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The Importance of Properly Addressing Mental Health on College Campuses

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Section I: Revised Philosophy of Service

In reassessing the Philosophy of Service that I wrote during my freshman year at Providence College, I found much of what I wrote to be somewhat superficial. I constructed my original paper with one goal in mind -- to get an A. I believe that I did get an A, but what good did that really do me? In this revision, I hope to address aspects of my original paper that I still do agree with, and refute other aspects that I believe to be less accurate. Thus, creating an improved Philosophy of Service.

In the introduction of my original Philosophy of Service, I discussed the ways in which my upbringing in the Catholic Church has impacted my core values. Charity, social justice, and kindness are some of the values that I do hold near to my heart, and that has not changed. However, what surprised me about my original paper was that I decided to open in such a way that deeply emphasized my relationship with God. My religious journey within the Catholic church and my own experience of spirituality has been a non-linear process over the past 22 years. As a child, I attended Catholic Mass every Sunday with my parents and my younger sister. Although it is difficult to remember exactly how I felt about attending mass in my earlier years, I do remember times in which I would sit in the pew between my parents, listen to the scripture, and benefit greatly from the mass. However, in my early adolescence I began to draw away from the church entirely and in all honesty have not fully returned since.

Although I am not as immersed in the church as my original paper made it seem, I still find myself to be heavily impacted by Catholic values, primarily due to my parents relationship with the church. My parents always taught me to act in a selfless manner and to give back to others, whether it be through service or through acts of kindness. Helpfulness, compassion, selflessness, and consideration of others are just a handful of values that my parents have

instilled in me from a young age. These values have always impacted, and will continue to impact the way in which I approach any situation in my life -- service being one of them. As I stated in my original paper, I am motivated to serve "because I strive to make other people happy" (Hunt 2017). It is in my nature to put others before myself and I feel as though my values in conjunction with my past experiences engaging in service work, have shaped how I have now come to define service.

In my original paper, I had defined service as "an act of selflessness that positively impacts the lives of others" (Hunt 2017). Although I do agree with my original statement, I believe service to be more than that -- it's multifaceted. Service involves the coming-together of individuals in hopes of doing something *for* someone or *with* someone in order to reach a common goal. There may be instances in which certain individuals rely heavily on the assistance of others to complete a task. For example, elderly individuals may not be able to attend to their daily tasks on their own, so they rely on volunteers to do things *for* them to help them get through the day. On the other hand, students in an after school program do not necessarily need help from those in the community to get through the day. However, working *with* volunteers to achieve a common goal often makes tasks easier and more manageable.

I personally have engaged in a number of service opportunities, some of my own accord and others for the sake of a requirement. As Martin Luther King Jr. wrote in his piece, *On Being A Good Neighbor*, he asserted that "the Samaritan had the capacity for a universal altruism" (King 2). That is, they do not serve others in hopes of receiving a reward -- They are invested in those around them for unselfish and genuine reasons. Upon reflection, I have come to realize that almost every single service experience that I have engaged in at Providence College has come with some sort of payoff, which begs the question of whether my service work was

altruistic. Of course, I always had the right intentions and wanted to serve others in the best way that I could, but I was always in some way rewarded for my work.

For example, in PSP 101, I received course credit for working at Esek-Hopkins middle school. In my sophomore year, I worked as a Community Liaison for the Feinstein Institute. During this time, I engaged in service at Nathan Bishop middle school. Subsequent to the completion of my time as a liaison, I was able to put the position on my resume under "Volunteer Experience," hence boosting my personal successes to prospective employees. Lastly, during my time as a Mental Health Worker & Activities Therapist, I was able to serve the vulnerable population of those suffering with serious psychiatric conditions. Whilst in this position though, I still received compensation in the form of paychecks. As Mother Theresa said in her poem, "At the end of life we will not be judged by how many diplomas we have received, how much money we made, how many great things we have done. We will be judged by 'I was hungry and you gave me to eat,' 'I was naked and you clothed me,' 'I was homeless and you took me in' (Mother Teresa 2). Similar to genuine service, there should be no payout or reward for time spent serving, but how realistic is that? I feel as though my service experiences were genuine, but I am not so sure I can say that I was engaged in them purely for altruistic reasons.

Another key concept with regard to community service that I addressed in my original paper was the idea of community. Whilst discussing the concept of "community" in my original Philosophy of Service, I defined the term as "something that I am actively involved in" (Hunt 2017). While I do believe that to be true, I also find it to be somewhat vague. In order to narrow in on my own definition of community, I now define it as a group of individuals who share common goals, who live in proximity to one another, share particular characteristics, or share

similar attitudes/beliefs. It is still a rather broad definition, as I believe that there are many interpretations of what a "community" could be.

I have found that I am a part of many communities. I am a part of the Providence College community, the community of student undergraduates, part of my hometown community, and many others. These communities that I am a part of shaped my identity as a daughter, friend, and student. In my original Philosophy of Service, I stated that I believed I was a part of the Esek-Hopkins community due to my service work at the middle school. I wrote that I was a member of the "Esek-Hopkins community because I had been accepted by the kids there, as well as the staff," to which I now disagree (Hunt 2017). I think I was actively engaged with the community of Esek-Hopkins and the greater Providence community, but in no way was I a part of it. I attended the afterschool program for 3 hours on a weekly basis for one semester of my entire college career, which is a miniscule chunk of time if you ask me. Looking back, I understand why I wrote what I did. I enjoyed establishing genuine connections with the children at my service site and always made myself available to listen to them. Brenda Ueland, in her work, *The Art of Listening*, says that she has "come to think listening is love, that's what it really is" (Ueland 3). I was able to show my love for the kids that I worked with by creating deep and authentic bonds through the art of conversation. My love for the kids was genuine, and I always felt very welcomed by the community that I had worked with. However, I now understand that although I had a lot of love for the individuals that I served, I realize that will never truly be a part of their community.

As for my current Philosophy of Service, I believe that my new perspective is very different from that of my past-self. My Philosophy of Service is to always try to give back to as many people as I can with the right intentions. From a young age, I have always tried my best to

make other people happy. Service, to me, does not have to be anything crazy. It can simply be spending time with someone to make their day a little bit better. Sometimes, I think our society has a bit of a skewed view as to what community service really is -- which oftentimes results in inauthentic acts of service work. To me, I believe that the quality of service is not the amount of hours you put in, but rather the impact you have on those around you paired with the right intentions. There are things we can do in our everyday lives that have an impact, such as holding the door for someone behind us or helping someone carry their books. Something that I have learned throughout my years in the PSP department is that service is more of a mindset than anything else. You cannot teach altruism, nor can you force genuine service.

