A secondary analysis of help seeking behaviors and psychological distress of graduate level students enrolled in CACREP accredited counseling programs

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A SECONDARY ANALYSIS OF HELP SEEKING BEHAVIORS AND PSYCHOLOGICAL DISTRESS OF GRADUATE LEVEL STUDENTS ENROLLED IN CACREP ACCREDITED COUNSELING PROGRAMS

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Dedication

To my late father and biggest supporter, Robert Andrews Bolding.
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Abstract

Few studies have examined help seeking behaviors and the mental health of graduate level counseling students. This study expands on the current research by examining the relationship between mental health help seeking behaviors and self-reported symptoms of psychological distress in graduate level counseling students enrolled in CACREP accredited counseling programs throughout the United States. Survey responses from 271 graduate level counseling students were analyzed. Parametric tests of ANOVA and Multiple regression, and nonparametric analyses of Kruskal-Wallis and Fishers exact test were used. Results from Kruskal-Wallis tests found significant differences in depression, anxiety, and stress scores based on the type of help sought. ANOVA results found statistically significant differences in depression and anxiety scores between sources of help received. Tukey HSD post-hoc analyses found that participants whom sought help from faculty had higher depression scores than those who received no help at all; participants who received no help had lower anxiety scores than both those who sought help from faculty, as well as, those who sought help from both faculty and counseling professionals. Results of Multiple Linear Regression model were significant for both depression and anxiety scores. Findings concluded that seeking faculty help and enrollment in specialty area of counseling in educational settings contributed to the variances in both depression and anxiety scores of participants. Implications for research, teaching, and practice are discussed. Limitations to current study, as well as, considerations for future research are provided.
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Chapter One: Introduction

Psychological distress is defined as a set of painful and unpleasant mental and physical symptoms associated with typical fluctuations of mood, that in some cases may indicate the beginning of a diagnosable clinical condition (American Psychological Association [APA], n.d.). It is an uncomfortable, multifactorial, emotional experience that can interfere with an individual’s ability to effectively function and cope with social and emotional stressors (Schuurhuizen et al., 2015). When distress is experienced well beyond the presence of an identified stressor or becomes disabling, it is an indication the consequential symptoms of stress have led to an internal dysfunction and possibly a diagnosable clinical condition (APA, n.d.; Mulder, 2008). Psychological distress is not only uncomfortable, it is also potentially perilous when ignored and not properly addressed.

Nearly one in five individuals experience mental health conditions in the U.S. (Substance Abuse and Mental Health Services Administration [SAMHSA], 2016). The prevalence of psychological distress and mental health concerns has increased since the start of the COVID-19 pandemic (Terlizzi & Schiller, 2021). Data from the National Health Interview Survey shows in 2019, 8.1% of adults in the United States experienced symptoms of anxiety disorder, 6.5% experienced symptoms of depressive disorder, and 10.8% experienced symptoms of anxiety disorder or depressive disorder (Terlizzi & Schiller, 2021). The Household Pulse Survey responses from December 29, 2021-January 10, 2022, revealed 27.9% of adults in the United States experienced symptoms of anxiety disorder, 22.8% experienced symptoms of depressive disorder, and 32.1% experienced symptoms of one or both disorders (National Center for Health Statistics, 2022).
Czeisler et al. (2020) conducted a survey to assess mental health, substance use, and suicidal ideation during the pandemic across the United States. Of the 5,470 respondents that completed the survey, 40.9% reported an adverse mental or behavioral health condition, and 30.9% reported symptoms of anxiety disorder or depressive disorder (Czeisler et al., 2020). Mental health providers are needed now more than ever as these numbers continue to rise and the conditions of health and safety remain unknown and ever changing. In order to ensure effective and healthy mental health professionals we must start at the beginning of their career development, during the formation of counseling related knowledge, personal development, and professional identity. We need to begin by better understanding and serving graduate level counseling students.

The pursuit of higher education is often accompanied with a demanding schedule, challenging coursework, performance expectations, practice obligations, and research requirements. Graduate students typically have responsibilities outside of these conditions as well, that may include vocations/careers, hobbies, families, friends, and other commitments. The pressures of successfully functioning both within and outside of a graduate program can be emotionally and mentally grueling. Personal and academic stressors experienced while pursuing a graduate level degree are positively related to symptoms of depression in graduate level students (O’Reilly et al., 2014). Mental health concerns are prominent in graduate students (Hyun et al., 2006) as they are almost six times more likely to experience symptoms of anxiety and depression than the general population (Evans et al., 2018). Though the research is limited, the disturbance and experience of psychological distress is also experienced by graduate level counseling students (Byars, 2005; Smith et al., 2007). In fact, graduate level counseling students
may experience mental health concerns at an increased level in comparison to the general population (White & Franzoni, 1990).

In knowing mental health concerns exist in graduate level students and counselors in training, it is important that we also come to understand the ways in which they seek help for these issues and how that help might impact them. Rickwood and Thomas (2012), define help seeking as “an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns” (p. 180). This proposed definition is made up of three main components, comprised of five separate elements of the help seeking process, which include: behavioral process, the time frame, the source and type of assistance, and type of mental health concern (Rickwood & Thomas, 2012).

A small percentage of individuals enrolled in graduate programs actually seek help for mental health concerns; some barriers to seeking this help are fear of stigma, cost/affordability, previous experience with help seeking, and time (McCarthy et al., 2010; Salaheddin & Mason, 2016; Troff, 2007). Students’ belief and value of counseling, the stigma associated with it, and previous counseling experience have been shown to be important predictors of help seeking attitudes in masters level counseling students (Troff, 2007).

It is the ethical duty of both counselors in training and counselor educators to be aware of possible signs of personal impairment in areas of physical, mental, and emotional functioning (American Counseling Association [ACA], 2014; Council for Accreditation of Counseling and Related Programs [CACREP], 2016). It is imperative these impairments are addressed as they could negatively impact both client and therapeutic functioning. As mental health professionals, it is also our duty to seek help and/or make referrals when impairments are observed (ACA, 2014; CACREP, 2016).
Exploring the ways in which graduate level counseling students conceptualize their own mental health and its relation to help seeking behavior may promote self-awareness, resources, and healthier graduate level counseling students, in turn healthier mental health professionals. Expanding counseling educators’ understanding of student experience related to psychological distress and help seeking behaviors may aid in better preparedness in addressing, navigating, and guiding graduate level counseling students throughout the course of their studies and professional development. Studying the relationship between mental health and help seeking behaviors of counseling graduate students can help us understand how students conceptualize their own mental health and its relationship to seeking and engaging in help for their own personal and professional well-being.

**Statement of Problem**

Graduate level students are constantly having to manage competing demands of their courses, research, practice, career, involvement, and social life (Offstein et al., 2004). The existence of stress in graduate level programs is not a secret. Some factors that have been identified as predictors of mental health related concerns in graduate level students include expectations, workload, and financial concerns (Andrews & Wilding, 2004; Rummell, 2015). Rummell (2015) postulates that the stressors and pressure of graduate level programs contribute to the experience of stress, anxiety, and depression in students.

