression, domination, suppression, alienation, and hegemony" (Creswell & Poth, 2018 p. 25). This study seeks to understand how HAWOC utilize mental health care resources and any experiences of stigma that may have been associated with using those health care services. As the researcher, it would be neglectful to not consider disparity when researching women, minorities, working, healthcare, access, privilege, and attitudes towards mental health. For example, people from some racial and ethnic minority groups are more likely to be uninsured than non-Hispanic whites (CDC, 2020). Additionally, the CDC has elaborated,

healthcare access can also be limited for these (minority) groups by many other factors, such as lack of transportation, childcare, or ability to take time off work... some people

from racial and ethnic minority groups may hesitate to seek care because they distrust the government and healthcare systems responsible for inequities in treatment... (CDC, 2020, paragraph 5)

Critical Race Theory

Critical race theory (CRT) emerged from the legal scholarship of the mid-1970s (Harris, Crenshaw et. al, 2012). There are four themes of CRT that are relevant to this study of working WOC:

1. The first is the understanding that racism is normalized in American society.
2. The second theme is that liberalism has failed and will continue to fail to eliminate racism.
3. Further the third theme goes on to examine how minority success can only happen within the larger interests of White people.
4. Lastly, the rejection of the dominant Eurocentric narrative can and should be countered with the perspectives and experiences (storytelling) of oppressed minority groups.

Race is a social construct with no true biological reality yet has powerful impact on how individuals move throughout the world—CRT maintains this stance (Abrams & Moio, 2009; Delgado & Stefancic, 2010; Harris et al., 2012). Although race is an arbitrary social construct, WOC often feel the ramifications of the value placed on race in their personal and high achieving lives. CRT's themes of normalized racism and rejecting the dominant culture through storytelling makes it an appropriate framework to explore the experiences of the participants. Racism can manifest in many ways, including when seeking and utilizing healthcare. By highlighting their experiences, I can contribute to the literature that will hopefully aid in developing best practices. Racism is embedded within the systemic structures of the United

States it is often invisible to those in the dominant culture. This invisibility maintains racist practices that impact high achieving WOC (Delgado & Stefancic, 2012; Harris, et al., 2012).

Intersectionality

Theorists who utilize intersectionality examine how different positions of power and oppression intersect to influence social relations across diverse societies as well as the individual's unique experiences that shape everyday life (Collins & Bilge, 2020). The intersectionality framework can be traced back to the 1970's, but the current conceptualization of intersectionality is often credited to Kimberly Crenshaw's groundbreaking work in the Stanford Law Review Journal (Crenshaw, 1991). The core of intersectionality is in a society, at any given time, identity factors such as race, class, and gender are not separate entities, but in fact, build upon one another. While these factors are sometimes invisible, they are powerful and impact every aspect of the social world (Collins & Bilge, 2020).

In the end, the overarching theme that permeates my world view is the belief that something must be understood before a change can occur. Mertens (2007) stated in her article that realities are shaped by social, political, cultural, economic, and racial/ethnic values which determine which realities will be privileged when conducting research: "The transformative paradigm is characterized as placing central importance on the lives and experiences of marginalized groups such as women, ethnic/racial minorities, people with disabilities, and those who are poor" (Mertens, 1999 pg. 4). To move forward blindly without first attempting to understand the phenomenon would be like throwing darts at a dart board in a dark room.

Ontology describes ideas about reality and within the transformative paradigm believes that there is no one reality and each reality can be explored, and themes derived from or constructed through human interaction. The transformative paradigm recognizes that different

realities emerge because different levels of privilege are associated with participant characteristics (Mertens, 2007). This is particularly important considering the study's focus on HAWOC. Epistemologically speaking, the transformative paradigm derives meaning via the cultural context (Mertens, 2007). This paradigm's methodology can be either quantitative, qualitative, or mixed, but the researcher must acknowledge the link and the interactive nature between the researcher, participants, and the research question (or problem) (Mertens, 2007; Romm, 2015). A qualitative study is preferable because no one experience is the same. In order to more fully understand the nuances of each woman's perspective the study needs to be structured in a way that gives the participants the space to expand on ideas and experiences. A qualitative design allows each person to describe the experience unabashedly. Qualitative researchers have a desire to give voice to another person's experience, therefore understanding that experience more fully. Listening to another person speak of their experiences allows the researcher to examine their own perspective as well as recognize the differences in others' experiences. The researcher also desires to explore what meaning participants make of their experiences. Only a qualitative research design would allow this meaning making to be explored.

Social Stigma Theory

In 1963 Goffman outlined three different types of stigmas. The first is described as physical stigmas, which are various deformities that one may have. Second are blemishes of an individual's character that are perceived as weakness, unnatural, treacherous, or dishonest. The third is what Goffman called the stigma of belonging to certain groups like a tribe, race, nation, or religion. Goffman goes on to describe possessing a stigma, an "undesired differentness from what we had anticipated" (1997, pg. 132). Goffman posits that stigma is used to dehumanize individuals so that we may ostracize and relegate those with stigmatized attributes to a lower

status. Individuals with mental illness fall into Goffman's second category of stigma and the results of that categorization are seen in our attitudes, beliefs, and interactions with PWMI. Link and Phelan's 2001 conceptualization and expansion on Goffman's 1963 Social Stigma Theory offers us 5 components of stigma that help us to understand how we stigmatize PWMI. First are the invention and use of labels to signify differences. Second is the acknowledgement of the existence of dominant cultural beliefs and how anything different contributes to the establishment of stereotypes. Third, is the prominence of a them versus us mentality that permeates our cultures. The fourth component of stigma theory is a loss of status that results in discrimination, and finally stigma is contingent on the power allows the first four constructs to exist in our society. This expansion of the theory is well suited to conceptualize how and why people experience stigmatization based on mental illness and mental healthcare resource utilization. The stigma associated with mental illness gives us some understanding about how and why people do or do not seek help for their mental health. Gary (2005) described the stigma associated with mental illness as "a collection of negative attitudes, beliefs, thoughts, and behaviors that influence the individual, or the general public, to fear, reject, avoid, be prejudiced, and discriminated against people with mental disorders. Stigma manifests in language, disrespect in interpersonal relationships, and behaviors" (pg.980). AAW and LW who also have a mental illness carry the burden of double stigma (Gary, 2005). Those with double stigma face discrimination based on minority group status and the discrimination that based on having mental illness (Gary, 2005).

Research Questions

Guiding this phenomenological design are the following research questions:

1. What are the lived experiences of HAWOC utilizing mental health care services?

2. What factors contributed to the initiation, cessation of or the continuation of services?
3. In what way if any did stigma impact the start or cessation of services?

Participants

The following sections describe in detail how participants were chosen. The descriptions include selection, desired demographics and eligibility and strategies used for recruitment. The process used for contacting participants is outlined in detail.

Selection

For the purpose of the study an ideal number of participants would be 8-10, with a maximum of 12. Polkinghorne (1989) recommends that 5-25 participants be interviewed for phenomenological studies. Many insurance plans offer a cap on the number of sessions that are paid for by insurance and the experience of those with a lower number of sessions will probably be vastly different than those who have more available to them. Additionally, participants who paid out of pocket or had no to low-cost options will be included.

Demographics and Eligibility

For this study, the participants were required to have a master's degree or higher. Women with higher levels of college education are more likely to be in jobs that have employer benefits that include mental health resources (Fletcher & Frisvold, 2009). Participants were between the age of 28 and 60. This age range was chosen so that there would be a diverse group of participants who had varying experiences and years in their chosen career (s). Participants must have been employed for at least two consecutive years at the time of data collection. This will help account for the time it takes for a person to get acclimated to a new workplace and for the typical waiting period between starting a job and accessing healthcare benefits. Two years in job may allow a person to have insight into the culture of the workplace, the management style

of the leadership, and to observe any patterns in increased stress or work. A person working at least two years is more likely to have accessed the mental health resources available than someone who had only worked for six months or a year. The participant must have accessed the mental health resource within the last 12 months at the time of the study. The high achieving women in this study will identify as AA or Latina. This is important as the experiences of women of color compared to their white counterparts is of a distinct uniqueness and experience.

Recruitment Strategies

To recruit participants for the study a flyer would be created and sent out to professional and academic list serves. Recruitment from professional networks and social media will be used if the flyers and list-serv do not yield enough participants.

The researcher will use both criterion sampling of high achieving women as well as recruit via the snowball method of sampling, until a minimum of 8 and a maximum of 12 participants agree to participate in the study. It is essential that all the participants can speak to their experience using mental health resources. “Criterion sampling works well when all participants studied have experienced the same phenomenon” (Creswell & Poth, 2018). The CDC has stated that some racial and ethnic minorities may distrust mental health professionals and for that reason the snowball method, which “identifies cases of inters from people who know people who know that cases are information rich” (Creswell & Poth, 2018, p. 159) will also be used to recruit participants. At the time of agreeance an email will be sent containing a letter of consent which will include information about the study, the purpose of the study, how the data will be collected, used, and protected. The letter will also describe the interview process and estimated length and number of interview(s).

Demographic information was gathered via a questionnaire which will be sent housed in a program called Qualtrics. A sample demographics questionnaire will be included in this proposal and titled Appendix B. I included three open ended questions regarding the experience in counseling. 1. Would you go back to the same or different counselor? Why or Why not? 2. What if any suggestions would you give to your insurance company about access to mental health care resources? What would you like counselors to know about supporting you and women like you?

Data for the study was collected using semi structured interviews that consists of 10-12 questions. Participants will participate in one interview, and then contacted by email. The interview will serve to establish rapport and get background information. The predetermined questions will be asked during the interview. Appendix C displays the initial list of interview questions.

I allotted 60-75 minutes for each interview. This allowed the participant and me to explore the questions and allowed for digressions which resulted in a better understanding of the experience. There were other factors that influenced the experience that emerged when given enough time to talk. The email correspondence served to conduct member checks and to ask about any themes that may have emerged. Members will be given the chance to clarify, expand and correct transcripts and meanings gleaned from the interview.

To protect the identity of each participant a pseudonym will be provided to each participant. No personal information will be revealed in the transcript or in this document. All data (contact information, transcripts, data analysis, and any other documents pertaining to the research) will be kept on an encrypted external hard drive which only the researcher has access to. After the conclusion of the study all data will be kept on the encrypted hard drive and in a

locked cabinet for a maximum of three years.

Contact and Interview Process

Contact information will be needed to conduct the interview. Participants will have the option of in person interviews or online interviews. Contact information was gathered as part of the initial demographic questionnaire where I gathered contact email, phone number, and preference of interview setting. Each participant was given an online, telephone, or in person option. To increase the likelihood of participation I considered convenience. In a world where time is limited and the participants are very busy, offering an online option is important for accessibility and flexibility. In person interviews were conducted in the participants' private office (assuming they have one and if within a 50-mile radius) or in a reserved private room in the community such as the library or counselor's office. Considering the current Covid-19 pandemic, socially distant protocols will be followed for in person meetings. These include sitting at least six feet apart, in a well-ventilated room or outside if possible. Participants will be given a preference of wearing a mask and I will be wearing one in all in person interviews. All nine the participants opted for the online Zoom option for their interviews.