Section II: Literature Review

1. Mental Health Treatment Barriers Among Racial/ Ethnic Minority Versus White Young Adults 6 Months After Intake at a College Counseling Center

Barriers to treatment are one of the primary reasons as to why individuals do not receive adequate care for their mental or physical health concerns. These barriers can be physical barriers, such as lack of access to a car to get to appointments, lack of financial resources, etc. However, barriers that we often neglect to address are the underlying prejudices and inequalities that oftentimes prevent individuals from receiving care.

In a study conducted by Miranda et. al (2015), researchers examined the ways in which mental health treatment barriers differed for students of color as opposed to white students. 122 college students with previous mental health concerns were recruited to participate in the study. Although there were no statistically significant differences in mental health outcomes, the study did find that "racial/ethnic minority students less often reported having sought treatment in the past, and also treatment after they were seen at the counseling center, compared with white students. In addition, they endorsed a greater number of barriers to treatment in the previous 6 months and anticipated future barriers" (294). These barriers included students' belief in themselves to overcome their mental health problems without treatment, a lack of time to receive care, the belief that treatment would not be helpful, the overarching stigma associated with mental health, and a lack of knowledge as to how to receive treatment.

In previous studies, researchers had really only drawn from pools of white students, and had yet to address racial/ethnic barriers. The barriers mentioned above can be detrimental to the health and well-being of many individuals. Despite a high prevalence of psychiatric disorders in the black community, black students of color are less likely to seek mental health treatment when compared to their white counterparts (291). Although this study was conducted with the

intention to gather numerical data, it also allowed researchers to begin to understand social concerns regarding mental health treatment. Something that I found to be particularly interesting was that "stigma" was not the primary barrier to treatment. This is due to a recent push for more inclusivity and acceptance on campuses with regard to mental health. In order to "minimize the 'us/them' thinking," many universities have led campus-wide initiatives to dismantle the stigma associated with mental health, and subsequently normalize receiving treatment for mental health concerns (291). What these universities have not done, however, is address the racial disparities with regard to receiving initial treatment, as well as follow-up care.

In sum, this study offered interesting insight as to the ways in which race and ethnicity may impact an individual's ability to receive treatment and continue to receive treatment. By discussing the racial and ethic disparities with regard to treatment utilization in college students, it is clear that there are underlying issues that are preventing individuals from receiving the care that they need. This is interesting for me to consider as I write my paper because my topic is specifically targeted to college-aged individuals. It is important that I address possible barriers to treatment that are not as well-known and this paper allowed me to begin to understand some of those barriers in a little bit more detail.

2. Therapist, Parent, and Youth Perspectives of Treatment Barriers to Family-Focused Community Outpatient Mental Health Services

This study offers a little bit of a different approach to barriers of treatment. In a qualitative study conducted by Baker-Ericzén, Jenkins, and Haine-Schlagel (2012), researchers attempted to perform a "qualitative study describing treatment barriers to receiving family-focused child mental health services for youths with disruptive behavior problems from multiple perspectives (1). Although this study is not rooted in the mental health concerns of college-aged individuals, it does address barriers to mental health intervention in childhood that could impact an individual's access to treatment later in life. Specifically, children who are untreated or under-treated for psychological concerns are at "significantly elevated risk for a variety of maladaptive outcomes in adolescence and adulthood, including adult conduct problems, criminal behavior, and psychopathology" (2). Early intervention for mental health concerns is crucial in the outcomes of those who struggle with mental health issues. This intervention is oftentimes family-oriented, and relies heavily on the involvement of the loved ones of those struggling. These family-based therapies utilize cognitive behavioral techniques, as well as parent training interventions to best address the needs of the children.

In theory, this seems to be a solid approach. However, "results indicated similar themes around treatment barriers and dissatisfaction with services within and across multiple stakeholder groups." Additionally, "several parent/family factors have been shown to be associated with parent engagement in family-focused treatment for child mental health problems, including motivation, expectations, and perceived barriers" (3). Acknowledging parents' views on barriers to treatment, as well as observing their engagement in their childrens' treatment is integral to understanding areas where the system might be lacking. For example, family-based treatment will only be successful in cases where the family is involved and engaged in the treatment. If

one or more individuals within a particular family choose not to comply, the treatment is essentially ineffective.

Although this study was conducted with children and their parents, the focus of the study is rather important in understanding the overarching themes of mental health treatment in general. The purpose of the study was to elicit these "meaningful themes, gather depth and richness to fully grasp the complexities of community-based care and examine the concordance across informants" (4). There seems to be a lack of awareness with regard to the variety of barriers that exist that prevent individuals from receiving the care that they need. These complex barriers can be "attitudinal, situational, structural," and oftentimes prevent individuals from fully engaging in treatment that would greatly benefit them.

Although this article does not specifically focus on college-aged individuals, which is what I plan to do in my paper, it does give good insight as to early interventions for treatment for mental health. It is also important to understand that there are barriers to treatment for many populations, whether they be college-aged individuals, young children, or older folk. Unfortunately, there will always be barriers that individuals may face in receiving treatment, but it is through the understanding of these barriers that we may best address the needs of those with mental health concerns.

3. Treatment Barriers for Low-Income, Urban African Americans With Undiagnosed Posttraumatic Stress Disorder

This study focuses on treatment barriers for African Americans living low-income urban environments who have been diagnosed with a mental illness, specifically PTSD. Due to the nature of these low-income neighborhoods, many residents have reported experiencing traumatic events, such as "having relatives/friends murdered (47%), being attacked with weapons (64% of men), and being sexually attacked (36% of women)" (1). In fact, a recent study found a "65% rate of life-time trauma exposure" for individuals in these low-income communities. These traumatic experiences often resulted in individuals reporting signs and symptoms of PTSD that were either diagnosed or remained undiagnosed. This high trauma prevalence leads to an increase in risk for the development of serious mental illnesses.

Of course, there are social, economic, and physical barriers that prevent individuals in these communities from receiving treatment. These barriers include "limited transportation and finances, family disapproval, and unfamiliarity with accessing treatment, among others" (2). These barriers to treatment for mental health are in part due to the social determinants of health, which oftentimes prevent individuals of lower socioeconomic statuses from receiving adequate health care. This is why many illnesses, physical and mental, go untreated, undertreated, or undiagnosed.

Stigma also plays a huge role in preventing individuals from accessing the care that they need. In fact, the individuals in this study reported cultural barriers with regard to stigma in the African American community. These individuals specifically noted "fear of family and community disapproval" as one of the most significant social barriers to treatment (3). This may be due to the African American view of faith, the church, and the healing process in general.

That is, many individuals in the study endorsed that they rely heavily on their church community in times of poor mental health instead of receiving care from a trained professional.