The experience of such mental health struggles negatively impacts academic performance and interferes with the well-being and optimal functioning of graduate students (Andrews & Wilding, 2004; El-Ghoroury et al., 2012; Hyun et al., 2007). According to Evans et al. (2018), graduate students are six times more likely to experience depression and anxiety than the general population. Few students actually seek help for mental health concerns, due to various personal,
More specifically, graduate level counseling students have also been found to experience struggles with mental health related symptoms (Byars, 2005; Parker, 2014; Rummell, 2015). The research has found that counseling students may exhibit increased levels of psychological disturbances compared to the general population (Byars, 2005; White & Franzoni, 1990). Counseling students tend to seek help at an increased rate however, few students actually seek assistance for mental health related concerns when symptoms are present (Martin, 2010; Rummell, 2015; Salaheddin & Mason, 2016).

The problem is these students end up graduating from counseling programs and risk becoming impaired practitioners, as it is likely that impaired counseling students become impaired counseling professionals, that risk doing harm to their clients (Witmer & Young, 1996). Our limited knowledge of both the mental health and help seeking behavior of counselors in training are problematic, as the emotional wellbeing and behaviors of these individuals not only impact them, but the clients they work with as helpers. It is the ethical duty of both educators and counselors in training to monitor, recognize, and seek/direct services when an impairment is present in mental, physical, or emotional areas of functioning (ACA, 2014; CACREP, 2016).

The research on psychological distress and help seeking behaviors of counselors in training is truly limited and there is a need for further investigation and understanding.

**Theoretical Framework**

Attribution theory considers how individuals use information to help explain, predict, and understand their environment, the events that occur within it, and how it relates to their thinking and behaving (Kelley, 1967). Attributions are assigned to internal and external factors to help us
make sense of social interactions through assumptive and predictive, cause and effect relationships (Heider, 1958). Kelly’s (1967) covariation model proposes the decision to attribute an individual’s behavior to internal or environmental factors is based on information from various points in time, situations, experiences, and observations.

Attributions are also assigned during the help seeking process. The actual act of help seeking may be impacted by whether one attributes the cause of needing help to internal or external factors. It is proposed that when an individual attributes responsibility for failure or need for help to external sources, rather than to one’s self, they are more likely to seek help than those who attribute it internally (Tessler & Schwartz, 1972).

When an individual attributes the need for help as internal in nature, there is a potential threat to self-esteem. The readiness and act of seeking help is a function of perceived threat to self-esteem. Tessler and Schwartz’s (1972) study on the relationship between attribution, self-esteem, and help seeking found the following: a) in individuals with high self-esteem, more help was sought when attributes linked to help seeking were peripheral rather than central to self-concept; b) in individuals with low self-esteem, more help was sought when help seeking reflected central attributes of self-concept; and c) help was sought more by subjects with low achievement motivation than high achievement, this was because the high achievement individuals tend to attribute their failure to lack of effort rather than ability.

Based on the assumptions of attribution theory, we can assume that students’ decision to seek help may be at least partly a result of specific attributional patterns (Jones & Davis, 1965; Kelley, 1967). Anxiety and stress are attributes that are more peripheral to one’s self-concept than depression. Assuming that graduate level students have high achievement, based on level of
academic pursuit, it may be predicted that graduate level counseling students with high levels of anxiety and stress are more likely to seek help than those with depression.

Based on the attribution theory’s view of ego centrality and help seeking, it may be hypothesized that graduate level counseling students with high levels of anxiety and stress are more likely to seek help from a mental health professional than a professor, friend, or family member because they may perceive the professor, family member, or friend as more threatening than the professional to seek help from (Tessler & Schwartz, 1972; Wallston, 1976).

Depression and low self-esteem are closely linked (Orth & Robins, 2013). In fact, according to Beck’s (1967) cognitive theory of depression, negative beliefs about one’s self play a critical casual role in the development of depression. Graduate level counseling students with symptoms of depression may be more likely to seek help from a friend or family member, than a mental health professional or professor (Tompkins et al., 2016). It may be hypothesized that the low self-esteem individual would perceive the friend or family member as less threatening than the professional to seek help from. This is under the assumption that individuals with anxiety and stress may have higher self-esteem, and those with depression may experience lower self-esteem. Keane and Loades (2017) systematic review on clinically significant anxiety, depression, and self-esteem in young people support this idea, as their findings reveal individuals with depression tend to report lower self-esteem than those with anxiety.

**Significance of Study**

A majority of the research surrounding the mental health of counseling graduate students has focused on well-being and wellness (Harris et al., 2013; Myers et al., 2003; Roach & Young, 2007; Smith et al., 2007). As research has concentrated on more strength-based experiences of counselors in training, limited exploration has been done to understand the
psychological distress experience of these students. Studies have found that graduate level

counseling students exhibit higher levels of wellness than the general population, and levels of
wellness are closely tied with psychological well-being (Harris et al., 2013; Myers et al., 2003;
Roach & Young, 2007; Smith et al., 2007). Conversely, some studies have found that graduate
level counseling students experience increased levels of psychological disturbances when
compared to the general population, and they also experience symptoms of depression,
loneliness, and extremely high levels of stress (Byars, 2005; White & Franzoni, 1990).

Stigma surrounding mental health problems and fear of academic and professional
discrimination have been found to influence students’ help seeking behaviors on university and
college campuses (Burrell-Smith, 2013; Degges-White, & Borzumato-Gainey, 2014; Martin,
2010). Studies reveal that individuals may not seek mental health services because of fear of
stigmatization, affordability, time, and lack of knowledge about services (Dunn, Harmond &
Roberts, 2009; Dearing et al., 2005; El-Ghoroury et al., 2012; Hyun et al., 2007; Rummell, 2015;
Stefl & Prosperi, 1985). Burrell-Smith’s (2013) qualitative analysis found that 25 percent of the
psychology graduate students interviewed provided responses with themes emphasizing shame,
embarrassment, and fear in regards to disclosing their history of mental illness or treatment. The
issue becomes relevant when we recognize that many times these mental health concerns are not
addressed. Despite emotional and psychological barriers present during the course of graduate
studies, very few students actually seek formal or informal mental health assistance (Martin,
2010; Salaheddin & Mason, 2016).

It would be assumed that counselors in training have a greater understanding of the need
and benefits of help seeking, due to the nature of the degree and courses, and seek out help when
needed. However, there is little research in the area of help seeking and mental health concerns
in counselors in training. Existing research has looked at the mental health of counseling students, mostly through the lens of wellness and prevention, (Smith, Robinson, & Young, 2007). The research has also looked at help seeking attitudes and behaviors, to uncover its barriers and benefits in counselors in training (McCarthy et al., 2010; Prosek et al., 2013). Membership in a counselling graduate program and personal counseling experience in counseling have been found to be associated with increased help seeking attitudes (McCarthy et al., 2010; Troff, 2007). Yet, the specifics of the act and experience of help seeking needs to be further examined. This study adds to the current literature by further examining the specifics of graduate level counseling students help seeking behaviors and its relationship with psychological distress, specifically in graduate level counseling students enrolled in CACREP accredited counseling programs.