Data Analysis

After participants were interviewed the recordings of those interviews were organized and transcribed. The researcher transcribed the interviews herself but reserved the right to utilize a transcription service should time become an issue. The transcriptions were read thoroughly and frequently to identify commonalities and differences described in the interviews. As transcripts were read, I wrote a reflection that outlined my understanding of the experiences. According to Moustakas (1994) there are five steps when analyzing phenomenological data. (a) phenomenological reduction, (b) textural descriptions, (c) structural descriptions, (d) overarching

themes, and (e) textural-structural synthesis (essence of experience). All responses were examined and coded until common ideas or themes emerged based on the participants responses to interview questions. From the transcripts, significant statements were identified and used to identify themes. Moustakas's (1996) writings about horizontalization meant that every statement was given equal value when evaluating emerging themes. Those themes were used to identify clusters of meaning. Those clusters and themes supported the development of rich and thick textural (the what of the experience) and structural (the how of the experience) descriptions detailing the essence of the experiences of the participants. To further support the themes, illustrative examples of participant narratives pertaining to each theme were identified.

Trustworthiness

This approach required the researcher to set aside or bracket experiences with mental health resources. This method of research is also beneficial when considering the sample size. Transcendental phenomenology studies have sample sizes from 10-20 people (Moustakas, 1994). For this research study a sample of 9 women were interviewed.

This researcher willingly admits a bias and feared that high achieving women's needs were not being met. There was journaling throughout the process in order to keep awareness and the influence of personal opinions at the forefront. Most researchers have some personal experiences with negative aspects, unnecessary influence of the participants was kept to a minimum so that data is was not skewed. Thus, it is necessary for questions to be reviewed by an advisor and an external auditor so that any issues can be identified and corrected. To address trustworthiness, the researcher recruited two students and conducted practice interviews. The questions were asked, and the information examined in order to make sure the instrument extracted the kind of information needed to answer the research questions. This peer

scrutiny increased the credibility. Emailing with the participants will include member checks about the emerging themes of the previous interview. The member checks are to strengthen credibility. The purpose of establishing credibility is to determine whether the research study was accurately described and identified (Marshall & Rossman, 2006).

External Auditing

Consulting with my committee chair and conversations with an external auditor provided time and space for processing and the verification of themes. I engaged with the external auditor via zoom, phone calls, and text messages. These interactions allowed me to engage in epoche. The external auditor, a Black doctoral student and mental health professional, has experience conducting qualitative research and interpreting data. Her experience in an advanced qualitative research course indicated that she was qualified to review clusters of meaning, textural and structural descriptions, and themes. The external auditor agreed with the clusters of meaning presented by the researcher, but also offered her own impressions of some of the data. These were incorporated into the analysis when appropriate. This external audit served to establish trustworthiness of the data analysis.

Member Checks

After interviews were transcribed, I emailed a copy of the transcription to each participant. Participants were asked to review the transcript and add any additional comments or clarifications via comments on the document or in the body of an email. 7 of the 9 participants responded to the initial member checks. 2 participants clarified points made about using employer benefits and insurance. I constructed tables with both textural and structural descriptions as well as initial themes. I sent those tables to participants and asked them to review

it for accuracy and interpretation. 5 participants responded and agreed that my themes were correct.

Participants were given the option to stop participation at any time, and there were multiple sessions between myself and my supervising committee member. To increase transferability, contextual data will be provided to ensure readers of the research can draw parallels between the given context and their own.

Limitations

After much consideration and thought this subject has revealed itself to be of great importance. Women are one half of the population, and women of color have specific mental health needs. There has been research done to explore the impact of different interventions on the binary genders. There have been multiple studies on mental health care utilization and poverty, stigma, minorities, and children. One gap in the research is how working HAWOC are dealing with the ever-increasing demands of multiple roles and work. Now, more than ever a woman's time has more than one demand and balance is a horizon that gets further away as one moves towards it. One challenge to this study was recruitment. To have a rigorous study a certain sample size is required. Although recruitment tools were utilized some HAWOC were hesitant to share negative or traumatic experiences. Attrition was another concern for this study. As previously mentioned HAWOC wear many hats and making time for an interview, a member check, and the time to give demographic information was a barrier.

Due to the exploratory nature of this study with this specific population (high achieving women of color) the findings are not generalizable for the entire population. A follow up study using quantitative methods could provide further information for this area of study. It is also

impossible for the researcher to remain completely neutral and unbiased when researching a population and an issue that personally affects them.

There were multiple attempts to find published research that addressed the intersection of women of color, work, and mental healthcare. What is known is that women experience certain mental health care issues exponentially more than their male counterparts. Employers, practitioners, researchers, and educators may be interested in knowing how to best support HAWOC.

CHAPTER IV: RESULTS

This chapter outlines the study findings and is presented in several sections. The first section expands on the study participants and outlines the clusters of meaning found in each participant's story. The second section includes an overview of how the data was coded. Next, I will provide details of the data analysis process. Both the data and a detailed illustration of the data analysis is included which further illuminates the textural descriptions. Further, the description is used to synthesize the essence of the phenomenon. Lastly, I will present my reflexive self-analysis and external audit process.

Participant Demographics

A total of 9 participants agreed to participate in this study. All participants were working women of color who had utilized a mental health resource in the last 12-18 months. All 9 women identified as Black/AA. The ages of the participants ranged from 29 years of age to 56 years of age, with an average age of 37. Participants were employed in various settings including academia, journalism, tech, school administration, and mental health. Each participant had a master's degree or higher and/or at least 5 years of experience in their field. All participants were interviewed via HIPAA-compliant Zoom account. Detailed demographic information is provided in chapter 4. Table 1 contains demographic information.

Table 1

Participant Demographic Data

Pseudonym	Age	Ethnicity	Occupation	Location
Eartha	34	Black	Program Coordinator	Arkansas
Bell	32	Black	Licensed Counselor	Arkansas
Michelle	29	Black	Licensed Counselor	Arkansas
Kamala	38	Black	Counselor, Doctoral Student	California
Regina	40	Black	Program Director	Kansas
Maya	56	Black	Journalist	Michigan
Henrietta	29	Nigerian, Black	Counselor, Doctoral Student	Arkansas
Toni	34	Black	Tech Startup Consultant	New York
Phyllis	43	Black	School Board Administrator	Texas

Participant Narratives

This section briefly describes each participant. The primary clustered meaning for each participant is described.

Eartha

Eartha's interview was one of the first conducted and her experiences contributed to several initial clusters. Eartha's interview revealed codes that would show up in many other interviews. Specifically, her interview coded heavily for importance of match, counseling is helpful/healing, and faith as a minimizer. Eartha was one of the many participants who utilized mental healthcare resources from a young age. Eartha believes that counseling should be ongoing and was raised with a family that believed that maintaining mental health is just as important as physical health. She noted that access to mental healthcare was limited for faculty and staff on her campus, and this seemed counter intuitive. The interview with Eartha supported textural and structural descriptions of impact of counselor match. As a program coordinator at a large predominantly white institution (PWI), Eartha said she feels as if she has to be careful to appear professional, calm, and well informed.

Bell

Data gathered from Bell's interview were coded primarily into the initial clusters of need for tangible incentives, difficulty connecting to counselor, and cultural stigma. Bell spoke extensively about her negative experience with a counselor who made her feel uncomfortable and unheard. Bell's negative experience shed light upon the glaring mistakes that can happen when a counselor forgets important information of a client's story and then is unable to take accountability and attempt to repair the relationship. Bell reiterated how important it is to make a client feel as though they can show the worst of themselves in the counseling space. As a Black

licensed counselor, Bell talked about how she appears in the counseling space and recalls her negative experience often. She attempts to be a better counselor each day in order to serve clients to the best of her ability.

Michelle

Michelle's interview supported several initial themes, particularly how important the counselor style is (counselor characteristics), and the stigma of mental health disclosure at work. Michelle's use of mental health resources began at an early age and the need for those services increased when she became pregnant while her mother was dealing with a cancer diagnosis. Michelle noted that she preferred counselors who were more experienced because they practiced from a place that blended personalized style with theoretical best practices. As a mental health clinician herself, Michelle emphasized that finding a counselor that did not have a wait list was probably due to the pandemic causing increased stress for the community.

Kamala

Data obtained from Kamala's interview were coded into several initial clusters including insurance/financial challenges, cultural stigma (within the AA culture), and importance of match. Kamala described using employer insurance benefits as difficult and preferred to pay out of pocket due to the limited resources available through her benefits. Considering her location in California, Kamala had more options for counselors with an identity match to her own but had difficulty finding the same match when she lived in the south. Kamala is a licensed marriage and family therapist in California and emphasized the need for counselors to engage in community outreach as well as making sure counselor websites include pertinent information like approach, cost, availability, and a picture.

Regina

Regina, a first-generation program coordinator in Kansas City, experienced a change in her identity around motherhood which led to her seeking mental health resources. Data from her interview was coded heavily for difficulty connecting to counselor, faith as a minimizer, tangible incentives to seek resource, and importance of match. She had an experience with a counselor who made her feel judged and dismissed because of a difference in values. Regina felt as though the counselor was too quick to suggest medication. Regina suggests that mental health professionals create sacred spaces for women of color while remembering the high achieving Black experience is not a monolith.

Maya

Maya, a journalist in Detroit, provided a rich and thick description of her experiences and opinions. Data gathered from Maya's interview were coded primarily into the initial clusters of therapy is helpful//healing, importance of match (race and gender), and cultural stigma. Maya shared her opinions about why mental health maintenance is not just helpful but crucial for the survival of Black women. Maya suggested counselors who want to support high-achieving women of color should be prepared to check their ego and provide high quality care for the community. She recognized that she needed counselor characteristics to include empathy, compassion, and support while understanding the racial trauma that women of color carry with them.

Henrietta

Henrietta's interview was coded most heavily for insurance/financial challenges, Cultural Stigma (both in her Nigerian culture and the AA culture) and faith as a minimizer. Henrietta struggled with her identity as a lesbian in the Nigerian community as well as being taught that

strong women do not need counselors, they need God. Henrietta spoke extensively about being judged and dismissed by a Black counselor earlier in her experiences and the impact that had on her seeking mental health services. She noted that POC counselors have bias too and this is not often discussed. Henrietta suggested that counselors need to be warm practice from a holistic lens. She noted that white counselors need to remember that women of color want a safe place where they can talk about their experiences as Black women without feeling like they need to make the counselor more comfortable or absolve the counselor from white guilt.