This particular study included 220 participants, all of whom completed the "Medical and Social Needs" questionnaire, as well as the "Barriers to Need" questionnaire. As for numerical data, researchers found that their participants reported higher rates of PTSD (22%), as compared to the general public (9-12%). The majority of participants with PTSD stated that they would like to receive treatment for their mental health condition, but have yet been able to receive PTSD-focused treatment.

Additionally, many mentioned the barriers that they have faced with regard to receiving, or not receiving, treatment. The barriers, as mentioned above, may have led to "inadequate treatment resulting in more severe PTSD symptoms as compared to those who reported fewer barriers" (4). This is significant, as even some forms of treatment can worsen pre-existing symptoms if not conducted in the appropriate manner. Additionally, "the reverse could also be true, that people who have increased barriers to treatment may be more likely to develop PTSD" due to their inability to receive the necessary care. The inability to access health care can cause unnecessary strain in an individual's life, and in some cases may be considered traumatic depending on the circumstances. Thus, one's inability to access health care, the prejudices they have faced, or oppression in the form of unequal treatment may contribute to the prevalence of their mental illness.

4. Mental Health Treatment Seeking Among Older Adults with Depression: The Impact of Stigma and Race

This article discusses the impact of stigma and race on the treatment of Major Depressive Disorder amongst older adults. Stigma continues to be one of the most significant barriers when it comes to treatment. It leads to a decrease in help-seeking behaviors, which negatively impacts attitudes about mental health. These attitudes may deter individuals from treatment that they could greatly benefit from. This particular study assessed the impact of "public stigma (negative attitudes held by the public) and internalized stigma (negative attitudes held by stigmatized individuals about themselves) on racial differences in treatment-seeking attitudes and behaviors" in adults struggling with diagnosed mental health conditions (1).

It is interesting that this article discusses both public and internalized stigma. Public stigma has been regularly addressed in the media, in research, and in everyday life. However, the internal stigma that an individual may feel due to their own illness is not one that is often addressed. Internal stigma may prevent those who need care from receiving it due to their internal beliefs and attitudes towards mental illness. Many times, the individual may not even realize that they may benefit from treatment for mental health, and therefore forego it. It is also important to keep in mind the demographic of this study, as older individuals have been found to not seek treatment for psychiatric conditions. Similarly, as an individual ages, it is sometimes difficult to decipher what is considered normal, healthy aging and what may be consistent with symptoms for a disorder. Less mobility/ability to engage in pleasurable activities, diminished ability to think or concentrate, loss of appetite, and fatigue are all normal signs of aging that also happen to be possible signs and symptoms of Major Depression.

In this study, researchers looked in depth at mental health treatment disparities in elderly African Americans individuals versus elderly white individuals. Looking it the issue of lack of

treatment through the lens of race, researchers found that due to their "life long exposure to and experiences with racism, discrimination, prejudice, poverty, and violence," black individuals tended to have "fewer psychological, social, and financial resources for coping with stress than their white counterparts" (2). These social determinants of health impact all medical areas of an individual's life, whether it be regarding physical or mental health. Due to these inequalities, it has been found that African Americans are 10 times less likely to seek out treatment for their mental health. Even if they do get treated, they typically attend fewer therapy sessions when compared to similar-aged white individuals. This demonstrates that race certainly plays a role in the disparities with regard to seeking and receiving treatment for mental health conditions.

In this study specifically, researchers used the "Patient Health" questionnaire, the "Perceived Public Stigma Scale," and the "Internalized Stigma of Mental Illness Scale" to assess stigma and race on mental health treatment. Something interesting that came out of this study was that the findings suggested that "older adult survey participants with higher levels of internalized stigma were significantly more likely to intend to seek mental health treatment" (5). This is interesting as often, stigma inhibits individuals from seeking treatment. However, in this study, that was the opposite. This is unlike findings from other similar studies, as these other studies have found that increased perceived public stigma and internalized stigma reduces an individual's likelihood to seek treatment. In sum, this was a very interesting study, as it looked at many different aspects of barriers to treatment, as well as the impact of two different types of stigma.

5. How Stigma Interferes With Mental Health Care

In the article *How Stigma Interferes With Mental Health Care*, Patrick Corrigan discusses the ways in which stigma has an impact on an individual's willingness to participate in treatment, and their compliance in said treatment. Although many individuals would benefit from treatment for mental health issues, many often elect not to engage, out of fear of stigma and social repercussions. Stigma, Corrigan says, leads to two kinds of harm: one that diminishes the self-esteem of the individual and one that robs people of social opportunities. Stigma specifically is a "social–cognitive process that motivates people to avoid the label of mental illness that results when people are associated with mental health care" (614). This label, and avoidance of such labels, oftentimes deters an individual from receiving the care that they need.

An important question throughout this article that Corrigan considers is whether the "problem of stigma and adherence applies to the generic concept of mental illness, or differs by diagnosis and/or level of disability" (614). There are a range of mental illnesses that impact individuals at varying levels. Even in psychiatric hospitals, for example, units are designed to treat individuals of similar mental health status per say. There are the Intensive Treatment Units, General Treatment Units, Outpatient Units, etc, that are designed to treat specific levels or degrees of mental health conditions. Sometimes, a more "intense" label may deter an individual from receiving treatment altogether, which results in poorer health outcomes. In fact, some studies suggest that the public "discriminates among psychiatric groups in terms of stigma; for example, people with psychotic disorders are judged more harshly than people with depression or anxiety disorders" (614). This could be in part due to the commonality of disorders, such as anxiety and depression in our society, as they seem to be more thoroughly understood, unlike most psychotic disorders.

Something that I found particularly interesting about this article was the way that Corrigan discusses public stigma and the effects it may have on one's social opportunities. Oftentimes we recognize the effects of mental illness on the individual in the present, but fail to recognize the lasting effects it may have on their future social opportunities and social engagement. The impact of "stereotype, prejudice, and discrimination can rob people labeled mentally ill of important life opportunities that are essential for achieving life goals" (616). Due to this discrimination, those struggling with mental illnesses are frequently unable to find jobs, good housing, or even engage in regular social activities.

Something that contributes to this discrimination is the way in which individuals with mental illnesses are portrayed in the media. Specifically, the criminal justice system is known for dealing with complex cases involving mental illness. The discrimination occurs when "police, rather than the mental health system, respond to mental health crises, thereby contributing to the increasing prevalence of people with serious mental illness in jail" (616). In covering such cases, the media often focuses on the mental status of the offender, sometimes neglecting other factors contributing to the crime.

Overall, this article covered an array of topics, ranging from public and self stigma to issues regarding social justice. I enjoyed reading Corrigan's point of view and believe him to be very informed in his beliefs and knowledgeable in this field.