Understanding the relationship between help seeking behaviors and mental health in graduate level counseling students is of increased relevance and importance to both counseling educators and counseling graduate students. It is the ethical duty of both counseling educators and students to monitor, recognize, and seek/direct services when an impairment is present in mental, physical, or emotional areas of functioning (ACA, 2014; CACREP, 2016). This research aids in understanding the way graduate level counseling students conceptualize their mental health, and its relationship to seeking help when in need. Having a deeper understanding of this relationship can promote self-awareness, normalcy, and resources for counseling students, as well as increase educators understanding of the experience, struggles, and tendencies of students and to be better prepared to address, navigate, and guide students in need.
Purpose of the Study

The purpose of this study was to examine the relationship between mental health help seeking behavior and self-reported symptoms of psychological distress in graduate level counseling students enrolled in a CACREP accredited counseling program, while considering the influence of counseling specialty and length of time enrolled in counseling specialty. This study examined factors related to mental health help seeking behaviors among graduate level counseling students by considering the help seeking behaviors of self-help, source of help sought, and type of help sought by graduate level counseling students. Symptoms of psychological distress included self-reported levels of depression, anxiety and stress.

Research Questions and Hypotheses

The general research question was developed from the purpose of the study. The research question guiding this study asked, what is the relationship between graduate level counseling students’ mental health help seeking behavior and self-reported symptoms of psychological distress of depression, anxiety and stress? From the general research question, the following hypotheses were examined:

Hypothesis 1

H₀: There is no statistically significant relationship between self-help and length of time enrolled in a counseling program.

Hₐ: There is a statistically significant relationship between self-help and length of time enrolled in a counseling program.
Hypothesis 2

H$_0$: There is no statistically significant difference in self-reported symptoms of psychological distress based on help seeking behavior of type of help sought or source of help received.

H$_a$: There is a statistically significant difference in self-reported symptoms of psychological distress based on help seeking behavior of type of help sought or source of help received.

Hypothesis 3

H$_0$: There is no statistically significant relationship between self-reported symptoms of psychological distress of depression, anxiety, and stress and help seeking behaviors.

H$_a$: Self-reported symptoms of psychological distress of depression, anxiety, and stress are statistically predictive of help seeking behaviors in graduate level counseling students.
Chapter Two: Literature Review

This chapter reviews current and past studies related to the mental health and help seeking behavior of graduate level counseling students. The discussion begins with a synthesis of professional standards of accrediting bodies including the Council for Accreditation of Counseling and Related Programs (CACREP, 2016) and American Counseling Association (ACA, 2014). A review of literature related to the mental health of students, including graduate students and graduate counseling students, psychological wellness and wellbeing of counseling students, as well as future mental health practitioners is presented. Relevant research on mental health help seeking behavior, help seeking in graduate level counseling students, and help seeking effectiveness in counseling students is reviewed. This section concludes with a discussion of attribution theory and its assumptions surrounding help seeking. A gap in research significant to this study is highlighted as evidence for farther investigation through this literature review.

ACA and CACREP Standards

The American Counseling Association (ACA) and Council for Accreditation of Counseling and Related Programs (CACREP) provide ethical and structural guidelines for counseling students, professionals, and educational institutions (ACA, 2014; CACREP, 2016). Student and professional functioning, evaluation, and responsibilities are presented within these guidelines.

American Counseling Association

The ACA (2014) code of ethics specifically addresses the issue of impairment in graduate level counseling students stating “students and supervisees monitor themselves for signs of impairment from their own physical, mental, or emotional problems and refrain from offering or
providing professional services when such impairment is likely to harm a client or others” (F.5.b. Impairment, p. 13). It is the students’ responsibility to recognize and identify a need, notify their advisor, and seek help before it reaches a level of professional impairment. This also requires the individual to stop providing any professional services in order to prevent harm to the helped.

Supervisors also have a responsibility to perform ongoing evaluations of students and are to be aware of any limitations that might impede their performance (ACA, 2014, F.6.b. Gatekeeping and Remediation). It is important to note that in seeking help from a supervisor or advisor, counseling services are not provided; the supervisor assists the supervisee in identifying appropriate services and addresses interpersonal competencies related to their functioning in the program (ACA, 2014, Section F.6.c Counseling for Supervisees, p. 14).

Council for Accreditation of Counseling and Related Educational Program

The Council for Accreditation of Counseling and Related Educational Program (CACREP) requires that “program faculty systematically assesses each student’s professional dispositions throughout the program” (CACREP, 2016, Section 4.G.). The importance of increased self-awareness and understanding of one’s own needs is taught throughout the counseling program. CACREP (2016) requires “strategies for personal and professional self-evaluation and implications for practice” as well as “self-care strategies appropriate to the counselor role” be included in the counseling curriculum of CACREP accredited counseling programs (Section 2.F.1). As expressed in the ACA and CACREP guidelines, it is evident that psychological wellbeing and help seeking for psychological distress of counselors in training are important ethical and structural components of the profession.
Mental Health of Students

The mental health of university and college students has shown to have an effect on personal, academic, and social aspects of learners’ lives. Some common concerns brought to mental health centers on college campuses include drug and alcohol use, mental health diagnoses, sexual identity, social issues, depression, anxiety, and relationship problems (Staff, 2015). Eisenberg et al. (2013), conducted an online mental health screening of students at 26 college campuses nation-wide. Their findings suggest a majority of mental health problems on college campuses to be associated with sex, race/ethnicity, religiosity, relationship status, living on campus, and finances.

Mental Health of Graduate Students

Many graduate level programs involve strenuous course work and demanding expectations in areas of academia, research, practice, and involvement (Offstein et al., 2004). Lowenberg (1969) describes the experience of graduate school as “helplessness, striving toward closeness often accompanied by submission anxiety and fear of being dominated” (p. 615). The demanding and vigorous nature of graduate school programs creates a high stress environment, and increases rates of exhaustion and feelings of being overwhelmed in graduate students (Hyun et al., 2006). In addition to the academic pressures experienced by these students, many of them also have responsibilities, roles, and stressors outside of the educational setting (Dickens, 2014). Some of these may include full-time or part-time jobs, social relationships, initiate partner relationships, and family responsibilities. Lowenberg (1969) states: “It is suggested that a large portion of graduate student dissatisfaction lies less with the pedagogical content of the curriculum of their program [and more] with the psychological conditions of infantilization to which the student…is subjected (p. 613).” Graduate students are living by the constrains of their
program and pressures of external responsibilities. This pressure, whether perceived or real, can result in impairments of physical, mental, and emotional functioning.