Toni

Toni's work as a tech start up consultant, coupled with having a baby during the height of the pandemic led to her valuing her mental health resources more than she ever thought she would. The data from Toni's interview was contributed to the initial clusters of importance of identity match, insurance/financial challenges, and. counseling is helpful/healing. Toni noted that she is privileged in that she sees one counselor for individual maintenance, and another for couple's counseling. Toni spoke about needing support during identity shifts when she became a mother and when she was changing careers. To Toni identity match is important because she wants a counselor who can relate to her experiences as a Black woman and a counselor who understands cultural references. Toni admitted that counselors need to help HAWOC understand how to integrate new behaviors, and process identity shifts.

Phyllis

A situation at work where Phyllis was unfairly targeted led to her seek mental health services. Phyllis's interview was coded for needing a tangible reason to seek services, cultural stigma in the AA community, and importance of match (gender and race). Phyllis explained that previously she thought of therapy being for certain people and always thought she could handle

any situation on her own. Mental health was not discussed in her family and Phyllis notes that while there was nothing negative said about mental health and counseling, the lack of discussions made her think it was not something she would need. Phyllis stated that her counselor listens, validates, and allows her room to process what is happening in her life while being non-threatening and nonjudgmental. Phyllis says that mental health professionals need to remember that the Black experience is not a monolith, and everyone has biases that get in the way of serving communities.

Data Coding Overview

There are three research questions that guided this study. Question 1 addresses the lived experiences of high-achieving women of color when they utilized mental health resources in the last 12-18 months. Question two examines what factors contribute to the cessation of or the continuation of services. The third question explores in what ways stigma impacted the initiation, continuation, or cessation of services.

Initial Analysis Process

The initial analysis began with a transcription of 9 interviews. Each interview was read multiple times to gain insight into each participant's experiences. Next, I began the analysis steps described by Moustakas (1994) for transcendental phenomenology. Moustakas's analysis includes engaging in epoche, transcendental-phenomenological reduction, imaginative variation and synthesis.

Epoche

Epoche requires the researcher to set aside any preconceived notions. Epoche is a Greek word meaning to stay away from or abstain (Moustakas, 1994). I employed epoche throughout the interview and analysis process. I maintained focus on each participant's experiences while

remaining curious and receptive to the meaning participants assigned to the phenomenon being explored.

Transcendental-Phenomenological Reduction

The following sections give an in-depth description of the steps necessary to achieve Transcendental-Phenomenological reduction. This includes descriptions of bracketing, horizontalizing, and clusters of meaning. Further, this section describes how I excluded some data, and the textural and structural descriptions that were gleaned from the interview data.

Bracketing

Transcendental-Phenomenological Reduction (TPR) begins with the researcher bracketing out preconceived opinions about utilizing mental healthcare resources. This was achieved by journaling. During the interview process, I maintained field notes and as data analysis commenced, I documented personal thoughts, feelings, and ideas. These journals offered an opportunity for me to examine and acknowledge my own experiences and note them while keeping them separate from the data being collected from each participant. This was crucial to the process as it allowed me to focus on examining the data with open curiosity.

Horizontalizing

For this step in the analysis, each statement related to the experience is given equal value. Each statement is horizontalized or has equal value “as we seek to disclose its nature and essence” (Moustakas, 1994, p. 95). Horizontalization allows the researcher to exclude statements that do not relate to the research questions. Overlapping and repetitive statements were omitted from the analysis at this stage.

Clusters of Meaning

The final step of this analysis was to examine the horizontalized statements in transcripts

and identify units of meaning. Each transcript had multiple units of meaning. Each meaning unit was coded into a cluster and quotes from each participant were used to support meaning units. Both the quotes and the meaning units were used to create textural descriptions of the phenomenon.

Excluding Data

Moustakas (1994) outlines a modified version of the Van KAAM method of analysis of phenomenological data. The reduction and elimination require the researcher to test each statement for two things. First the statement must contain a moment of the experience that is necessary for understanding. Second, it must be possible to abstract and label the experience. If statements do not meet the above criteria, then it is eliminated. Some data was eliminated from the analysis. Specifically, when participants began to speak about experiences that they did not have themselves. Many participants gave information about their workplace, names of partners, and cultural events that were not related to the phenomenon. This study was designed to elicit mental health resource utilization experiences during the last 12-18 months. While illuminating, information about auxiliary experiences and political discussions were outside the scope of this study.

Clusters of Meaning

A full representation of the quotes supporting each cluster can be found in Appendix (). Similar clusters of meaning were group together to develop themes. Table 2 lists the preliminary codes. These initial codes were reviewed and revised as data analysis continued. Eventually the codes were clustered into 6 textural descriptions with 5 subthemes

Clusters of Meaning

Main Themes	Number of References	Participant Sources	Textual Descriptions	Research Question
Faith as Minimizer	10	4	Strength comes from God	Q2
Importance of Match	22	9	Counselor can't understand my experiences	Q1
Stigma	15	9	My mental health struggles are seen as negative	Q3
Therapy is Helpful/Healing	10	7	Without therapy I would not be where I am	Q2
Difficulty Connecting with Counselor	26	7	Geography, insurance, and counselor style impact connection	Q2
Tangible Reason to Seek Resource	9	7	Need a "valid" reason to seek help	Q3

Textural Descriptions/Group Synthesis

This phase of transcendental phenomenological reduction is to obtain textural descriptions from the transcriptions of interviews. Textual descriptions are taken from each participant's words verbatim to illustrate each theme (Moustakas, 1994). Major themes and sub-themes are presented with multiple and supportive participant quotes to further understand the phenomenon. The themes and subthemes are outlined below in Table 1.2.

Theme	Subtheme(s)
Difficulty Connecting with Counselor	Importance of Match Race/Ethnicity/Gender Feeling Judged and/or Dismissed
Stigma	Stigma Within the AA Culture Stigma in the Workplace
Faith as a Minimizer	
Insurance/Financial Challenges	
Tangible Reasons for Seeking Help	
Therapy is Helpful/Healing	

Difficulty Connecting With Counselor

The first theme to emerge related to each participant's experiences in the mental health space, specifically perceived factors that impacted the strength of the counseling relationship and the continuation or cessation of services. Three subthemes emerged in relation to this theme;

importance of match, lack of resources/counselors, and feeling judged/misunderstood.

The Importance of Match

As each participant spoke about their experiences utilizing a mental health resource, it was clear that many of their negative experiences could be attributed to a difference in identity and values.

Race/Ethnicity/Gender

Participants were vocal about needing and wanting someone who could identify with their experiences as Black women.

Regina stated,

Race ethnicity gender those are very important to me. Say when it came to me talking about the desire to be a mom and that not happening in my life I don't think I would have had the same comfort level with the man you know I or even a white woman when I talk about the pressure from my family that you know we don't have these kind of problems some of the things that I would share just in in taking off the code switching and really just being real about it I don't think someone who didn't have that similar makeup would understand.

Similarly, Toni responded

I think just as a black woman specifically I just I in either reason being so yeah black and woman yeah like I just feel like the types of things I would talk about and even just bringing up things that would happen at work there's just a certain baseline that I don't have to explain.

Phyllis shared similar feelings,

I was looking for someone that was I mean just to be honest I wanted an African American female right because I wanted to- because I never experienced counseling and I wanted to be able to relate and I wanted this person to be able to relate to my experience and I and I and so I was specifically looking for an AA female.

Participants noted that counselors having respect for their religious identity and beliefs was sometimes a problem. Regina stated,

I went to someone when I was going through I was having challenges reproducing or getting pregnant and just trying to figure out okay if this is not part of my life then where do I want my life to go how can I shift my mindset? It was obvious that they were not a Christian that they were not pro-marriage because a lot of the things that I would say about my relationship and you know how we were able to move past it the person would

say well it sounds like you're in a codependent relationship and it was it just all of these labels based on their difference in opinion about Christianity and marriage or my type of marriage um it was it was obvious it was almost like those pieces of me were under attack and I it was because I was othered in a way (Regina).

Participants expressed how hard it was to find a counselor who matched them in race and identity. Bell added, “I know just like for clients or people that I'm trying to help find services it's really difficult in this area um for one because especially if they're looking for a black therapist so we don't have that many.” Phyllis expressed how difficult her experience was, “Believe it or not there were only in the whole list there were only like three AAs and they were all over right one was in Tennessee one was in Dallas.” Michelle responded, “Because everybody decided with the pandemic that they should seek mental health services made it very difficult to find somebody to see.” Kamala spoke at length about her preferences and added, “I think the cultural match is a good one before seeing him I didn't have a lot of experience with being able to access black therapists.”

Feeling Judged and Dismissed

Another subtheme that emerged because of poor match was feeling judged or dismissed in the counseling space. Regina shared details of her experience.

(counselor)...if you're a Christian does that mean you don't believe in medication? Because I think you would really benefit from being medicated and my response being very much so that's not what I'm here for, I know where I am I know what I need. I'm just asking you to help me get there so then because of the difference in me and the individual I felt like they couldn't support me because they had othered me from the get-go (Regina)

Henrietta had a similar experience of feeling labeled and dismissed.

we did multiple tests and things like that and she was like I think you're bipolar I think you should take meds you know like why you are suicidal and all this stuff and it was just a very judgmental tone (Henrietta).

Bell recounted the details of a counselor who forgot she had been through multiple painful miscarriages and insisted she do an exercise that made her feel uncomfortable and unheard:

she wanted me to do this screen type of technique where I was watching there were little bitty fetuses floating around on the screen and when I sat down and I saw it I was like I don't want to do this and she said why not I was like well because I told you I just had two miscarriages and she was like no you didn't it's like ma'am we've talked about that more than once in our sessions she's like no we've never mentioned that.

Stigma

While it may seem that stigma is lessening for those who utilize mental health resources, participants acknowledged that stigma still exists and impacts their feelings about and use of mental health resources. There were three subthemes that emerged as a result of stigma: stigma in the AA culture, stigma in the workplace, and stigma in the counseling space.

Stigma Within the AA Culture

Many participants went into detail about how mental illness and help seeking behaviors is viewed within their families and inner circles. Henrietta reported that her Nigerian family was silent when it comes to discussing mental health. "So being Nigerian it was very interesting because mental health isn't something that we talk about and we still don't talk about it um even though all my degrees have been some type of mental health capacity (Henrietta).

Bell discussed her she was once not receptive to seeking help for mental health.

When I didn't even want to get into the field like I remember thinking that black people don't go to counselors or shrinks right or we don't you know we don't talk about mental health that's not a thing you're just weak like um or your faith isn't strong enough like thinking all of I thought all of these things initially.

Bell also disclosed,

The stigma behind it like one thing that it bothers me the most but like this 'what happens in this house stays in this house' kind of thing or you know we don't talk about that you we don't talk about that in public.