6. Mental Health Consumers' Experience of Stigma

In this article, Otto Wahl discusses the extent to which individuals with mental illnesses encounter the effects of stigma on a regular basis. Much of the time, there are "negative responses to people who have been identified as having a mental illness," which "are seen as a major obstacle to recovery, limiting opportunities and undermining self-esteem" (467). Labelling mental illness in a negative light stigmatizes those who may struggle with it. There have been numerous studies that have attempted to demonstrate the effects of the labelling of mental illness and the implications it may have on those who are struggling.

Similar to *How Stigma Interferes With Mental Health Care* by Patrick Corrigan, this article discusses stigma research. In his first approach, he involves self-reports from the general public. These self-reports are able to assess the attitudes of the general public towards individuals who are mentally ill. Interestingly, more recent surveys suggest "improved attitudes" towards those with mental illness. One study found that "the majority of people in a 1993 Parade Magazine survey agree that "more tax money should be devoted to caring for the mentally ill'" (467). This shows a step in the right direction with regard to the general public's opinion on mental health and the treatment of such conditions.

In this study, 1,301 individuals with mental conditions, who Walh calls "consumers of mental health," respond to a survey regarding their personal experiences of stigma and discrimation. First, participants were asked to take a *Consumer Experience Survey*, which contained three sections that asked specific questions regarding stigma, discrimination, and demographics. The questions were generated using "commonly reported stigma experiences through examination of first-person accounts of mental illness, such as those appearing regularly in the *Schizophrenia Bulletin and the Journal of the California Alliance for the Mentally Ill*"

(468). These accounts led to an initial selection of experiences which were included in the survey.

The study also included a round of interviews for a select number of participants. One hundred participants were randomly selected to partake in the interview round of the study. Participants were asked questions regarding discriminatory experiences they had had due to their mental illness. The participants were also asked to relay "what his or her behavioral and emotional reactions had been, how the experiences had affected his or her life, and what strategies had been useful in dealing with stigma" (469). This part of the study allowed researchers to really understand their participants in a more personal way, which I found to be incredibly valuable.

What researchers found was that the most commonly reported experience of stigma by those with mental illness involved "witnessing stigmatizing comments or depictions of mental illness" in everyday life. In fact, almost "80 percent of survey respondents indicated that they had overheard people making hurtful or offensive comments about mental illness; half reported noticing these often or very often" (470). Although these offenses do not seem to be an outward act of discriminatory behavior, even comments or small remarks in conversation have the capacity to truly impact an individual living with a mental health condition. Of course, more outward acts of discrimination were also reported, but were not nearly as common as smaller comments and conversations. This study provided great insight as to the ways in which stigma can impact those living with mental illnesses.

7. Stigma and Help Seeking for Mental Health Among College Students

This article really ties into where I see my entire Capstone Thesis going. Mental health and mental illness in college students is especially relevant in the lives of many of my friends, peers, and fellow Friars. Stigma regarding mental health has been identified as one of the most common barriers to receiving treatment. One in four individuals will experience some form of mental illness at some point in their lives, which is quite significant given the disparities in the health/mental health care systems. Those who do receive substantial care often delay seeking help in times of crisis, or "do not adhere to recommended treatment" (522). This is especially relevant in the lives of college students, seeing as approximately three quarters of lifetime mental disorders will first appear before the age of 24-years-old. Studies have found that those who receive treatment for mental health in college will benefit in the long-term.

Stigma, however, often prevents an individual from engaging in treatment and receiving care. Attitudes and behavior are greatly impacted by stigma and the social perceptions associated with that stigma. In fact, "higher perceived stigma is associated with lower treatment adherence and premature termination" (523). Now, there are two types of stigma: perceived stigma and personal stigma. Perceived stigma involves the opinions of those in our social world; friends, family, teachers, etc. If an individual was to perceive his or her social circle as unacceptable to those with mental health concerns, they are less likely to remain in treatment, and may forego it all together. Personal stigma relates to an individual's own idea of mental health and their attitudes and beliefs about receiving treatment. If an individual were to have a high personal stigma, they may be less inclined to initially seek treatment or comply with treatment they may already be involved in.

In this study, Daniel Eisenberg, head researcher, conducted an online survey of college students regarding a multitude of topics related to mental health. A total of 13 schools participated in the study, all of which contributed to the overall diversity of the geographic population. Reserchers measured perceived public stigma using the Discrimination Devaluation Scale. It asked participants "how much they agree with each of 12 statements that begin with "*Most people believe* . . ." or "*Most people think* . . . ," or "*Most people would* . . ." followed by a stereotype, example of discrimination, or the opposite" (an accepting view or behavior) (527). They also measured help-seeking tendencies of participants by asking them questions such as: "*In the past 12 months, did you think you needed help for emotional or mental health problems such as feeling sad, blue, anxious or nervous?*" (527).

As for results, researchers found that females had slightly lower perceived and personal stigma when compared to males. Interestingly, "many students reported high perceived public stigma and low personal stigma, but almost no student reported the reverse—high personal stigma and low perceived public stigma" (530). This is noteworthy because the results suggest a greater impact of social perception on stigma and attitudes towards mental health. Similarly, increased personal stigma was significantly associated with decreased help-seeking behaviors, such as need for medication, as well as non-invasive treatment options. The findings from this study suggest that stigma reduction efforts on college campuses, specifically personal stigmatization of mental illness, will increase the number of students that are able to receive the care that they need.

8. Young people's help-seeking for mental health problems

This paper discusses the abundant amount of completed research on the factors that impact the beliefs and attitudes of young people regarding mental health concerns. This paper aims to specifically address "why young people, and particularly young males, do not seek help when they are in psychological distress or suicidal" (1). Adolescence and young adulthood presents an array of physical, psychological, and social changes in the lives of all young adults. Most mental health disorders appear before the age of 24, making this time period ever the more crucial when discussing mental illnesses. Depression, substance abuse, anxiety, eating disorders, bipolar disorders, and schizophrenia are just a handful of the many disorders that impact the lives of many young adults. The "lack of mental health literacy is especially salient as it is during adolescence and early adulthood that health-related behaviours are formed and when young people assume responsibility for their own health actions" (3). Several initiatives have been organized to educate the youth on resources to address their mental health concerns, which have proven to be particularly effective.

The current study aims to address ambiguity with regard to prior research involving factors that impact help-seeking behaviors in treatment for mental health. There are some barriers to help-seeking, however, that Rickwood aims to address. First, he addresses the lack of emotional competence by participants. As expected, "adolescents who were low in emotional awareness, and who were poor at identifying, describing, and managing their emotions were the least likely to seek help from informal sources and had the highest intention of not seeking help from anyone" (13). During one's adolescent years there are many physical and emotional changes that impact the health and well-being of individuals. Compared to adults, adolescents

have a more difficult time really understanding their emotions and consequently are not as inclined to seek out care.