When compared to the general population, graduate students are more than six times as likely to experience depression and anxiety (Evans et al., 2018). Hyun et al., (2006) studied the mental health needs, knowledge, and utilization of services on college campuses, found that half of the graduate student participants self-reported experiencing an emotional or stress-related problem within the past 12 months and more than half reported knowing a colleague with such concerns.

A study conducted by the Graduate Assembly of the University of California, Berkley found that approximately 47 percent of Berkley Ph. D students, whom participated in the survey, reported symptoms indicative of clinical depression (The Graduate Assembly, 2014). The report also revealed that 47% of doctoral degree seeking students and 37% of master’s degree seeking students experienced symptoms of depression (The Graduate Assembly, 2014). Studies consistently find that graduate students frequently experience symptoms of psychological distress and/or meet criteria for a diagnosable mental health disorder (Evans et al., 2018; Hyun et al., 2006; Hyun et al., 2007; O’Reilly et al., 2014). Graduate students also experience a reemergence of mental health struggles during the course of their studies (Siegel & Keeler, 2020). In Siegel and Keelers’ (2020) qualitative study several participants revealed that the intensity of workload and uncertainty of being in a new place as factors leading to the reemergence of prior mental health challenges.

Several research studies have looked at the stress and anxiety experienced by graduate level students (Hoying et al., 2020; Jungbluth et al., 2011). Finding from O’Reilly et al., (2014) study on graduate level medical students suggest the increased stress and pressure experienced,
directly associated with the medical school environment, contributes to depressive symptoms in students over and above personal stressors. Stressors of graduate level programs may contribute to clinically significant levels of stress, anxiety, and depression (Rummell, 2015) and interfere with academic functioning in graduate level students (El-Ghoroury, et al., 2012). Some predictors of mental health related concerns in graduate level students include the expectations and workload in graduate programs and financial concerns (Andrews & Wilding, 2004; El-Ghoroury et al., 2012). There seems to be an array of factors contributing to mental health concerns of graduate students. Some of these include academic and coursework pressures (El-Ghoroury et al., 2012; Gruttadaro & Crudo, 2012), financial and debt concerns (Andrews & Wilding, 2004; El-Ghoroury et al., 2012; Hyun et al., 2006), managing work–life balance (El-Ghoroury et al., 2012), and the expectations and workload in graduate programs (Rummell, 2015).

Graduate students’ well-being (Hyun et al., 2006; Hyun et al., 2007), optimal functioning (El-Ghoroury et al., 2012), and academic performance (Andrews & Wilding, 2004; Hyun et al., 2006, 2007) are impacted when mental health concerns and symptoms are present. Symptoms of depression and anxiety among college students negatively impact student’s academic performance (Andrews & Wilding, 2004) and well-being (Hyun et al., 2006; Hyun et al., 2007). In a large survey of psychology graduate students, over 70 percent reported at least one stressor that interfered with optimal functioning in their respective graduate program (El-Ghoroury et al., 2012). A survey conducted on international graduate students found that approximately half (44.7%) of the graduate students surveyed experienced an emotional or stress-related problem that affected their well-being or academic performance within the past 12 months (Hyun et al.,
The effects of psychological distress can cause problems in graduate students social, emotional, and academic functioning and success.

There are various ways in which graduate level students may cope with these stressors. El-Ghoroury et al. (2012) study on graduate level psychology student revealed common coping strategies used by participants to be support from family, friends, peers/classmates, exercise, and hobbies. Offstein et al. (2004) found graduate student participants identified family members, peers, friends, and seeking the aid of a mentoring advisor as support related coping strategies.

**Mental Health of Counseling Graduate Students**

As presented above, there is an increased amount of research being done on the mental health of undergraduate and graduate level college students (Hyun et al., 2006; Wyatt & Oswalt 2013). However, research on the mental health and psychological distress of students enrolled in graduate level counseling programs continues to remain marginal. White and Franzoni’s (1990) study on beginning graduate level counselors in training found an increased level of psychological disturbance in counselor trainees than that found in the general population.

Smith, Robinson, and Young’s (2007) study of overall wellness and psychological distress of counselors in training found that a large proportion of counseling students reported experiencing disturbance levels similar to those found in clinical settings; 10.7% of participants experienced psychological distress in areas related to interpersonal relationships, social roles, somatic symptoms and stress, anxiety, and depression. Specifically, their study reported 16.8% of the counseling students studied experienced significant difficulties in interpersonal relationships, 14.2% indicated symptoms of common mental health disorders (e.g., mood, anxiety and adjustment disorders), and 16.8% noted significant difficulties in meeting requirements and fulfilling workplace, home, and school duties (Smith et al., 2007).
Byars (2005) conducted a study on the effectiveness of group counseling and exercise in alleviating the symptoms of stress, anxiety, depression, and loneliness in 57 counseling students from a CACREP-accredited program. In this study, all of the participants showed moderate levels of depression and loneliness, and extremely high levels of stress (Byars, 2005). A limitation of this study is generalizability since the author utilized convenience sampling, and all of the participants were recruited from the same counselor education program.

Parker (2014) study of counseling students enrolled in the internship portion of their program, found seven stressors considered problematic, as indicated by marked responses of feeling stressed to extremely stressed, effecting more than 51% of participants. These stressors included survey questions related to maintaining physical health, mental health, financial concerns of paying household bills and taking out student loans, strain and conflict between internships, personal and professional life, and stress related to site placement. Drabowicz (2017) found there to be a positive correlation between stress, anxiety, and depression levels and impostor phenomenon scores of graduate level counseling students.

The experience of stress and anxiety in counseling graduate programs can impact wellbeing, effectiveness in practice, and relationships with faculty members and clients. High levels of stress have been shown to negatively impact the working alliance of counseling students and clients (Gnilka, 2010; Gnilka et al., 2012) and that of counseling student and supervisor relationship (Gnilka, 2010; Gnilka et al., 2012). The relationship and working alliance between student and supervisor are important, as they correlate with self-efficacy, self-disclosure, and working alliance in counseling relationships (Park et al., 2019). Role dynamics within the working alliance is also an important factor in these relationships. Truell’s (2001) qualitative study on counselors in training, found confusion of role dynamics within teacher
student relationships to be a contributing factor to stress during the learning process. This confusion may be the result of a multiple relationship which exists when practitioner is engaged in a secondary relationship with a person in addition to the primary professional relationship (Corey et al., 2007).

**Psychological Well-being and Wellness of Counseling Graduate Students**

Topics of wellness and well-being have been the focus of most research related to the mental health of counseling graduate students (Harris et al., 2013; Myers et al., 2003; Roach & Young, 2007; Witmer & Granello, 2005). Psychological well-being is the combination of several aspects of positive psychological functioning which include: self-acceptance, autonomy, purpose in life, positive relations with others, environmental mastery, and personal growth (Ryff & Singer, 2008). Perceived wellness is present when an individual experiences consistent and balanced growth in six wellness dimensions of physical, psychological, spiritual, emotional, social, and intellectual matters (Harari et al., 2005).