Kamala revealed her own experiences with stigma,

I remember growing up feeling like there was a lot of stigma and taboo...my mom was like nah you don't do that. So yeah I think growing up there's definitely some stigma around it. It was like a combination of not really talking about it much at all and then just

kind of like being told like we don't do that or we don't need that (mental illness) (Kamala).

Regina discussed how her family talked about mental illness,

That's kind of how my family is you go get mental health support when you are well my family's term "crazy" right but because I'm first generation a lot of that was just part of the program we don't need help.

Stigma in the workplace

Disclosing a mental health issue in the workplace caused fear and apprehension for participants. Henrietta noted,

I didn't really tell the company I was going to counseling just because it's like oh only people that have serious mental health issues go to counseling. Oh I have a doctor's appointment and that's you know and that was and that was all they needed to know about that.

Michelle added,

I recently switched jobs and so I had a moment of like oh do I tell them that I you know because when they ask about do you have disabilities or whatever and I'm like do I tell them that I'm diagnosed with anxiety and major depressive do I mention that (Michelle).

Eartha had similar feelings and said,

I could tell my supervisor and that they're supposed to give me that time to go seek therapy, but I haven't brought up with her I just say I have an appointment... I guess maybe I don't feel comfortable enough to say that that's what's going on (Eartha).

Stigma did not only impact disclosing the use of mental health resources, in some cases

participants were hesitant to use employer benefits in any capacity. Kamala explained,

I think have to use benefits I would not have felt comfortable in that um in that environment because there just was so much like going on systemically... I would have felt like my anonymity wouldn't have been protected or it would have been you know what I mean an issue.

Faith as a minimizer

Many participants disclosed that along with the stigma that was experienced, their

mental health was often minimized or dismissed by loved ones with religion or faith. Eartha shared,

I have known some a couple women at my church that speak about sometimes I'll get into discussions about depression and anxiety to speak about like people being weak or you have to be strong or something like that and that kind of hurts.

Bell mentioned how members of her church talked about mental illness. “You know we don't talk about mental health that's not a thing you're just weak like um or your faith isn't strong enough. Regina's experiences echoed the other participants' experiences. “I didn't tell anyone like my family says call on the lord and let him you know help you he'll you'll make it through that's kind of how my family is”. Maya's friends and family minimized her mental health issues,

Your friends and your family are you know ‘aww girl ain't nothing wrong with you good’ you know especially when you're coming from a traditional a traditional church background Black church background where it's like oh just pray it away.

Henrietta heard similar messages about faith, religion and mental health

If you have any mental problem or issue then my mom usually says yeah like let's just pray about it and let's which is a very like toxic optimistic person when it comes to mental health...it was a lot of you know god won't give you more than you can handle we're just going to go to church you know you need to pray because you've done some type of sin um and so that really terrified me.

Insurance/Financial Challenges

There were a number of participants who disclosed the difficulty that resulted from issues using employer benefits and how access is restricted because of the cost of utilizing mental health resources. These barriers were seen most often when employer benefits/insurance lagged

and the difficulty of finding a counselor who was covered by those insurance and benefits.

Henrietta commented about having to reduce the number of sessions she attended,

Within this last year insurance did cover some of it but our company got bought over so with the new insurance turns out she (counselor) actually didn't accept my insurance so I did have to pay out of pocket which got quite expensive...we went from meeting once a week um you know whenever I had insurance and they would cover most of it to like once a month just because it was very expensive but yeah that part kind of sucked.

Toni discussed how expensive counseling can be when insurance benefits caused issues,

Depending on like what you want to spend your money on so I always reflect on that too but when I first started going or even thinking about it I definitely was like sticker shock like oh wait how much is this ...it can still be funky so even with the person that we're that I see now at this practice like at one point they like weren't reimbursing her (Toni).

Phyllis was not sure about her options when insurance limited her choices for a counselor,

I do want to put in this caveat these were their African American female therapists that took blue cross blue shield I'm sure if we did cash only or something like that I'm sure there would have been more options but we were specifically looking for therapists that took blue cross blue shield (Phyllis).

Maya discussed how cost impacted her when insurance did not cover cost. "(Cost) it's a very strong barrier um because just the way it's billed you don't necessarily get anything back".

Kamala paid out of pocket for many of her services because of insurance issues,

I just paid the copay for that, but all the other ones have been out of pocket and I think yeah it's a combination of wanting to be able to choose like without limitation who I wanted to see and what kind of delivery method I was most comfortable with or felt like was most accessible and then just not wanting to go through insurance to do it.

Michelle noted how difficult it was to find someone who did not have a waiting list and who took her insurance,

Finding somebody that accepted the insurance right then and had availability right then because that was the struggle too. I could find a therapist that would see me you know I can take you but it's going to be out of pocket with no option to move into oh we take your insurance so that was that was a struggle.

Kamala stated,

Twice before, early on as I was beginning to explore services, I had to either discontinue services or wait to initiate services because I could not afford the hourly fees ...if I pay out of pocket instead of through work provided insurance, I won't have to deal with a lag in service payment by the insurance company if my enrollment ends quickly after I leave the job.

Tangible Reasons for Seeking Help

As participants shared their experiences accessing mental health resources and counseling it was apparent that many of them needed an event or a tangible reason to seek counseling.

Phyllis described why she went back to counseling,

I really did not access or take advantage of any kind of mental health resources until I had a crisis at work and so you know that experience ... was very traumatic for me and it was such a shock to my system that I knew I was not going to be able to like just to manage it without being able to talk through it and so that's when I reached out to a therapist.

Maya talked about her reasons for seeking services. "The access and the convenience and the curiosity and the desperation to ground myself in a global pandemic was what drove me like okay let's try it I'll try anything. Henrietta's master's counseling master's program encouraged her to seek help.

I actually started because I didn't want to go for the longest time and in my master's program they did encourage us to go like it was part of our grade and so I'm like well since that's part of my grade I could justify you know going to see somebody.

Regina initially used services after losing a best friend when she was in college,

My best friend who was back home was shot and killed and I had a hard time coming back to school after that because I felt like I abandoned him to begin with so now I'm going to leave again and go back to school and one of my friends who was white, my roommate, she was like I think you need to talk to someone and up until that point I hadn't really even thought about that.

Kamala expressed her reason for seeking services,

I was under a lot of um pressure and had a lot of stress um at the master's level in that program um so it felt like something that I was doing for me in the same way that I was like going to the gym or you know trying to get enough rest um so that was kind of like my attitude about I think it was more of like and like an experiment.

Losing her mother while becoming a mother was why Michelle sought services.

My mom was diagnosed with breast cancer five years ago now and then last year or two years ago now right at the time that I found out that I was pregnant she was diagnosed with stage four metastatic breast cancer and so I started receiving services because I was really struggling with the idea that I was going to lose my mom as I was becoming a mom.

Therapy is Helpful/Healing.

Most participants remarked on how they felt after seeking services. Despite having some bad experiences many participants described how helpful and healing it was to utilize services.

Eartha commented, "I found myself back in a place where I needed therapy again, I knew it would help and um since being in therapy I've seen I felt tremendous growth and healing and value in therapy (Eartha).

Michelle encourages everyone to go to counseling because it is beneficial, "My mindset towards mental health is I think everybody needs it whether you have a diagnosis or not. I think it's beneficial for everybody to seek some sort of service.

For some participants, utilizing mental healthcare services will be done throughout the lifespan.

I kind of see therapy as you might be working on different things but there is always something kind of there and maybe for logistical reasons you might take some time off, but I see seasons I don't see an end destination necessarily (Toni).

Maya expressed how she benefited from utilizing mental healthcare services, "(Going to Therapy) ... that ultimately gives me peace and helps me matriculate to my best self because I know I can't do it by myself. I was created to be great".

Phyllis related to how it feels to work through something in counseling,

I think in my head when I started going to therapy, I would be rid of all of these you know emotions that I have surrounding that very traumatic experience and what I realize is they don't go away talking about them, processing through them, goal setting around how to move past them it helps you to heal from the depth of emotions that you have.

Imaginative Variation

The imaginative variation step of the phenomenological analysis asks the researcher to use their imagination to seek multiple and possible meanings of the experiences to identify the underlying structures of experiences (Moustakas, 1994). This process of considering possibilities moves the study forward to meaning and essence. Ultimately, the purpose of imaginative variation is to discover the underlying, structural descriptions of each experience.

Structural Descriptions

After textural descriptions were gleaned from the transcripts, I described the context or conditions, also known as the structural descriptions, wherein the participants experienced the phenomenon (Cresswell, et al., 2007). Moustakas (1994) describes arriving at structural descriptions by varying the possible underlying meanings, recognizing underlying themes and contexts, considering possible universal structures (time, space, relation to self/others), and searching for vivid, descriptive, invariant structural themes to obtain structural descriptions. This process allows me to connect the essence to the meaning of each experience.

All the experiences that were described were connected by a motivation to relieve some of the emotional stress that accompanies existing as a person of color and occupying multiple roles as women, professionals, and caregivers. These participants sought mental health spaces that would allow them to reveal their vulnerabilities and work through situations that were impacting their mental health. It was clear that many participants internalized many of the negative messages around mental illness from their families and inner circles within their communities. Mental illness was not discussed and if it was there was a negative connotation

associated with having mental health issues and speaking to outsiders about any mental health issues. Participants often needed a reason or an event to seek mental health services to allow themselves to use those supports while decreasing the feelings of shame or weakness that accompany the stigmatized messages from family. Many participants expressed feelings of hesitancy and reluctance to seeking services. A crisis or incentive from their environment would increase the likelihood of pursuing a therapeutic relationship with a trained professional.

Central to theme development were the impressions and style that mental health professionals presented during counseling sessions. Frequently participants spoke about how hard it was to find a mental health professional that looked like them both in race and gender. All of the women sought to be understood by someone who could relate to their experiences at the intersections of their identities. Although their experiences as Black women are not a monolith, the participants expressed that there was an obligation to explain things to a non-POC counselor that were foundational to their experiences and cultural references. Participants sought to be understood because it was so rare that they felt that way. The extra burden of explaining the nuances of existing in Black bodies was not something most participants were willing to bear. A few participants found counselors who shared their identity but experienced a disconnect and that caused disappointment. Those participants found that their expectations and needs is more than skin deep. They needed counselors of color who could still set aside their bias and judgment.