Researchers also address the threat of negative attitudes and beliefs related to seeking professional help. These negative attitudes are "derived from negative past experiences and also from negative beliefs about seeking professional help" (16). Additionally, stigma contributes to an individual's negative beliefs towards the seeking professional help in terms of mental illness. Of note, positive attitudes, past experiences and mental health literacy have all positively contributed to mental health care facilitation. Just as stigma and other barriers impede individuals from receiving treatment, positive experiences in the world of mental health can help form positive opinions on mental health care in general and oftentimes facilitate continued treatment. This notion has been "reflected in comments made in the focus groups where the young people who had positive past experiences reported more positive attitudes to seeking help in the future" (18).

In sum, there are many factors that increase (or decrease) an individual's likelihood to receive and continue treatment. The "help-negation effect for suicidal thoughts, lack of emotional competence, and negative attitudes and beliefs regarding seeking professional mental health care" can all inhibit an individual from receiving care. By focusing on factors that facilitate help-seeking behaviors, such as the "existence of established social relationships that are based on trust and understanding," individuals are more likely able to benefit from treatment that could impact their health and well-being in the long term.

9. Mental Health Problems and Help-Seeking Behavior Among College Students

This article discusses mental disorders that are prevalent among college students, which seem to be increasing in number and severity. Although "college students are often viewed as a privileged population, they are not immune to the suffering and disability associated with mental illness" (1). In fact, "mental disorders account for nearly one-half of the disease burden for young adults in the United States" (1). Since college is a time of immense transition, social development, substance use, and academic endeavours, it makes sense that many students could possibly be struggling with mental health conditions. Many campuses offer substantial mental health services to their students, which is something that I will discuss later on in this paper. Past research has found that more than one in three undergraduates reported "feeling so depressed it was difficult to function" at least once in the previous year, and nearly one in 10 reported "seriously considering attempting suicide" in the previous year (4). This demonstrates the prevalence and seriousness of mental illness in college-aged individuals and the gravity of such disorders.

By separating males and females responses on a risk factor analysis questionnaire, males tended to be at higher risk of suicide. Females, on the other hand, tended to be at elevated risk for disorders such as Generalized Anxiety Disorder and Major Depressive Disorder. Additionally, individuals who have a low socioeconomic status, who engage in poor familial and romantic relationships, those who lack in social support, or those who have been victimized by acts of sexual assault are more likely to develop mental illness. There are also personal characteristics that make an individual more susceptible to psychopathology, such as perfectionism. In an academic setting, such as a college classroom, these personality traits may be apparent.

One of the leading questions in this field is: are mental health problems increasing among college students? Although research has not found whether more students are affected by mental health problems today as opposed to 50 years ago, they did find that mental health problems are highly prevalent among college students as a whole. In a preliminary study, the "national survey of directors of campus psychological counseling centers, 95% of directors reported a significant increase in severe psychological problems among their students," which lends to the belief that mental illness is more prevalent than it has ever been (5).

Another leading question is: to what extent are students receiving treatment? Even given the "surge in help seeking, multiple studies indicate that untreated mental disorders are highly prevalent in student populations" (6). This is consistent with findings that match that of the general population, but it is still incredibly significant to note. Many students can recognize when their mental health is poor, or times in which they may benefit from professional services, but many still do not receive adequate care. This could mainly be in part due to a lack of compliance in treatment, or reluctance to continue to engage in treatment due to external factors. Whatever the case may be, mental illness affects many individuals on a daily basis and is especially prevalent on college campuses, which lends to the significance of this essay.

10. The Mental Health Needs of Today's College Students: Challenges & Recommendations

This paper reviews the literature on mental health in today's society as it relates to college-aged individuals. It also addresses the challenges faced by students and the implications of student mental health problems on students, peers, friends, faculty, staff, and the institution as a whole. In recent years, college counselling has continued to evolve as the prevalence of mental illness has continued to increase. The role of personal counselling on college campuses originally emphasized "developmental and preventive counselling" (167). Nowadays, counselling centers across the United States have begun shifting their focus to be adequately trained to respond to " a variety of social, political, and economic factors" that impact the lives of many college students (167). For example, "today's college students are increasingly diverse: 30% are minorities, 20% are foreign born or first generation, 55% are female, and 44% of all undergraduates are over the age of 25" (167). This presents a great amount of diversity within undergraduate populations. But with great diversity comes challenges and obstacles, many of which have never been tackled by counselling centers before. There is now a new need to "provide counseling for such a broad range of students and issues—including multicultural and gender issues, career and developmental needs, life transitions, stress, violence, and serious psychological problems" (168).

In addition to an increase in diversity in undergraduate populations, there has also been an increase in severe psychological issues. One study found that "counseling center clients consistently presented with severe concerns including 'suicidality, substance abuse, history of psychiatric treatment or hospitalization, depression and anxiety'" (168). Seeing as the psychological issues are becoming more and more serious, some personal counselling centers have found that they are not equipped to handle the severity of some of the cases. These

"severe" psychological problems including "learning disabilities (71%), self-injury incidents (51%), eating disorders (38%), alcohol problems (45%), other illicit drug use (49%), sexual assault concerns on campus (33%), and problems related to earlier sexual abuse 34%" (169). There are hypotheses as to why students are experiencing more psychological concerns, but it is clear that students are exceedingly more "overwhelmed and more damaged than those of previous years" (169).

Since mental health conditions and illnesses seem to be on the rise, there has simultaneously been an increase in demand for counselling services. Factors that may explain increased prevalense of psychopathology are as follows: "A variety of social and cultural factors such as divorce, family dysfunction, instability, poor parenting skills, poor frustration tolerance, violence, early experimentation with drugs, alcohol and sex, and poor interpersonal attachments" (171). The increased demand for college counselling is reflective of the academic and social pressures that are present in the life of a college student. These issues are more common amongst college-aged individuals during this transitional period and what can be an incredibly stressful time period in their lives.

In sum, this article helps to demonstrate the impact of mental illness on college campuses and subsequent use of personal counselling centers. As I begin to research colleges and universities in Rhode Island, it is important to keep in mind the prevalence of such illnesses and try to look into how much of the resources for mental health are being utilized by students.

Section III: Proposal Paper

I. Introduction

Over the years, mental health has become an increasingly popular topic of conversation. As of recently, individuals across the globe have been changing the conversation surrounding mental health for the better. Organizations and initiatives aim to combat the stigma by advocating for those with mental health issues, thus changing the lives of individuals living with psychiatric conditions, as well as their caretakers. Studying trends in help-seeking behaviors and literacy of mental health allow for a better understanding of patterns regarding engagement in and compliance with treatment. Similarly, understanding the stigma associated with mental illness regarding labels, as well as public and internalized stigma is incredibly important. Lastly, narrowing in on college-aged individuals, I would like to address how mental health is addressed on college campuses, specifically Providence College (both pre and post-Coronavirus). Furthermore, I will propose some solutions that aim to make the Providence College Personal Counselling Center the best of its kind that will cater to the psychological needs of its students.