Studies have found that graduate level counseling students exhibit higher levels of wellness than the general population (Myers et al., 2003; Roach & Young, 2007; Smith et al., 2007), but also indicate that participants may report higher levels of wellness than truly experienced (Myers et al., 2003). Harris et al. (2013) studied the relationship between psychological well-being and perceived wellness in graduate-level counseling students enrolled in a CACREP-accredited counseling program. A multiple regression analysis revealed a significant relationship between psychological well-being and perceived wellness, concluding that graduate level counseling students tend to have greater levels of perceived wellness when they also have increased levels of psychological well-being (Harris et al., 2013).
Smith et al. (2007) studied incoming master level counseling students and found an inverse relationship between psychological disturbance and wellness, and also discovered that a large number participants indicated high levels of psychological distress. Taylor et al. (2018) found that graduate level counseling students had moderate levels of total perceived wellness; with spiritual wellness and intellectual wellness scoring the highest and physical wellness and emotional wellness scoring the lowest. This is an important thing to note as emotional wellness would appear to be an imperative area of wellness in mental health professionals.

The importance of a “saturated” approach to wellness in counselor training programs has been presented in literature (Witmer & Granello, 2005). Research has found that a negative relationship exists between psychological stress and personal well-being in counselors in training, as the amount of psychological stress increases, personal wellness decreases (Smith et al., 2007). Even when counselor education programs promote wellness in their students, this does not mean students will improve their wellness as they go through their program (Roach & Young, 2007). As research has shown from both the psychological distress and wellness perspectives, emotional dysregulation exists in graduate level students and counselors in training, and there is a need for further understanding of the mental health of graduate level counselors in training.

Future Mental Health Practitioners

The mental health of graduate level counseling students is important to study because these individuals will one day become practicing therapists. Skovholt and Rønnestad’s (2003) review of literature uncovered seven key stressors to novice counselors including: (1) acute performance anxiety, (2) scrutiny of professional gatekeepers, (3) porous or rigid emotional boundaries, (4) fragile and incomplete practitioner-self, (5) inadequate conceptual maps, (6)
glamorized expectations and (7) an acute need for positive mentors. In this review, they also identified the major catalyst for stress of novice counselors to be the ambiguity of professional work. Stress and anxiety can lead to challenges in professional and personal functioning. Meyer and Ponton’s (2006) study support this as they found that mentally unhealthy counselors experience more difficulties professionally and personally than their healthy counterparts. This prolonged distress experienced well beyond the completion of graduate studies, may indicate consequential symptoms of internal dysfunction or lead to a diagnosable clinical condition (APA, n.d.; Mulder, 2008).

Gaubatz and Vera (2002) study on gate-keeping and the mental health of graduate counseling students surveyed counselor educators nationwide to investigate faculty estimates of impairment levels of graduate counseling students. Faculty members estimated that approximately 10.4% of their counseling students were poorly or marginally suited for the counseling field, in seven programs the student deficit rate was 30% or more, and in four programs faculty members reported rates that exceeded 50% (Gaubatz & Vera, 2002). Even more so, from the sample data an estimated 353 deficient counseling students graduated in the investigated year nationwide.

There is a need for healthy functioning mental health professionals. It is likely that impaired counseling students become impaired counseling professionals that risk doing harm to their clients if concerns are not addressed while in school (Witmer & Young, 1996). It is important for mental health related concerns to be addressed and attended to, at least in part, prior to graduation in order to aid in the production of healthy mental health professionals, to reduce potential harm of clients, and to increase the likelihood that help is sought in the future when needed. Gaining a better understanding of graduate level counselors in trainings experience
with help seeking and perceived mental health concerns can aid in the development of better resources, gatekeeping tools, and strategies for counseling educators, and the promotion of healthier functioning mental health professionals.

**Mental Health Help Seeking Behaviors**

Recognizing and admitting that one needs help can be a difficult thing to do, especially for self-motivated and independent individuals. Seeking help can come with various challenges and emotions of its own, including risk of vulnerability, discomfort, and potential feelings of fear and shame. In order to better understand the process, patterns, and motivation of this practice, it is imperative that we first define what help seeking is in the context of mental health. Rickwood and Thomas (2012) define help seeking in the context of mental health as “an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns” (p. 180). In now knowing what it is, we will take a closer look at the behavioral patterns and challenges of help seeking in students.

**Help Seeking in Students**

Salaheddin and Mason (2016) found that 35% of participants between the ages of 18-25 who reported having an emotional or mental health difficulty did not seek formal or informal mental health assistance. Studies have found that individuals may not seek mental health services for fear of stigmatization (Dunn, Harmond & Roberts, 2009; Hyun et al., 2006), cost and affordability (El-Ghoroury et al., 2012; Rummell, 2015; Stefl & Prosperi, 1985), lack of knowledge about services (Hyun et al., 2007; Stefl & Prosperi, 1985), and previous counseling experience (Ciarrochi & Deane, 2001; McCarthy et al., 2010).

Salaheddin and Mason (2016), conducted a cross-sectional survey to identify mental health help seeking among individuals aged 18-25 from the United Kingdom. In this study they
identified some of the major barriers to seeking help to be stigmatizing beliefs, feelings of embarrassment and shame, and access to services. The perceived stigma surrounding mental health concerns and the fear of discrimination influence the discussion of the topic and help seeking behaviors on university and college campuses (Burrell-Smith, 2013; Degges-White, & Borzumato-Gainey, 2014; Martin, 2010; Siegel & Keeler, 2020). This idea of there being a stigmatization surrounding mental health comes from students experience and exposure to the topic on campus. Wynaden et al. (2014) conducted a descriptive study of student and staff attitudes toward mental health problems, and found the silence surrounding mental health concerns on university campus to impact help seeking behaviors, support, recovery, and wellbeing of individuals experiencing psychological distress.

Cost, time, affordability, and lack of insurance coverage are more factors impeding help seeking in graduate students (McCarthy et al, 2010). Pursuing higher education can put a halt on or even greatly reduce vocational activity, thus impacting individuals’ financial revenue and standing. Therapy can be expensive, and as a reflection of this, the cost of services is a major barrier to students seeking mental health services on or off university and college campuses (Dearing et al., 2005; Stefl & Prosperi, 1985). Stefl and Prosperi (1985) investigated the relative importance of four key barriers to help seeking of mental health services, which include: availability (knowledge about services), accessibility (transportation), acceptability (what others would think), and affordability (cost-related concerns). Their study found affordability as the greatest barrier to seeking mental health services, followed by availability, accessibility, and acceptability (Stefl & Prosperi, 1985). Dearing et al. (2005) study on help seeking behaviors in clinical and counseling psychology graduate students found the greatest barriers to seeking therapy in participants to be cost of therapy, time, and confidentiality issues. Other potential
obstacles included general attitudes about therapy, and perceptions of the importance of personal therapy for professional development.