The unifying experience of facing financial and insurance challenges was threaded throughout many experiences. Although each participant had experienced working high stress well-paying jobs, almost all of them had at one time or another to pay out of pocket for mental health services. For some it was a burden that could be overcome due to having a partner with

insurance. While other had to make the cost of mental health services part of the family budget, and still others had to see their counselors less because they could not afford it. Each participant had utilized employee benefits to offset the cost but would encounter issues with payments, reimbursements, and limitations that would restrict them to in network services. The services available through employee benefits did not always allow participants to find a counselor who looked like them. This caused extra stress for participants, especially when having an acute crisis. Each participant contributed thoughts and opinions about how mental health professionals could better support women like them. An awareness of bias, more counselors of color, and more training for all (but especially non-POC) counselors around diversity, equity, and inclusion

Synthesis

The final step in the transcendental phenomenological analysis is synthesis. I combined the textural and structural descriptions to present the essence of the participants' experiences (Moustakas, 1994). Black women who have utilized mental healthcare resources in the last 12-18 months sought these services to work through issues that caused them mental and emotional anguish. High achieving women still battle internalized stigma when seeking services and want to have counselors who look like them that understand the unique experiences of being a woman of color.

Individual Synthesis

In this section I will present an individual synthesis for each participant. Unique themes have been identified for individuals that were not experienced by the entire group. These unique experiences provide important contextual information that I believe are relevant to the study.

Eartha

Eartha is a program coordinator at a predominately white institution (PWI) and has been using mental health services intermittently since she was a teenager. She attempted to utilize mental health services on her campus but was told she could only have a few sessions because she was not a student. Eartha experienced some marital issues and identity shifts when she became a parent and wanted to find a Black counselor who embraced faith-based counseling. She spoke about her spiritual identity frequently and how she knew how helpful counseling could be and needed that support again after many years of not seeing a counselor.

It's been a very difficult marriage, we're a little over three years now, but I mean there have been some things that felt psychologically and emotionally abusive and I felt anxiety returned and it was very intense so then I sought therapy again.

Unlike many other participants, Eartha's family embraced seeking mental health services and prioritized mental health as well as physical health, but she still felt as though her issues made her a burden to others.

I was in a very severe clinical depression, so it was like clearly a medical issue it's like if you're feeling like a fever and sore throat and all that stuff you go to the doctor be treated for it or you know you have some other physical issue you go to the doctor, so it was that situation.

Eartha stated that she will always attend counseling because she wants to be proactive in her treatments especially considering her past struggles with mental health. Though there have been some financial barriers, she continues to work on traumas from her past and likes that her counselor utilizes EMDR.

Bell

Bell is one of the women that I interviewed who is not only a client but is a practicing mental health clinician. She is a mom, a wife, and a doctoral student at a PWI. She was encouraged to attend counseling during her master's program in clinical mental health

counseling. Bell's family did not talk about mental illness and when it came up she was told to pray about whatever issues she was having. Being a clinician and a client has given Bell a unique perspective on both seeking and providing services. Bell had one of the most negative experiences of all participants when she was seeking services early on.

She wanted me to do this screen type of technique where I was watching there were little bitty fetuses floating around on the screen and when I sat down and I saw it I was like I don't want to do this and she said why not I was like well because I told you I just had two miscarriages and she was like no you didn't.

Bell expressed frustration and anger while recalling this experience. She felt like the counselor had not listened to her when she was vulnerable about the great loss she had experienced. She stated that this incident happened during the fifth session, and she was appalled that the counselor was arguing with her about her own experiences. Bell is not currently seeing a Black female counselor and while that was her preference, she said that she is comfortable despite the identity differences.

She's really relatable ironically and I say that because she's not black, but you know and then her husband's a police officer so we talk about a lot of stuff, but she makes me feel comfortable she makes it safe and it can be something that I talked to her about two years ago and she remembers it and she can go there with me and she's not afraid to challenge me either

Bell continues to see this counselor today but often spoke about how we need more Black men and women in the mental health professions. It is hard to serve the community and have identity match if more Black people and people of color are not interested in the field. Bell suggests that mental health professionals need to take risks and try new things with clients to increase skills and competencies.

Michelle

Michelle is a counselor who has been in the field for 6 years. Michelle's experiences with mental illness started from an early age when her sister struggled with her own mental health.

Michelle's family had family therapy when she was small which inspired her to join the field herself. She is a mother from California and sought mental health services recently because she was pregnant, and her mother was diagnosed with cancer. The thought of becoming a mom while losing her mom made Michelle anxious and sad.

My mom was diagnosed with breast cancer five years ago now and then the last year or two years ago now right at the time that I found out that I was pregnant she was diagnosed with stage four metastatic breast cancer. I started receiving services because I was really struggling with the idea that I was going to lose my mom as I was becoming a mom.

Michelle experienced judgment and stigma in the counseling space. She encountered a clinician who treated her as if she was a child because of her area of study.

I've struggled a lot with like I said I work mental health and especially when I was in my master's program the individual, I was seeing then sort of treated me like a student well you know what you should be doing like more like they were my mentor instead of a therapist

Michelle was frustrated by this treatment. She expressed feelings of self-consciousness and anger because she was seeking support but instead encountered condescension and dismissal. Michelle wants mental health professionals to remember that challenging clients is a good thing and experience shows because experienced counselors have personalized textbook approaches taught in classes.

Kamala

Kamala is a licensed marriage and family therapist who is pursuing her doctorate at a PWI. While her family insisted that talking to outsiders about her issues was not appropriate, Kamala chose to work in the mental health field and to utilize services as part of her master's program. Kamala was adamant that employer benefits are nice but limiting, and businesses

needed to be aware of how that impacts women of color who are looking for counselors who look like them.

If I pay out of pocket instead of through work provided insurance, I won't have to deal with a lag in service payment by the insurance company if my enrollment ends quickly after I leave the job. I think that maybe it's more important for me to make enough money so that whatever resources I want to access let's say like just broadly like medical resources I look at what kind of health insurance they would offer so that I don't have to get caught up in like bureaucratic mess and not able to access my preferred providers.

Kamala expressed that at one point having a counselor who matched her racial and gender identity was not something she thought much about.

I think for a while it wasn't something that I felt like was absolutely necessary um I think a gender match was more important to me at one point and then looking at some of my own patterns and some of the things that I was struggling with I thought maybe a different gender would be a more beneficial experience for me um but and then I think the more that I have engaged in my own kind of like cultural exploration and identity formation that it's been helpful to have a therapist who's the same culture has some like shared cultural identity

Kamala said that she experienced less microaggressions and microinvalidations when she worked with a Black counselor. Her current counselor is a Black man, and she appreciates how open his availability is. She uses telemental health often, making his services more accessible. Kamala wants mental health professionals to know that your website says a lot to clients and in this technological age there should be as much information as possible about your modalities, style, and practice. She stated that HAWOC need to be asked questions that make them consider their needs, wants, and recognitions because they are not often give the space to explore those things.

Regina

Regina is a program services coordinator for a busy healthcare company. Her negative experiences culminated in a counselor suggesting medication and judging her values around marriage and faith. Regina described not feeling comfortable and dismissed by a counselor who

she could tell did not share her same values. While a value mismatch can be okay, Regina did not need or want medication. Regina stated that her counselor was clearly atheist and took many opportunities to criticize her relationship even though that was not the issue Regina was there to address.

It was obvious that they were not a Christian that they were not pro-marriage because a lot of the things that I would say about my relationship and you know how we were able to move past it, the person would say well it sounds like you're in a codependent relationship and it was it just all of these labels based on their difference in opinion about Christianity and marriage or my type of marriage. It was it was obvious it was almost like those pieces of me were under attack and I it was because I was othered in a way.

Regina is an advocate of utilizing mental healthcare services but sometimes feels undeserving or like others might have it worse than her.

I think in back to that piece of just feeling like somebody else probably needs his time you know somebody else is going through something and I don't want to take away from maybe that per though that's kind of how I talk myself out of it

Regina spoke about the mental anguish caused by not being able to conceive a child. She had prepared all her life to be a mother, and this was reinforced by messages from her family and her culture about what women should and should not be. She was able to find a counselor who helped her make peace with what her body was and was not able to do and she was given the space to explore who she could be outside of those expectations she had been clinging to for so long. Regina needed help shifting her idea of identity and sought counseling as well as life coaching to help her through the transition. Regina wants mental health professionals to know HAWOC need a space that is safe and sacred to talk about uncomfortable things that might be scary.

Maya

Maya, an experienced journalist, first sought mental health services when she was a young mother. Her family did not approve of talking to people about your personal business, but

Maya describes herself as rebel from an early age. Maya believes that friends and family mean well but they cannot be truly objective like a mental health professional. “You can have your friends and you can have your family but sometimes you need someone who is objective and removed from any aspect of what you're dealing with

Maya’s preferences in a counselor were talked about extensively. She prefers Black women so that she does not have to explain certain aspects of her experiences, but she also prefers a woman who acknowledges the inequity in our systems.

I specifically prefer AAW who are not male centered because I don't want that skewed patriarchal misogynistic “pick me pick me” perspective because it's not empowering and it's not helpful and I would feel much further defeated.

Maya described how those who need mental health resources the most in her community have the least amount of access. She discussed how considering how technology has made accessing resources easier, many members of her community do not have access to a computer or smart phone. Maya has had issues with employer benefits and how payments lag either to the counselor or to her when she needed to be reimbursed. This means she was not able to utilize services as much as she needed to in the past. She has recently tried Reiki on a whim to experiment. Maya spoke of the generational trauma that exists in her family and how she had had trouble connecting to white counselors.

It's not that they're not qualified sure it's just I didn't feel a connection I mean it's a lot of qualified people but if I'm not connected and there's no chemistry because it's a relationship that I'm building and it's my right to build a relationship with somebody I feel comfortable first of all developing a trust with and a relationship with and then sharing and becoming vulnerable which is already a big step.

Maya wants mental health professionals to know that supporting HAWOC means understanding and valuing experiences, checking your ego, and building safety for secrets.

Henrietta

Henrietta is Nigerian and has had unique experiences utilizing services here in the United States. Henrietta is a current doctoral student but has practiced as a licensed therapist. Her experiences were negative when she sought services from an AA counselor who made her feel as though her experiences were not important. She encountered negativity and bias from someone she feels she should have been safe with.

I did change counselors the last two years and initially I was in a very bad place and I thought it would be better to see a clinician of color and that wasn't a very pleasant experience. I guess she had her own biases as to being Black and mental health...that kind of deterred me from any type of mental health experience because I felt judged and not really heard. She was like I think you're bipolar I think you should take meds you know like why are you suicidal and all this stuff and it was just a very judgmental tone

As a Nigerian woman, Henrietta's family dismissed her mental health issues by telling her that God would not give her more than she could handle. She described this as toxic optimism. Her current counselor practices from a holistic lens and is described as warm and welcoming. Henrietta describes how creative she is and how she has grown during their time together. Henrietta does admit that she is interested in seeing a Black woman because she wants to find a safer space. "The more I'm getting to know myself it's like I would prefer a clinician of color, but I just keep thinking back to you know my first experience and if they're going to be as welcoming".