II. Mental Health on College Campuses

Trends: Over the past few years, it seems quite evident that certain trends, issues, and problems have arisen with regard to the number of cases of mental illness amongst college students, as well as the way in which those cases are addressed. Research has suggested that mental disorders account for nearly "one-half of the disease burden for young adults in the United States" (9). The increase in serious cases has caused great concern for the many psychologists working in counselling centers across the United States. Adequately preparing psychologists and psychiatrists for the influx of student cases, as well as an increase in severity

of such cases is crucial in assisting students' mental health concerns. In a recent study, researchers found "that counseling center clients consistently presented with severe concerns including 'suicidality, substance abuse, history of psychiatric treatment or hospitalization, depression and anxiety'" (10). Of course, there are hypotheses as to why students are experiencing more psychological concerns, but it is clear that students are exceedingly more "overwhelmed and more damaged than those of previous years" (10). Given that college is a time of immense transition, social development, substance use, and academic endeavours, it is quite possible that many students could be struggling with mental health conditions. Additionally, the academic climate of universities has become increasingly competitive in recent years, lending to additional stress and anxiety amongst the student body. As compared to generations past, students nowadays are held to higher academic and social standards. In order to stand out to future employers, students must excel academically, as well as distinguish themselves from their peers in terms of club involvement, community service, etc. Similarly, there are a variety of social, cultural, and familial factors, such as "divorce, family dysfunction, instability, poor parenting skills, poor frustration tolerance, violence, early experimentation with drugs, alcohol and sex, and poor interpersonal attachments" that may explain the considerable rise in cases (10).

Help-Seeking Behaviors: Once a student is able to recognize that they might be struggling in some capacity, they often report to their personal counselling center to receive the help that they need. In recent years, given the increase in cases, there has also been a surge in help-seeking behaviors. Much of the time, students do not even realize that they are grappling with psychological concerns until it severely impacts their ability to function daily. In fact, many personal counselling centers have reported a substantial increase in "untreated mental

disorders" that have become "highly prevalent in student populations" (6). There are many reasons as to why so many mental illnesses go undiagnosed or untreated -- Campus climate, stigma, barriers to treatment, lack of resources, and lack of literacy regarding mental health are all factors that impact whether an individual will receive the treatment that they need.

Literacy of Mental Health: Literacy of mental health is just one of the many factors that impacts students' understanding of the severity of their own mental illness and subsequent treatment. The "lack of mental health literacy is especially salient as it is during adolescence and early adulthood that health-related behaviours are formed and when young people assume responsibility for their own health actions" (8). I believe that a lack of literacy stems from a lack of education in students' younger years regarding mental health training. Elementary, middle, and high schools stress the importance of maintaining physical health and well-being, while neglecting mental health and self-care techniques. Although physical activity and physical health are important, we must also teach children the importance of mental health as well. Children oftentimes experience mental health issues as a byproduct of bullying, poor-self image, etc. However, if teachers and staff emphasize the importance of a healthy mind in conjunction with a healthy body, I thoroughly believe that there will be better health outcomes in terms of mental health amongst college students. Already, several initiatives have already been organized to educate the youth on resources to address their mental health concerns. However, we must continue to push for more education programs nationally and eventually globally. These programs will be effective in addressing the lack of mental health literacy that we see in college-aged students now, so that future generations will be better equipped to handle their own mental health, as well as concerns amongst their peers.

III. Barriers to Treatment

Barriers to treatment are one of the primary reasons as to why individuals do not receive adequate care for their mental or physical health concerns. These barriers can be physical barriers, such as lack of access to a car to get to appointments, lack of financial resources, etc. However, there are also barriers that we tend to neglect, such as underlying prejudices, inequalities, and the effect of stigma that oftentimes prevent individuals from receiving care.

Race: With regard to racial disparities in the treatment of mental illness, studies have found that due to their "life long exposure to and experiences with racism, discrimination, prejudice, poverty, and violence," black individuals tend to have "fewer psychological, social, and financial resources for coping with stress than their white counterparts" (2). Furthermore, a study published in *Mental Health Treatment Barriers Among Racial/ Ethnic Minority Versus White Young Adults 6 Months After Intake at a College Counseling Center*, stated that although there were no statistically significant differences in mental health outcomes, "racial/ethnic minority students less often reported having sought treatment in the past, and also treatment after they were seen at the counseling center, compared with white students. In addition, they endorsed a greater number of barriers to treatment in the previous 6 months and anticipated future barriers" (1). These barriers included students' belief in themselves to overcome their mental health problems without treatment, a lack of time to receive care, the belief that treatment would not be helpful, the overarching stigma associated with mental health, and a lack of knowledge as to how to receive treatment. These social determinants of health impact all medical areas of an individual's life, whether it be regarding physical or mental health. Due to these inequalities, it has been found that African Americans are 10 times less likely to seek out

treatment for their mental health. Even if they do receive treatment, they typically attend fewer therapy sessions when compared to similar-aged white individuals.

Low Socio-Economic Status: There are many treatment barriers faced by those living low-income urban environments as well. Due to the nature of these low-income neighborhoods, many residents have reported experiencing traumatic events, such as "having relatives/friends murdered (47%), being attacked with weapons (64% of men), and being sexually attacked (36% of women)" (1). In fact, a recent study found a "65% rate of life-time trauma exposure" for individuals in these low-income communities. These traumatic experiences often resulted in individuals reporting signs and symptoms of PTSD that were not usually diagnosed. The individuals affected remain undiagnosed for a number of reasons -- whether it was due to "limited transportation and finances, family disapproval, or unfamiliarity with accessing treatment" (3). These barriers to treatment for mental health are in part due to the social determinants of health, which oftentimes prevent individuals of lower socioeconomic statuses from receiving adequate health care. This is why many illnesses, physical and mental, go untreated, undertreated, and/or undiagnosed.

Stigma: Stigma also plays a huge role in preventing individuals from accessing the care that they need. In fact, individuals in one study reported extreme cultural barriers with regard to stigma in the African American community. These individuals specifically noted "fear of family and community disapproval" as one of the most significant social barriers to treatment (3). This may be due to the African American view of faith, the church, and the healing process in general. That is, many individuals in the study endorsed that they rely heavily on their church community in times of poor mental health instead of receiving care from a trained professional. In the next

section, I will narrow in on the concept of stigma and break down the factors that contribute to the stigma associated with mental illness.