Waight and Giordano (2018) conducted a qualitative study on doctoral level graduate students and found they sought help from external sources, rather than institutional ones for mental health support. In fact, some participants whom disclosed such vulnerable information to faculty experienced an increase in distress symptoms (Waight & Giordano, 2018). Interactions with faculty may feel strained as faculty members in higher education also experience stressors and mental-health concerns as a result of various demands and expectations (Fontinha et al., 2019; Gmelch et al., 1986; Hart & Cress, 2008; Johnson et al., 2019). Graduate students are concerned with the possible repercussions of disclosing such sensitive information about mental health related concerns to program faculty members, and how it may impact their academic and professional future (Dyrbye et al., 2015).

Winter et al. (2017), found self-awareness about the mental health problem and prioritization of well-being as two major drivers and barriers of help seeking behaviors during psychological distress in graduate level medical students. Ciarrochi and Deane’s (2001) study suggested that students whom may have a greater need for counseling, as indicated by having poor emotional regulation skills, were actually less likely to seek the help they might need. Yet, individuals whom have previously sought professional help were more willing to seek out this help once again. It has been observed that female students’ attitude toward getting help are higher than male students (Civan & Haskan Avci, 2021).

**Help Seeking of Graduate Level Counseling Students**

The research on help seeking of graduate level counseling students is somewhat limited and mostly focuses on help seeking attitudes. McCarthy et al. (2010) studied help seeking
attitudes, behaviors, and perceived barriers to seeking counseling in graduate level counseling students. Forty-four percent of participants indicated they had participated in counseling at some point in their lives, with more favorable help seeking attitudes to be associated with prior counseling experience.

Trofis’ (2007) study on 209 masters level counseling students found that belief in the value of counseling, belief of stigma, and personal counseling experience to be the three most important predictors of help seeking attitudes among counselors-in-training. Trainees with personal counseling experience had more positive attitudes toward seeking counseling than students with no personal counseling experience. On the other hand, graduate level counseling student’s whom have not previously sought psychological help may possess more negative attitudes toward seeking help as well as greater stigma concerns (Pfohl, 2010).

McCarthy et al. (2010) study on help seeking attitudes indicates some of the top-rated barriers to mental health help seeking among students to be time, money, and lack of insurance coverage, with the fourth highest rated obstacle being stigma from professors. Driscoll’s (2020) qualitative study on counselors in training experience within personal counseling identified major themes of noted barriers to counseling being logistical, familial cultural, and personal internal barriers. Sullivan and Mancillas (2015) also discovered stigma being a barrier to seeking mental health services in counselors in training, with self-stigma being a more prevalent factor than public-stigma in relation to seeking help. Some motivating factors in the utilization of counseling services have been identified as academic and professional encouragement, as well as, family and peer influences (Driscoll, 2020).

Helpers in training may be more likely to seek help from a friend or family member than a mental health professional or professor (Tompkins et al., 2016). A study by Tompkins et al.
(2016) looked at support and satisfaction outcomes in students enrolled in American Psychological Association accredited professional psychology programs. Participants of this study reported that academic socioemotional support from friends and family, as well as, other students and peers was significantly greater than that from faculty (Tompkins et al., 2016). Farbers’ (2020) study on counseling psychology doctoral students help seeking tendencies, concluded that psychologists in training may seek professional help as a last resort.

Strozier et al. (2003) study on the use of psychological help in masters level marriage and family counseling students found length of time enrolled in the program significantly correlated with help seeking in participants, with an increased rate in service usage to be during the start of their practicum placement.

**Effectiveness of Help Seeking in Graduate Counseling Students**

Why does it even matter if counseling students seek help for mental health concerns? Are the benefits of seeking help greater than the risks? Psychological distress is defined as a set of painful and unpleasant mental and physical symptoms associated with typical fluctuations of mood, that in some cases may indicate the beginning of a diagnosable clinical condition (APA, n.d.). The presence of distress and mental health concerns is an indication that some kind of assistance or support is needed. Not seeking help when such concerns are present “is sometimes itself seen as pathological, a refusal to acknowledge the real need to be treated” (Mulder, 2008, p. 244).

The personal counseling experience of counselors in training has shown to influence professional development and have a positive impact on counselor development (Driscoll, 2020). The use of counseling services has been shown to be helpful in providing relief and decrease symptoms of distress in counselors in training. Byrne and Shufelt (2014) studied the use of
counseling services and the characteristics of counselors in training. Of the respondents whom sought counseling at some point in time, a significant number of them noted their experience contributed to moderate or significant improvement in situational concerns (81% of participants), and mental health symptoms (72% of participants). Prosek et al. (2013) studied the potential benefits of required counseling services for counselors in training, and found that after receiving counseling services while enrolled in an introductory counseling course, students reported a decrease in overall problems, depressive symptoms, and anxiety symptoms. As discussed through research findings, seeking help during times of psychological distress is beneficial for overall mental and emotional health, and aids in the reduction of distress symptoms.

Impact of COVID-19 and Racial Injustice

The social and political environment has been one of divisive and unavoidable struggle over the past few years, specifically as we have been faced with a global pandemic and racial strife and injustices, just to name a few (McCarthy et al., 2022; Lee et al., 2020; Kelly et al., 2020). It is important that we acknowledge the impact of these events and explore the ways in which they may have impacted mental health and help seeking behaviors.

The COVID-19 pandemic disrobed the lives of many students and impacted mental health conditions and experiences of anxiety, depression, and feelings of loneliness (Lee et al., 2020). Studies found that during the pandemic, students enrolled in higher education programs experienced increased levels of stress and anxiety (Chirikov et al., 2020; Son et al., 2020; Wang et al., 2020). The prevalence of major depressive disorder and generalized anxiety disorder in graduate students’ population was significantly higher in 2020 compared to 2019 (Chirikov et al., 2020). Students whom identified as Black, Indigenous, or people of color were disproportionately impacted by the COVID-19 pandemic and were more likely to experience
academic obstacles, financial hardships, food and housing insecurities, and symptoms of depression and anxiety (Soria et al., 2020).

COVID-19 also impacted help seeking for mental health concerns. Son et al. (2020) found a majority of the participants in their study who indicated an increase in stress and anxiety symptoms reported not using counseling services, and only one-third of the participants mentioned seeking help from families and friends. Students primarily used various forms of self-management methods to cope with feelings of stress and anxiety during the COVID-19 pandemic (Son et al., 2020). Lee et al. (2020) supported these findings with a majority of participants reporting engagement in mindfulness activities or exercise/physical activities as how they cared for mental health during the COVID-19 pandemic. Only 17% of participants indicated they obtained professional mental health care (Lee et al., 2020). Tomlin (2021) observed the lived experiences of counselors in training during the COVID-19 pandemic and found themes experienced by students to be parallel experiences, personal and professional disconnect, grief and loss, concerns for clients and preparedness and support.