Toni

Toni, a startup consultant, started utilizing mental health services as a young adult when she switched from her ivy league school on the west coast to the east coast for work. Toni sees both an individual counselor and a couple's counselor. Her experiences have overall been positive apart from a couple's counselor who was not a great fit due to the perceived counselor's inexperience. Toni's most recent experience with therapy was a response to the stress of many major life events at one time. Toni found herself having a baby and switching jobs during the

height of the Covid 19 pandemic in New York City. At the same time, she lost a parent, experienced postpartum depression, and was dealing with a multiple sclerosis diagnosis.

We moved and co-lived with our cousins that was big. Then postpartum is like its own hell and so that was like one thing along with the pandemic and becoming a parent in the pandemic giving birth and then for me just my like MS diagnosis that was like a huge thing and then my dad passing away that was a huge thing. Parenthood's effects on marriage that's like a huge thing even for me so this was a big point of transition.

Toni's expressed her gratitude for not having to switch counselors very often. Toni was able to find Black counselors through referrals from friends in her community.

I've actually felt fortunate in terms of finding someone that I really liked and gelled with. I actually when I first started going to therapy only saw that one person and then in terms of couple therapy that definitely took longer because it was kind of both of us finding someone finding a black couple's therapist finding someone who we thought was great.

Toni acknowledged her position of privilege and admits that she has had financial challenges in the past, but she is fortunate to have a partner whose employee benefits cover 80% of the expense. Toni said the right fit in a counselor is important and that includes feeling like the session was worth her time, leaving with a feeling of relief and comfort. Toni's situation is unique in that she is aware of mental health startups due to the nature of her work. She referenced at least three companies that are attempting to make mental health resources more accessible.

I'm definitely aware of all the different things outside of psychology today where you can try to find a therapist... I feel like if you can pay for it some of those are definitely trying to make it cheaper.

Toni wants mental health professionals to understand collective trauma and identity shifts because high-achieving women of color are dealing with those things daily.

I think there has to be an understanding of all the different hats that women are wearing, in general, and an understanding of collective trauma and grief. I think that's huge because that's literally an undercurrent.

Phyllis

Phyllis is a school administrator in a large Texas city. She had never attempted to utilize mental health resources before a crisis at work caused her to experience turmoil. Phyllis admitted that she always thought mental health services were for other people, not her. She thought that she could handle anything that came her way. That changed when she was unfairly targeted at work and was put on involuntary leave from her job.

I felt like I could manage it on my own um I've always had a strong faith I've always had uh really high confidence um and I just never thought I needed someone else to help me process either a situation a crisis or my feelings and so that's why I never reached out but this particular crisis was at such a magnitude I knew I couldn't.

When Phyllis was searching for a counselor that was covered by her insurance, only three Black women were in her network. While she did not want to see anyone too close to the community she lived in, she didn't expect them to be in completely different neighboring states. Phyllis was one of the few participants to talk about needing a counselor who understood what it was like to have a high-stress political job.

I needed somebody that was going to actually listen, and I felt like they could understand the context right because what happened to me was political in nature and it's not logical and there are different things that impact you at different levels of the journey in terms of education career.

Phyllis ended our interview by noting the following in support of continuing to maintain mental health. "There are triggers that happen all the time but you kind of have tools to manage them versus the raw feeling that you have you know when you first experience it".

Reflexive Self-Analysis

Throughout the data collection and analysis process, I engaged in journaling so I could record my thoughts and perceptions. I engaged in conversations with my colleagues of color who

had similar experiences both as researchers, and clients. I discussed with these colleagues the interview process and the feelings and thoughts that arose during the entire study. This helped me recognize my attitudes and brought to my awareness some assumptions I had that could impact how I interpreted the data. Reading my journal, I realized that I had assumed that counselors of color would be better at broaching certain topics because of their racial identity. In fact, when counselors of color were dismissive or lacking broaching skills, it was even more hurtful to the participants. There was an element of betrayal that I felt and wrote about in my journal.

While many themes were not a surprise to me, there were some that I found interesting, and I did not anticipate. Specifically, the needing a tangible reason to seek mental health resources was a theme that emerged that made me think that there were even more themes that I needed to be open to. Looking back over the literature around the Strong Black Woman schema this makes sense. Documenting my thoughts and reactions allowed me to engage with the data and offered relief from the research process as I had somewhere to put those thoughts and feelings that felt safe. These journals contributed to the data analysis process by showing me patterns from participant to participant. I shared some of these thoughts with an external auditor through numerous zoom and text conversations. This allowed room for me to consult about some of the themes I found in the data.

CHAPTER V: SUMMARY, DISCUSSION, IMPLICATIONS, LIMITATIONS, AND RECOMMENDATIONS

This research study aimed to understand high achieving Black women and their experiences utilizing mental health resources and any perceived stigma they have experienced. This chapter focuses on implications for counselor education related to supporting high-achieving Black women. Suggestions for preparing counselors in training are discussed along with suggestions for practicing counselors. Study limitations and suggestions for future research are included.

Summary

The transcendental phenomenological data analysis revealed themes related to barriers to access and continued utilization including insurance/financial challenges, difficulty connecting with counselors, and stigma. The data also revealed that while participants often needed a tangible reason or crisis to seek services in the last 18 months, most participants reported that counseling is and was healing and helpful. The essence of the participants' experiences accessing and utilizing mental healthcare resources can be characterized as perseverance despite barriers and stigma. Participants described still feeling the effects of stigma but generally feeling as though counseling can be healing and helpful when identity, counselor style, and values are matched. When given the space and safety needed to explore their unique experiences, high-achieving Black women can heal from generational and racialized trauma.

Discussion

This section pairs study findings with the existing literature on mental health counseling and women of color, specifically Black women. The findings and implications are discussed, and suggestions are made for practitioners and counselor education programs. This section concludes

with directions for future research that would further explore the experiences of HAWOC.

Findings, Related Literature, and Potential Implications

This study contributed to the knowledge needed to support high achieving Black women in a plethora of ways. First, all participants in this study identified as AA /Black women. This was one of the few studies of its kind that focused exclusively on the experiences of high achieving minority women. The stigma that these women have experienced is supported by research that states that minority women experience stigma both in their personal circle and in society (Corrigan et al., 2003; Harris et al., 1996; Jones, 2003; Johnson & Cameron, 2001; Rosette & Livingston, 2012; Settles, 2006; Williams et al., 2014). Participants described experiences including feeling dismissed by family and friends, faith used as a coping tool, and feeling weak or burdensome for needing assistance with their mental health. These descriptions echo the existing literature that highlighted the AA tendency to cope with stress by using strategies including the tendency to deal with crisis alone and to view that as heroic (Adams et al., 1999). Within the AA culture, there is an expectation for its members that perpetuates the idea that AA cannot be depressed or feel anguish because they should be able to deal with anything (Campbell & Mowbray, 2016). Participants went into detail about the messages from family and friends to keep issues and struggles to themselves because it was not appropriate to talk to strangers about personal affairs. This reinforces studies by Abdullah and Brown (2011) and Rao et al. (2007). The study by Samuel in 2015 highlighted attitudes shared by AA towards mental illness. Participants in the 2015 study explained that there was little tolerance within the AA community for mental illness and disclosing a diagnosis indicated signs of weakness or laziness which in turn caused internalization of one's experience instead of help-seeking behaviors. These themes emerged from the data in this study, proving that stigma around mental

illness within the AA culture is alive and well. The greater stigma around needing mental healthcare, such as what has been observed in the AA population, reduces AAs' openness to seek treatment (Hopkins & Shook, 2017). The high-achieving Black women in this study disclosed time and again the feelings and hesitancy they experienced when accessing and utilizing mental healthcare services. In fact, one theme that emerged was needing a tangible reason to allow themselves to seek mental healthcare resources. Burkett (2017) stated that gaining an accurate understanding of the low utilization of mental health services in the AA population requires an increased focus on the social and cultural experiences of the AA population including the effects of trauma, feelings of medical mistrust, and the environment. This is important to note and further supports giving space in research for minority women.

The considerations for applying the data from this research are important because the participants belong to underrepresented groups, both in the client role and the counselor role. Although each experience was unique and the Black experience is not a monolith, there were threads that were found throughout each study participant's experience. Based on my observations, experiences conducting interviews, a review of the literature, and the themes that emerged from the data, some aspects of the experience will be shared by those who do not possess multiple marginalized identities. Further, because each participant is an amalgamation of intersecting identities some aspects of the counseling relationship are experienced differently depending on culture, context, time, and perception. There exists a power dynamic in the counseling relationship as well as a history of marginalized individuals being left out of the formation of theories and models that were not built to address systemic racism and trauma (Singh et al., 2020). It is not unreasonable to presume that counseling relationships are impacted by the ethnic, racial, cultural identities of both the mental health clinician and the client. This

study is important as it supports the findings of Mathews et al. (2018) that counselors must invest in and continue to increase cultural competency because clients benefit from greater satisfaction in clinical progress and better treatment outcomes when counselors strive to be culturally competent. The current study demonstrated that it is possible to recruit participants from underrepresented groups. This study also demonstrates the willingness of clients to talk about what happens in the counseling space that may encourage continuation or cessation of services. It should be noted that there are circumstances that exist that may have made it easier for me to recruit these participants. I, myself, meet all the criteria for participants and I work in a higher education institution. Were I to trying to study low-income women of color or women without graduate degrees I may have faced more difficulty. Four of my participants identified as counselors themselves and speaking about mental health is an inherent part of their jobs.

Participants were explicit about their experiences with counselors and how impactful style, modality, and counselor characteristics are. It would be beneficial to conduct studies that examine how match and values influence high-achieving groups. Participants reflected on their experiences of counselors being quick to try to prescribe medication for issues or labeling participants with a diagnosis before they felt the rapport had been built. This was an issue when the counselor was white, but in a few instances these negative experiences happened with Black counselors. Many participants had negative experiences with counselors who were blatantly dismissive or who refused to talk about important issues like racism. Most participants wanted to talk with other Black women, but because there are not enough Black women in the counseling field their choices were often limited. Insurance played a part in this due to the restrictions around network and reimbursement.

Stigma

Stigma played an important part in the help seeking behaviors of the participants. This implies that counselors and supervisors should spend some time exploring any stigma that the client has or is experiencing regarding mental health. Stigma was discussed as being present in the AA community, in the workplace, and sometimes, in the counseling room. Participants explained that mental health and mental illness were either ignored all together by their families (both in the past and in the present) or that it was talked about negatively. Prior to utilizing a mental health resource, many participants felt that the stigma of having or disclosing a mental illness was for other people and that if you were strong or strong in your faith then there should be no issues they could not handle alone. The belief that one does not need to share their personal information with a stranger would delay the initiation of mental health services.