IV. Stigma

The increase in stigma surrounding mental health has become one of the primary barriers that prevents individuals from receiving the care that they need. Stigma specifically is a "social–cognitive process that motivates people to avoid the label of mental illness that results when people are associated with mental health care" (614). This label, and avoidance of such labels, oftentimes deters an individual from receiving care. Historically, those with psychological conditions were thought to be societal outcasts. Ostracized from their families, excluded from social activities, etc., individuals with mental illnesses have not always been as accepted as they are today. Treatment of those with mental illnesses, especially those who were institutionalized in the early 1900's, was substandard to say the least. Malpractice, human rights violations, and unethical treatment methods all contribute to the stigma we still associate with mental illness all these years later. This historically bad perception of mental health has trickled down throughout the generations and still impacts the ideals and opinions of many today regarding the stigma surrounding mental health.

Labels & Severity of Illness: It is important to consider whether the "problem of stigma and adherence applies to the generic concept of mental illness, or differs by diagnosis and/or level of disability" (5). There are a range of mental illnesses that impact individuals at varying levels. Even in psychiatric hospitals, for example, units are designed to treat individuals of similar mental health statuses. Intensive Treatment Units, General Treatment Units, Outpatient Units, etc, are all designed to cater towards those with specific levels or degrees of mental health

conditions. Additionally, research has suggested that the public "discriminates among psychiatric groups in terms of stigma; for example, people with psychotic disorders are judged more harshly than people with depression or anxiety disorders" (5). Sometimes, a more "intense" label may deter an individual from receiving treatment altogether due to the publics' perception of diagnosed mental illnesses. This, of course, results in poorer health outcomes, higher suicide rates, etc. This discrimination could be in part due to a lack of public education with regard to severe mental illnesses. Furthermore, labelling mental illness in a negative light stigmatizes those who may struggle with it. There have been numerous studies that have attempted to demonstrate the effects of the labelling of mental illness and the implications it may have on those who are struggling. Many individuals do not understand the complexities behind mental illnesses and rely solely on heuristics and the knowledge (or lack of knowledge) of others while formulating their own opinions, which is essentially how public stigma is formed.

Public Stigma: While public stigma can impact one's social opportunities in the present, we fail to recognize the lasting effects it may have on their future social opportunities and social engagement. The impact of "stereotype, prejudice, and discrimination can rob people labeled mentally ill of important life opportunities that are essential for achieving life goals" (616). Due to this discrimination, those struggling with mental illnesses are frequently unable to find jobs, good housing, or even engage in regular social activities. Much of the time, there are "negative responses to people who have been identified as having a mental illness," which is a major obstacle to recovery that limits opportunities and undermines one's self-esteem (467). One study assessed the impact of "public stigma (negative attitudes held by the public) and internalized stigma (negative attitudes held by stigmatized individuals about themselves) on treatment-

seeking attitudes and behaviors" in adults struggling with diagnosed mental health conditions (4).

In personal testimonies published in *Mental Health Consumers' Experience of Stigma,* researchers found that the most commonly reported experience of public stigma by those with mental illness involved "witnessing stigmatizing comments or depictions of mental illness" in everyday life. In fact, almost "80 percent of survey respondents indicated that they had overheard people making hurtful or offensive comments about mental illness; half reported noticing these often or very often" (470). Although these offenses do not seem to be an outward act of discriminatory behavior, even comments or small remarks in conversation have the capacity to truly impact an individual living with a mental health condition. Of course, more outward acts of discrimination were also reported, but were not nearly as common as smaller comments and conversations. These testimonies provided detailed insight as to the ways in which stigma can impact those living with mental illnesses.

Internalized Stigma: Along with public stigma comes a strengthening of one's internalized stigma, or an individual's feelings about their own illness. Public stigma is a byproduct of society's ideas and attitudes towards those with mental health conditions -- But that is only half of the story. Internalized stigma arises as a result of the ideals imposed on us by society. So, in other words: Internalized stigma is learned through public stigma and the opinions of those around us. However, there was something that I came across regarding internalized stigma that I found to be particularly interesting. A study published in *Mental Health Treatment Seeking Among Older Adults with Depression: The Impact of Stigma and Race* suggested that "older adult survey participants with higher levels of internalized stigma were significantly more likely to intend to seek mental health treatment" (4). This is interesting as

oftentimes stigma inhibits individuals from seeking treatment. However, findings from this study were quite the opposite. This is unlike findings from other similar studies, as public and internalized stigma are often positively correlated. This goes to show the differences between individuals and the way in which stigma and mental illnesses may be interpreted and addressed.

Gender Differences: Young people, particularly young males, are notorious for electing not to "seek help when they are in psychological distress or suicidal" (8). Of course, this could be due to both the public and internalized stigma associated with the label of "mental illness." Males, in particular, have a different set of expectations imposed on them regarding mental health. From a young age, males are expected to be strong, emotionless, and brave, which is completely unrealistic all of the time. They are taught to "Be a Man" and are expected to adhere to other male stereotypes that can be incredibly damaging in the long-term These unrealistic and outdated models to the male existence generate an extremely harmful stigma that impacts the mental health of men globally. In fact, the rate of suicide is highest in middle-aged white men. Additionally, men die by suicide 3.54 times more often than women and account for almost 70% of suicide deaths (American Foundation for Suicide Prevention). These numbers definitely speak for themselves in terms of highlighting the deficits of our society in addressing the emotional needs of men from an early age.

Females, on the other hand, are forced to grapple with a different set of societal expectations. Females are expected to be nurturing, more sensitive, and more emotional. Of course, that is a sweeping generalization, but after taking Social Psychology, I have realized that as a society, we tend to internalize these stereotypes and act accordingly. In fact, women are diagnosed with mental illness more frequently than men and are at elevated risk for disorders such as Generalized Anxiety Disorder and Major Depressive Disorder. There are many theories

as to why this may be the case. Research has suggested that there are somewhat equal cases of anxiety and depression in both men and women. However, women are more likely to report signs and symptoms, and therefore receive a diagnosis. It is more socially acceptable for women to come forward and report symptoms, as women tend to be seen as "more emotionally fragile," when compared to their male counterparts. These gender differences and stereotypes fuel the stigma that surrounds mental health and psychological conditions.

Now, regardless of gender, we all experience the feeling of needing to belong. Whether it means "being a man" for men, or being a "kind nurturing mother" for women, we all experience the innate desire to fit in. There is a theory that researchers have dubbed the "Self-Fulfilling Prophecy" theory. Self-fulfilling prophecies are an individual's subconscious desire to fulfil the expectations or roles placed upon them by other individuals. In the context of mental illness, these roles to fit in with what society deems normal may come about as a byproduct of the unconscious biases of others and those within ourselves. The subconscious and innate desire we have to fit in with others, feeds into the strength of the effect of stigma on us and those around us.