Accompanying the COVID-19 pandemic, were horrific racial traumas and injustices. Social awareness of racial injustices experienced by Black Americans increased followed by the tragic deaths of George Floyd, Breonna Taylor, Ahmaud Arbery, Rayshard Brooks, and Jacob Blake (Kelly et al., 2020; Smith Lee & Robinson, 2019). Black graduate students have reported being in a state of hypervigilance, fight or flight responses, and significant psychological distress as a result of the recent racial trauma experienced throughout our country (Kiles et al., 2021). Black counseling students have reported feeling uncomfortable and overlooked in counseling programs (Seward, 2019), and have experienced overt and covert racism (Jangha et al., 2018). The political climate also affected trainees’ clinical training experience, as well as their
therapeutic work with clients (McCarthy et al. 2022). The tense environment also effected the therapeutic relationship and process for Black counselors in training (Solomonov & Barber, 2019).

The presence of the national pandemic and racial injustices have increased the need for greater knowledge and understanding of the experience, the mental health, and help seeking of graduate level counseling students. In the face of fear and tragedy there is a need for an increase in both personal and professional support for young therapists to help face the challenges of this current environment (Aafies va-Doorn, et al, 2020).

**Attribution Theory**

Attribution theory deals with how individuals use information to help explain, predict, and understand their environment, the events that occur within it, and how it relates to their thinking and behaving (Kelley, 1967). Attributions are assigned to internal (self) and external factors (environmental) to aid in understanding situations, events, and behaviors. The first credited influencer of attribution theory was Fritz Heider. He believed that people are inquisitive in nature and are trying to make sense of the social world around them through assumptive and predictive, cause and effect relationships (Heider, 1958). His ideas surrounding person perception involving dispositional (internal) and situational (external) attributions drove much of this theory. Heider referred to dispositional attributes as traits, inferred perceptions and “motives, intentions, sentiments ... the core processes which manifest themselves in overt behavior” (Heider, 1958, p. 34) (as cited in p. 73). The cause of behavior is due to some internal characteristic of a person. Situational attributes refer to an individual’s judgment of causality, either being impersonal or personal; here the cause of behavior is due to some situation or event
outside of one’s control. Heider’s ideas on attribution were expanded and further theorized by Jones and Davis (1965) and Kelley (1967).

Jones and Davis (1965) introduced theory of correspondent inference, believing people pay close attention to intentional behaviors of others, which in turn helps them understand and predict behaviors. Behaviors that are socially desirable or specific to the role prescribed, don’t usually result in intent attributions, but may be assigned when negative outcomes are endured (Fisher, 1983). Individuals assign dispositional (internal) attributes when they see a correlation between and individuals motive and behavior. When this match is inferred by an observer, it is called a correspondent inference. Jones and Davis (1965) outline five sources that impact whether or not a person makes a correspondent inference which include: accidental vs intentional behavior, choice, social desirability, hedonistic relevance, and personalism.

Kelly’s (1967) covariation model sought to understand the how of peoples’ decision to attribute a behavior or action to internal or environmental factors. Kelly (1967) developed a model for judging whether a behavior is to be attributed to characteristics of a person or to the environment. This theory of attribution proposed that attribution is a choice between internal and external causes where people access information from various points in time, from different situations, experiences, and observations to aid in making an attribution. Consensus, consistency, and distinctiveness are the three ways in which we explain an individual’s behavior (Fiske & Taylor, 1991). When we don’t have enough information to make a judgment we fall back on past experiences and look for either multiple necessary causes or multiple sufficient causes (Kelley, 1967).

In considering attribution theory as it relates to help seeking behavior, the recipient of assistance is actively trying to make sense of the helpers’ behavior and motivation. The receiver
wants to know, “Why did the donor help me? (i.e., What were the donor’s intentions?) and, Why did I need help? (e.g., because of incompetent or task difficulty)” (Fisher et al., 1983, p. 60).

Recipients of help may attribute the helpers’ behavior to three possible motives including (1) they acted from a place of genuine concern, (2) they acted for ulterior motives, or (3) they acted out of role responsibility (Fisher et al., 1983).

When it comes to seeking help, there is a potential threat to self-esteem and this threat is related to whether the individual attributes responsibility for the struggle, failure, or need for help to themselves or external factors (Jones & Davis, 1965; Kelley, 1965; Tessler & Schwartz, 1972). An individual will assign blame to one’s self for struggle or failure when there is a lack of evidence to support external cause. They will assume responsibility for the deficit and in tale that poses a threat to self-esteem. The intensity of the threat experienced is determined by the acknowledged inadequacy’s nature when seeking help to overcome the failure; this includes the ego centrality of the attributes on which the failure necessitating the act reflects (Tessler & Schwartz, 1972). Tessler and Schwartz (1972) provided an example of this by noting that seeking services from a psychiatrist is likely to be more threatening than that of a lawyer because for most of us, mental health is an attribute that is more central to our self-concept than is knowledge of legal practice. Nadlers (1987) research supports this idea that seeking help for an ego-central related task from a helper that is perceived as similar to oneself would be most threatening to.

The readiness to seek help is a function of perceived threat to ones’ self-esteem. Tessler and Schwartz (1972) investigated situational and personality determinants of help seeking based on an attributional analysis of experiences as threatening to self-esteem in female undergraduate students. The results indicated that help was sought sooner and more frequently in the external
attrition condition than in the self-attribution condition, when responsibility for failure could be attributed to external sources rather than to internal ones. In subjects with high self-esteem, more help was sought when attributes linked to help seeking were peripheral rather than central to self-concept. In subjects with low self-esteem more help was sought when help seeking reflected central attributes of self-concept. Help was sought more by subjects with low achievement motivation than high achievement, this was because the high achievement individuals tend to attribute their failure to lack of effort rather than ability (Tessler & Schwartz, 1972). This theory is relevant to the current study as it hypothesizes the how and why of help seeking behaviors.

Summary

Studies have found that graduate counseling students have a greater amount of stress than the typical population, and experience symptoms of anxiety and depression. This study expanded on these findings by observing the relationship between help seeking behaviors and psychological distress of graduate level counseling students enrolled in CACREP accredited counseling programs across the United States. Help seeking is “an adaptive coping process that is the attempt to obtain external assistance to deal with mental health concerns” (Rickwood & Thomas, 2012, p. 180). This definition is made up of three main components, comprised of five separate elements of the help seeking process, which include: behavioral process, the time frame, the source and type of assistance, and type of mental health concern (Rickwood & Thomas, 2012). This study attempted to better understanding the time frame, type of mental health concern, and source of help seeking sought by graduate level counseling students.
Chapter 3: Methodology

Chapter 1 introduced the proposed area of research, a description of the research problem, the research purpose, and the research question and hypotheses. Chapter 2 presented a review of the literature related to the major study variables of psychological distress and help seeking in existing research. A research gap was identified specifically in the area of CACREP accredited counseling education programs.