When asked about disclosing the use of mental healthcare resources or a diagnosis, most participants refrained from sharing those experiences with supervisors and coworkers, even though employer benefits were being used to offset the cost of mental healthcare resources. Participants reflected the fear of being judged or being viewed as incapable of doing their work were a supervisor or coworker were to find out about their use of resources or diagnosis. These experiences and thoughts reflect Gary's (2005) research around stigma and mental illness, stating that stigma is a collection of negative attitudes, beliefs, and thoughts that influence people to fear, reject, avoid, or be prejudiced. The women in this study are hyper aware of the stereotypes and biases that exist in society for Black women. It makes sense that these women would want to avoid the stigma that accompanies mental illness. This is of importance because of the other health issues that can arise from internalized stigma. A major barrier to psychiatric treatment, internalized stigma exacerbates several health-related issues due to its known ability to obstruct

symptom relief and recovery and heighten existing problems such as low self-esteem (Pearl et al., 2017)

On a discouraging note, some of the participants in this study experienced stigma from Black counselors in the counseling space. Each participant discussed how important it was for them to talk to a counselor who could relate to their lived experiences as working Black women. There was a resounding effort from all participants to initially seek out a counselor who identified as Black and female. What was discovered by some participants is that although match in identity was important it was not all that was needed to be able to build rapport and establish a healthy working alliance. Participants reported feeling judged or dismissed by Black counselors as demonstrated by the counselor's behaviors. These included insisting the client needed to be on medication, diminishing the issues faced by the client, and assumptions that made the client feel as though their issue or struggles were not serious.

Insurance and Financial Barriers

For many the utilization of mental health resources is impeded by the inability to pay for services. This was an issue for many participants in the study at one time or another. Although all of the participants are employed and have benefits that would cover some of the costs, there were still issues that prohibited utilization, access, and frequency of utilization. One theme that emerged from the data was the issues that arise from using insurance benefits due to clinicians being out of the provider network. Essentially, participants who had health benefits through work experienced having to work with a clinician simply because they accepted a company's insurance. This severely limited the choices that each participant had when searching for a counselor. The alternative to that would be to work with the preferred clinician but pay for those services out of pocket. These expenses could cost participants upward of 150 dollars per session

or more. Some clinicians charged more depending on the region the participants were located. Additionally, considering that the participants were often looking for clinicians who shared the same racial and gender identity, the choices were limited even further. Many participants articulated how frustrating it was to navigate the reimbursement process associated with using their employer healthcare benefits. Since the pandemic more people have sought mental health care services which has contributed to long wait lists for clients, resulting in extended wait times for participants. Thankfully, the addition of telehealth services has made the use of mental health care resources more accessible, but the financial strain has not been remedied.

Difficulty Connecting with Counselor

Participants who were able to overcome the financial barriers and find counselors who had availability had difficulty connecting to counselors for a myriad of reasons. According to the data those reasons mostly related to the importance of match. Match included a match in identity (race and ethnicity) and similar values (faith). The style of the counselor impacted the relationship in ways that should be explored in future research. Participants divulged in detail the negative experiences that directly contributed to the cessation of services. The importance of match was one of the themes featured heavily in the data. There was one participant who matched and worked well with the first counselor they tried, even after having to switch for geographical reasons. Every other participant had a story about a time it was difficult to work with their counselors at one time or another or the difficulty working with a new counselor. Participants noted that finding another Black woman to work with was challenging so when they were not able to find a counselor with those identities, they worked with counselors who were white or male, or white and female. Participants recounted tales of having their experiences as Black women minimized and not feeling comfortable discussing important social issues because

those subjects were not broached by their White counselors. This was especially hurtful during times like the murder of George Floyd and other incidents that involved police brutality against Black people. Black clients who worked with white counselors felt as though they had to present in specific ways that mirrored the way they presented in the workplace (visually and verbally). Meaning, participants felt as though they could not fully relax and disengage from code-switching. Code-switching refers to alternating between two or more linguistic varieties within an interaction, which can apply to two different languages or to linguistic variations within the same language (e.g., Standardized American English and AA Vernacular English) (Scotton & Ury, 1977). Code-switching is a useful tactic in conversations that aids in effective communication, especially when interacting with others from different cultural backgrounds (Gafaranga, 2007; Gordon, 2014). AA often code-switch in many instances to increase the likelihood of pleasant interactions and to project an image of professionalism and to avoid judgment associated with AA Vernacular English (Rivera, 2020). The constant energy it takes to make sure you are interacting with people of the dominant culture is exhausting. Participants described how tiring it can be to be on constant alert. Similarly, participants who had a strong religious or spiritual identity had experiences with counselors diminishing that aspect or not incorporating faith into treatment. Although it was not explicitly stated, participants felt that some counselors were quick to label their relationships as codependent or unhealthy when they would talk about how important traditional gender roles were for them and their faith identity. The recent emphasis on diversity, equity, inclusion, cultural competencies, and social justice has encouraged many counselors to examine their social location and increase awareness of positions of power and oppression. It is important to remember that all counselors need to be doing reflective work to examine our attitudes and beliefs, no matter our ethnicity or race. Although the

dominant culture is steeped in white supremacy, many counselors of color may assume that their work around these issues is not as important or needed. Those counselors are wrong.

Tangibility

Another theme that emerged from the data is one of tangibility. Meaning many participants needed a very specific reason or crisis to justify seeking and utilizing mental health services. For some, it was a death of a best friend or the unrealized dream of being a parent. For others, it was an attack on their professional identity, while others were faced with losing a parent. For many, the pandemic was enough of a strain that it pushed them towards needing more mental health support. The data revealed that there was emotional and mental anguish present for each participant before they sought resources. This reluctance to seek support parallels the strong black woman (SBW) framework referenced in research conducted by Woods-Giscombe, (2010) and Liao et al. (2020). The SBW schema is a race and gender schema that assigns culturally specific expectations for Black women that include unwavering strength, assumption of multiple roles, and being a caretaker for other people. Further, Black women are taught by society to internalize and accept the SBW schema (Beauboeuf-Lafontant, 2007; Settles et al., 2008; Liao et al., 2020). Many participants expressed how they felt weak for seeking services. The words “strong” and “strength” were used often. Among Black women, the concept of “strength” is a central and important aspect of their identity (Abrams et al., 2014). What should be noted is that many studies support a link between the SBW schema and negative health outcomes (Beauboeuf-Lafontant, 2009; Romero, 2000; Woods-Giscombe, 2010). Perhaps these participants have internalized the SBW schema to survive the issues related to their intersected race and gender identity. Counselors should familiarize themselves with this schema and be

ready to acknowledge and explore these beliefs and attitudes.

Therapy is Healing/Helpful

Despite some painful experiences, all the participants in this study agreed that considering all barriers, counseling and other mental health resources were both healing and helpful. This theme was found in every participant interview. Each woman in the study spoke extensively about the benefits of utilizing mental healthcare resources and through these services they were able to work through issues like career, identity shifts, marital issues, and parenthood. When the working alliance and counselor match was ideal, participants avowed that they were able to take up space in a way that was not available in other parts of their lives. Because these participants were working high-stress jobs, managing relationships, and navigating complicated mental health issues they needed a place where they felt accepted and heard. Many of the participants talked about what a relief it was to be able to unburden their minds for at least 1 hour a week or 2 hours per month. That time and relationship shared with their counselor contributed to feelings of safety. The space that was created within the relationship was described as sacred. Some women described the time it took to establish rapport and admitted that it took longer with some therapists due to the internalized stigma of divulging your issues to a stranger and appearing weak. When match (identity and values) was ideal, the participants reported that using mental health services gave them the tools they needed to recognize patterns of behaviors, set boundaries, explore possibilities, and take care of themselves and their families better.

Interpretive Lens

Critical Race Theory (CRT) and the intersectionality framework were the lenses used for interpreting participants' responses. Considering each participant identified as a Black woman, the intersectionality framework helps me to understand the experiences of these women and how

different positions of power and oppression intersected to influence social relations and their distinct points of view that shape and influence their everyday life. Harris and Crenshaw et al. (2012) described four themes that are relevant to this qualitative study. In particular, the theme that states that the rejection of the dominant Eurocentric narrative can and should be countered with the perspectives and experiences of oppressed minority groups. The current study is an attempt to understand the experiences of this oppressed minority group (high-achieving Black women) and I acknowledge that my desire was to understand the lived experiences of these women when using mental health resources. Although race is a social construct with no true biological reality, it plays a key role in how these women move throughout their worlds. Consistent with both intersectionality and CRT, participants disclosed feeling misunderstood and dismissed in their lives because of the intersections of their identities, both race and gender.

Counseling Profession Implications

The following sections describe and outline how the results of this research can be used by counselors, counselors in training, and counselor educators. The suggestions include the use of outside resources, opportunities to engage students, and partnering with professional organizations. While these suggestions are not exhaustive, they are potentially a great place to start for professionals and counselors in training.

Clinical Implications

Counseling scholars and practitioners have stated that multicultural competence is imperative to working effectively with diverse communities. Both counselor and client bring several identities to the counseling space, all of which can impact the therapeutic relationship. These identities bring privileged and marginalized statuses, cultural values, beliefs, and biases. The original multicultural counseling competencies (MCC) focused on attitudes, knowledge, and

skills and focused on the “majority” counselors working with “minority” clients. While well-intentioned, these competencies did not acknowledge the salience of intersecting identities and how minority counselors would often work with privileged clients. Further, no longer is it sufficient to engage in only multicultural counseling and competencies, it is now necessary for counselors to engage in social justice and advocacy. If the point of the MCSJCC is to consider how the dynamics of power, privilege, and oppression impact the counseling relationship, then this study exhibits how counselors from all cultural backgrounds can make the counseling experience better for high-achieving Black women. The women in this study identified feelings of dismissal and judgment and many of those interactions may have been more positive if counselors were trained better in how to broach sensitive subjects that clients of color experience. Practicing counselors must intentionally engage with communities of color to understand what is wanted and needed in those communities. Counselors can take trainings that focus on racial and generational trauma, earn continued education credits by choosing workshops or committees that aim to address systemic barriers, or by finding resources that help counselors understand privilege, racism, and healing. There are numerous workbooks and books available that a counselor could use to increase competencies that would partner well with trainings or service. The Racial Healing Handbook (Singh, 2019), The Queer Transgender Resilience Workbook (Singh, 2018), and the Unapologetic Guide to Black Mental Health (Walker, 2020) are a few examples of workbooks and literature available for those who want to increase knowledge and understanding about these topics. These resources do not offer counselors all the answers but serve as a starting point to increase competencies and offer tools that can be useful. Counselors need to consider the bias that exists in certain assessment instruments when working with marginalized clients. Context matters when assessing clients. It is possible that the client

may be exhibiting maladaptive behaviors because of some mental health issue, but it should be considered that perhaps the client is reacting to an environment that increases anxiety, aggression, or anti-social behavior. Counselors should consider a comprehensive approach when assessing clients. Assessment may include collecting information from significant persons in the client's life as well as the patient themselves. Many clients may show a reluctance to having others involved with their mental healthcare but the topic should be broached regardless.