V. University Comparisons

The way in which mental health concerns are addressed on college campuses is always changing. Each year, new organizations and initiatives work to combat stigma and increase mental health awareness. Views amongst the public are changing, and as we continue to advocate for those with mental health issues, we have the power to change the lives of many. Students at universities around the globe are pushing for a surge in mental health acceptance and support -- and many universities have responded positively. Revamping Personal Counselling

Centers, advocating for inclusivity, and inviting guest speakers from NAMI, are all ways in which universities have really taken on students' desires to advocate for themselves and others. I decided to take a look at some local universities and colleges, such as Johnson and Wales University (JWU), the Rhode Island School of Design (RSDI), and of course, Providence College, to assess the ways in which each college's personal counselling center is operated. Similarly, given the recent global Coronavirus pandemic, I would like to analyze how each of these universities have responded to this unprecedented time. I would also like to see if there are any similarities or differences in approach, given that the centers are now operating via a remote platform.

Johnson and Wales University: JWU is a private, non-profit university located in Providence, Rhode Island. The mission statement of the Counseling Center at JWU is as follows: "*Services are a confidential resource for students where they can access support to help manage their emotional well being. Services offered include short term-individual therapy, group therapy, crisis intervention, consultation, outreach educational programs, and referrals."* JWU offers a variety of services to their students and have trained professionals that work in their offices who are specialized in a number of different areas, such as general mental health, LGBTQ+, alcohol and addication, sexual assault, eating disorders, etc. These are just a handful of the services that the university offers in-person (pre-Coronavirus) as well as online. Additionally, they have also recently launched on-campus events with the help of students focusing on suicide prevention training, recognizing signs of substance abuse issues and how to intervene, etc.

After the Coronavirus pandemic, Mim L. Runey, Chancellor of JWU stated that the "health, safety and well-being of our students, faculty, staff and community are the university's

number-one priority" (2020). Seeing as in-person classes have been suspended, the current semester has been moved to online, and graduation has been postponed, Runey does not know what the future will hold with regard to returning to campus. In a recent email, titled *Preparing for What is Next*, Runey states that the board at the college does not know what the fall semester has in store for them. Similarly, she states that there are three options for this upcoming fall: To return to campus as usual, to allow some students to come back and others to live at home, and to continue remote online learning. Of all the services on-campus, I hypothesize that the counselling center will remain online until all students are allowed back to campus.

The Rhode Island School of Design: RISD is another university located in Providence, Rhode Island. The mission statement of its Counselling center is as follows: *"Office of Counseling and Psychological Services (CAPS) provides a range of mental health services to help students improve emotional, interpersonal, and academic functioning."* This counselling center offers crisis and referral services, counselling and psychological services, tools and resources, and support for faculty and staff. An interesting aspect of RISD's Counselling center is that they offer drop-off and pick-up to students to and from the counselling center who are in need of a ride. They state that they have an online, on-demand, door-to-door transportation service that allows students to call for rides. This is a really important aspect of the Counseling Center because it makes the services accessible to all, regardless of rides. This feature of the center addresses accessibility for all, which can sometimes be a physical barrier to treatment that students may face.

As for services available after the onset of the Coronavirus, the RISD Health and Wellness Site states that "Confidential health and counseling services are still available to students by calling 401-454-6625 for Health Services or 401-454-6637 for CAPS."

Additionally, "employees and their dependents can access 24/7 confidential assistance through our partner *AllOne Health.*" Amidst the chaos that is the Coronavirus, it was really pleasing to see that the Counselling Center at RISD took the time to update their website to ensure that students were able to have access to the resources that they need.

Providence College: PC is a private university located in Providence, Rhode Island. The mission statement from the Personal Counselling Center is as follows: "*The Personal Counseling Center supports the mission of the Providence College Community by contributing to the personal development of undergraduate students. The professional counseling staff provides a program of high quality individual and group counseling services, developmental and preventative programming, as well as, supportive and consultative services for the faculty and administration."* The college offers individual counselling, group therapy and workshops, campus outreach programs, and much more. Something I found to be quite interesting is that they have a *Mission of Diversity* section on their Counselling homepage. Under this heading, they state that they have services for men, LGBTQ+ students, international students, and 1st generation college students. This is important because individuals who fit one of these categories are statistically less likely to receive treatment than others.

Providence College also updated their Counselling Center's website with a post-Coronavirus status. They stated that "counselors in the PCC remain available to consult and assist with referrals with students and offer support during this time." Additionally, something that I found to be really interesting and unique about the Personal Counselling Center's website update is that although in-person meetings are suspended until further notice, counsellors would be reaching out to students directly. Specifically, all students who were receiving care at the PCC before break, would be contacted by their counselor directly over the phone, pending on

when their next appointment was. This allows the PCC to provide further information, as well as allow students to stay connected with their counsellor. This is something that surprised me, as no other school had offered a service like this. It made me proud to go to a school that cares so deeply about the mental well-being of their students that they are willing to call students personally to check-in.

VI: Proposal

As for my proposal on ways to improve Providence College's counselling services, I have a few ideas. From the surface, it seems as though the counselling center is doing a great job -- and I do think they are doing their best, especially given the current circumstances. However, there are some internal issues (pre-Coronavirus) that must be addressed in order to make the center the best it can be.

First, I would propose that the college expand or move their facilities. The counselling center, along with student heath, are located in the basement of Bedford Hall. I would propose moving student health to a different building and expanding the counselling center into the entire downstairs area under Bedford. This will give counsellors more office space and give students more privacy regarding their treatment. Many of the counsellors' office spaces now are located adjacent to the front desk, so as other individuals enter the space, it is easy to hear private conversations that are happening in the offices. By expanding the space, the counsellors and students will feel more at ease when discussing deeply personal issues.

Second, I propose that the Personal Counselling Center hire more faculty members and create more appointment times. I have heard numerous accounts from students regarding the lack of appointment times and available staff. After conducting some research on my own, I

discovered that counsellors meet with students on a biweekly basis, for a 50-minute appointment. I understand that there are many students that utilize the services provided by the center, but this does not seem too useful to me. Especially in the context of severe mental illness, individuals should have the ability to meet with counsellors at least once per week, if not more, depending on the needs of the client. If the college considered expanding their space, hiring more staff, and possibly extending their hours, they would have the capacity to meet with more students who could benefit from their services.

Lastly, I would suggest that when the therapists and counsellors return to campus that they be educated on the impacts of the Coronavirus on the mental health of college-aged individuals. Quarantine has been difficult for all, but has been especially difficult for those struggling with mental illnesses. Social isolation and lack of interaction with the outside world can cause an individual with a pre-existing mental health condition to experience an array of emotions. Having a literacy on mental health, especially in the context of the Coronavirus pandemic is crucial in ensuring the mental health and well-being of all Providence College students.