The findings of the current study emphasize the need to directly ask clients what is wanted and needed from mental health professionals. Counselors should be cognizant of the stigma that permeates AA culture (families, friends, church) and the lasting effects on help seeking behaviors. It is important to remember that high achieving Black women are facing discrimination and pressure at home and at work. Repeatedly participants emphasized the need for a sacred and safe space to take off all their armor that is needed in the outside world to survive. Counselors should practice addressing societal pressures and the need to be one person in the professional space and another in the personal space. The term "code-switching" is used to describe the language and disposition Black women must assume when they are in prominent white spaces (McCluney et al., (2019). This requires a large amount of energy and constant monitoring and modification. Counselors should also be prepared to address the reason's this community seeks mental health resources and be aware that many high achieving Black women need a tangible reason to seek services. Ultimately, counselors need to understand that no client is alike and that there is no way to practice perfectly. The key to being comfortable broaching these topics can only come from practice and revision of techniques. To read about doing something is one thing, to be in the counseling space having these conversations is another. Counselors who identify as a person of color are not excused from the difficulties that can occur

when building relationships with clients of color. Counselors with marginalized identities are still responsible for identifying their own bias and working to minimize the impact of those biases on the counseling relationship. No matter which identities counselors possess building a relationship with clients must start with transparency and honesty about cultural knowledge and discussions about how experiences differ and how that may impact the therapeutic relationship.

Counselors can benefit from examining their own social locations and world views. This could enhance the therapeutic relationship between the counselor and client as it would demonstrate the counselor's commitment to reflecting and acknowledging the systemic barriers that exist in our society. Self-reflection would allow the counselor to become more comfortable and increase self-awareness. This should then result in more ease in conversations around positions of power and oppression. Counselors of color who have their own experiences with systemic barriers and oppression will need to reflect on their bias and make sure that their assumptions are not a barrier to creating a working alliance with other clients of color. There seems to be an extra layer of disappointment when clients of color have bad experiences with counselors of color. Clients go seeking validation from someone they think can understand their struggles and instead are met with resistance and judgment from members of their own cultural community.

Counselors can contribute to reducing within-group stigma for seeking counseling by first being made aware of the extent of the stigma and talking about it directly. This direct conversation should be with clients and with colleagues who serve communities of color, specifically the Black community. Unfortunately, within-group stigma can detour a person from sharing their mental health struggles, seeking counseling, and attending counseling. So often the experiences of these participants were dismissed or minimized using religion, faith, and strength.

Keeping these things in mind will only aid counselors to recognize and reduce within-group stigma.

Counselor Education and Training

Considering counselors receive the most support when they are in training during their master's programs, there are many opportunities for students and faculty to practice and apply knowledge to better serve high achieving Black women.

In the classroom curriculum, educators should use case studies, media, texts, and examples that address this community and their specific challenges. Guest speakers should be used to supplement class curriculum. Hearing directly from Black women about their needs would be advantages and would give the class an opportunity to ask questions and clarify. This is with the understanding that no one speaker can represent an entire group but offer personal experiences of what does and does not work for them in the counseling space. Class discussions around identity and intersectionality would be an ideal way to examine how individuals from different groups have distinct points of view. Further, intentional discussions that highlight the counseling field's cultural encapsulation, and how that impacts how we view clients and mental illness would be beneficial to students. Counselor Education programs have to make better efforts to recruit and retain counselors of color so that more students can see themselves represented in their programs. This could start a trend of more students of color and therefore more clients of color.

Supervision provides another opportunity for students to engage in practical application of broaching subjects that impact different communities. Frequently incorporating the MCSJCC into supervision can facilitate a better understanding of the positions power and oppression that counselors and clients occupy. Counselors in training will benefit from having in depth

conversations throughout supervision that will help develop not only comfortability around these topics but solidify their counselor identities. Counselor education programs can provide different training opportunities for counselors in training by partnering with different professional organizations to establish professional affiliations and have professionals already in the field model their techniques and approaches to serving communities of color. This also serves as a way to hold those professional groups accountable for putting actions to words. Both counselor education programs and professional counseling associations can benefit from spending more time figuring out how to attract more Black and Brown people to the field. This may consist of forming task groups, dedicating more time to research around this subject, as well as going directly to the community and asking: What can we do to attract more people like you to this field because frankly, we need you.

Limitations

There are a few potential limitations that need to be considered when examining the research study's findings. The first limitation is the sample size. Moustakas (1994) recommends that the sample size for a transcendental phenomenological study be between 10 and 15 participants. Unfortunately, while many efforts were made to recruit at least 12 participants, only nine participants were willing and eligible to participate in the study. I, as the researcher, had to move forward at a certain point due to time constraints. With more participants sharing their stories, more data could be gathered, which may have resulted in more insight into the phenomenon. A second limitation is that while all the women in the study identified as women of color, all the participants identified as Black/AA. Initially, this study was meant to examine the experiences of both Black/AA and LW. The lack of these perspectives means that I was not able

to gain any insight into how LW have been experiencing the counseling space, counselor style, match, and stigma.

Suggestions for Future Research

The results of this study suggest some ideas for future research that would add important information to the current literature that is focused on how mental health practitioners can better serve communities of color, those with multiple marginalized identities and women. These recommendations are organized into categories and include importance and relevance to the profession.

Employer Benefits and Mental Healthcare Resources

Future research should focus on further exploring the use of employer benefits. The employer benefits that are used to reduce the financial barrier for clients is still precarious and limiting. The importance of offsetting the cost of mental healthcare is important when looking at utilization trends and better understanding of how employer benefits create and remove barriers could help us better understand what benefits should look like in the future. Insurance companies and policy is not simple or easy so this will require researchers to gain knowledge of that sector and how it impacts employees and clients. The use of employee benefits was discussed heavily during interviews so that I could get a better picture of how helpful/harmful the benefits were. An exploration of those who choose not to use employer benefits would be great information for counselors and employers.

Application and Integration of MCSJCC in Counselor Education and Continued Education

There is still a strong need to show counselors in training, educators, and counselors how to integrate and apply the Multicultural and Social Justice Counseling Competencies (MCSJCC).

The research already supports these ideas, but I believe that counselors need continued concrete ways to integrate the MCSJCC into practice and conceptualization. Future research that explores how counselors apply these in practice would be a great way to contribute to the field. It would also expose what is missing when counselors integrate the competencies into practice. What language works best when broaching these subjects with clients? How would you model these competencies for other counselors who have identities of privilege and oppression? These are a few questions that could be explored. While counselor education programs attempt to integrate the MCSJCC into curriculum, there are opportunities to explore what is working for students and programs.

How Other High-Achieving Women of Color Are Experiencing the Counseling Space and Post-Partum Depression

While this study focused on Black women, future research should focus on other minoritized groups of high achieving women. Each group has their own stereotypes, cultural experiences, and coping mechanisms. There is an opportunity for researchers to explore mental health utilization for other women of color. This future research could again result in best practices and heightened knowledge of minoritized groups to better understand their experiences and develop tools to support them.

Another consideration for future research includes the exploration of how WOC access treatment after having children. AA and LW are less likely to begin treatment for postpartum depression compared to their White counterparts. To better support mothers and their mental health we should examine why this happens. There are probably a number of factors that influence why these women choose to deal with post-partum on their own. Is it simply the aversion to help seeking behaviors or is it the internalized notions of strength and weakness? Is it

the systemic barriers that exist in the healthcare system that continues to exclude women of color? These women deserve to have their experiences highlighted in a respectful and sensitive way. This information can benefit families, companies, healthcare workers, counselors, and doctors.

Conclusion

This research was conducted to explore the experiences of high achieving Black women and any perceived stigma when utilizing mental healthcare resources. The purpose of the research was to provide helpful information about these experiences so that mental health clinicians and counselor educators could provide the highest quality of care to this population. This study was a transcendental phenomenological study that culminated in the description of 9 Black women's experiences accessing and utilizing mental healthcare resources. Semi-structured interviews were conducted with these participants and these women shared with me fragile and personal stories. Their experiences demonstrate the work that still needs to be done to support this community, as well as how helpful and healing it can be when this community is given the space, financial support, and safety to attend to their mental health.

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Appendix A

1. Tell me about your experience with using employer provided mental health care resources through your health insurance plan.
2. How did you family feel about mental health and mental health services when you were growing up?
3. How did you decide what agency or counselor to use?
4. What factors led to your use of mental healthcare resources?
5. How were these services paid for?
6. How helpful was your time in counseling?
7. Would you recommend mental health counseling? Why or why not?
8. Were there any unforeseen consequences to utilizing your employer provided mental health services?
9. Were there any financial barriers to accessing your employer provided mental health care resources?
10. What was your impression on the available resources available to you in your community?
11. If you used your own money to pay for counseling, when resources were available, why did you choose to do so?
12. How would you describe how you felt about mental health counseling before and after you sought services?
13. What was you experience in accessing and utilizing mental health care resources either through your employer or outside of employer benefits?
14. What factors contributed to the cessation of or the continuation of services?

15. In what ways if any does Stigma impact the use of employer benefits and/or cessation or continuation of counseling?
16. Is there anything that we haven't talked about that you want to make sure is known about your experience?

Appendix B



To: Andrea D Hampton Hall
From: Justin R Chimka, Chair
 IRB Expedited Review
Date: 11/15/2021
Action: Expedited Approval
Action Date: 11/15/2021
Protocol #: 2108353814
Study Title: Something Like a Phenomenon: Working Minority Women and Experiences of Stigma in Mental Health Utilization
Expiration Date: 10/02/2022
Last Approval Date:

The above-referenced protocol has been approved following expedited review by the IRB Committee that oversees research with human subjects.

If the research involves collaboration with another institution then the research cannot commence until the Committee receives written notification of approval from the collaborating institution's IRB.

It is the Principal Investigator's responsibility to obtain review and continued approval before the expiration date.

Protocols are approved for a maximum period of one year. You may not continue any research activity beyond the expiration date without Committee approval. Please submit continuation requests early enough to allow sufficient time for review. Failure to receive approval for continuation before the expiration date will result in the automatic suspension of the approval of this protocol. Information collected following suspension is unapproved research and cannot be reported or published as research data. If you do not wish continued approval, please notify the Committee of the study closure.

Adverse Events: Any serious or unexpected adverse event must be reported to the IRB Committee within 48 hours. All other adverse events should be reported within 10 working days.

Amendments: If you wish to change any aspect of this study, such as the procedures, the consent forms, study personnel, or number of participants, please submit an amendment to the IRB. All changes must be approved by the IRB Committee before they can be initiated.

You must maintain a research file for at least 3 years after completion of the study. This file should include all correspondence with the IRB Committee, original signed consent forms, and study data.

cc: Erin K Popejoy, Investigator