Chapter 3 outlines the methodology implemented in this study which expanded on the existing research of help seeking and psychological distress related to graduate level students enrolled in CACREP accredited counseling education programs. The purpose of this study was to examine the relationship between mental health help seeking behaviors and self-reported symptoms of psychological distress in graduate level counseling students enrolled in a CACREP accredited counseling program, while considering the influence of counseling specialty and length of time enrolled.

This chapter presents a description of study participants including recruitment, the research design including survey instruments, data collection, and the methodology used for data analysis. This discussion is intended to inform the reader of the procedures that were conducted to address the research question: What is the relationship between graduate level counseling students’ mental health help seeking behavior and self-reported symptoms of psychological distress of depression, anxiety and stress?

Participants

The data used in this study was previously collected during the Fall 2016 and Spring 2017 semesters (Cogdal et al., 2016). The survey was originally conducted to assess the mental health of graduate level students (Cogdal et al., 2016; Drabowicz et al., 2016). Drabowicz (2017)
used the raw data to examine impostor phenomenon and psychological distress in graduate counseling students.

For the current study, the survey participants included were masters’ level counseling students enrolled in CACREP accredited counseling programs throughout the United States during the Fall 2016 and Spring 2017 academic semesters. A total of 307 graduate counseling students completed the survey. Thirty two out of the 307 respondents were eliminated from the data set due to incomplete or missing responses. Participants not in specialty groups identified as unspecified, clinical mental health, or counseling in educational settings were also eliminated from the data set for a remaining total of 270 respondents. The participants surveyed in this study ranged between 21 to 61 years of age.

**Recruitment**

Participants were recruited using snowball sampling procedures. Snowball sampling is a method of sampling used by researchers to generate a study sample of participants “through referrals made among people who share or know of others who possess some characteristics that are of research interest” (Biernacki & Waldorf, 1981, p. 141). This form of recruitment was used in order to locate participants via program coordinators of CACREP accredited counseling programs throughout the United States. The participants of this study were identified through their status as active full-time or part-time graduate students enrolled in a CACREP accredited counseling program throughout the United States.

Participants were recruited via email notification with assistance from CACREP program coordinators identified through the CACREP website directory, the Council for Accreditation of Counseling and Related Educational Programs, 2015b. Emails were sent to a total of 328 CACREP accredited graduate counseling program coordinators asking them to distribute the
electronic surveys to students actively enrolled in their counseling program. Program coordinators were contacted via email and asked to send out the survey link to their active students enrolled in a CACREP accredited counseling program at their university. The specific number of survey invitations distributed to students was unknown. Two email notifications requesting participation in the study were sent over the academic semesters of Fall 2016 and Spring 2017. Participants did not receive any monetary incentive to participate in the study.

**Research Design**

A quantitative research design was employed to investigate factors of mental health help seeking behaviors of graduate level counseling students to address the differences in self-reported psychological distress symptoms of anxiety, depression and stress, area of study, and length of time enrolled in counseling program. The following discussion reviews the overall study strategies conducted in this study, including an overview of the survey instrument with demographic questions specific to counseling specialty, time enrolled in program, and help seeking behaviors along with the scale measurements of the Beck Anxiety Inventory (BAI), the Beck Depression Inventory, Second Edition (BDI-II), and the Perceived Stress Scale-10 (PSS-10).

**Survey Instrument**

Open ended questions were asked to gather demographic information to identify participants help seeking behaviors, counseling specialty area, and length of time enrolled in said program. Three instruments were used to gather data on psychological distress of participants: (1) the Beck Anxiety Inventory (BAI), (2) the Beck Depression Inventory, Second Edition (BDI-II), and (3) the Perceived Stress Scale-10 (PSS-10).
The BAI is a self-report measure designed to identify somatic, cognitive, and affective anxiety symptoms (Beck et al., 1988). The BDI-II assesses depressive symptoms present over the previous two weeks (Beck, Steer, & Brown, 1996). The PSS-10 measures the degree to which situations in an individual’s life are appraised as stressful (Cohen & Williamson, 1988).

**Demographics**

A brief demographics questionnaire was included in the survey administered to participants. Information requested included: (1) counseling specialty (unspecified, clinical mental health, and counseling in educational settings), (2) number of semesters enrollment in program named time enrolled, and (3) help seeking, which included three specific questions about their current or past use of professional counseling services, whom they talk to about psychological distress, and whether or not they previously sought help from faculty regarding psychological distress.

**Counseling Specialty.** Participants were asked to fill in their “degree” to determine counseling specialty. The responses were organized and coded based on major themes, and were then separated into eight groups of specialty areas based on CACREP counseling specialties. Responses were further narrowed down to form three specialty area groups: (1) unspecified, (2) clinical mental health, and (3) counseling in educational settings. Participants not in specialty groups of unspecified, clinical mental health, or counseling in educational settings were eliminated from the data set.

**Time Enrolled.** To identify the length of time participants had been enrolled in the current program, an open-ended question stating “How many semesters have you been in your current program” was presented. Responses were organized and coded into four different groups based on the number of semesters reported by participants. These groups were: (1) less than one
to one semester, (2) two to five semesters, (3) six to nine semesters, and (4) ten or more semesters.

**Help-Seeking.** Help seeking behavior information was gathered in three specific questions about current or past use of professional counseling services, whom they usually talk to about their psychological distress, and whether they previously had gone to faculty to seek help regarding psychological distress. The first asked if the participant had received professional counseling services on or off campus since enrolling in their current graduate program. Yes or no response options were given.

The second question asked participants to share about whom they usually talk to about their stress, anxiety, and depression. Responses were open-ended and coded based on major themes: 0) no one, 1) spouse/significant other, 2) friend, 3) classmate, 4) parent/ family member, 5) mental health professional, 6) advisor/supervisor/teacher, 7) sponsor/mentor, 8) doctor, 9) co-worker, 10) religious leader, 11) higher power, and 12) everyone. The twelve possible sources of help were further divided into three help groups named Formal (responses 5, 6, & 8), Informal (responses 1, 2, 3, 4, 7, 9, & 10), and Other (responses 0, 11, & 12).

The third question asked if participants have previously gone to their advisor/chair or another faculty member to discuss their stress, anxiety, and/or depression was also asked with dichotomous response options of yes or no.

**Scale Measurements**

Three areas of psychological distress measured in this study were anxiety, depression, and stress. The Beck Anxiety Inventory (BAI) was included in the survey to measure symptoms of anxiety, the Beck Depression Inventory Second Edition (BDI-II) measured symptoms of depression, and the Perceived Stress Scale-10 (PSS-10) measured stress level of participants.
**Beck Anxiety Inventory (BAI).** The BAI is a self-report measure designed to identify somatic, cognitive, and affective anxiety symptoms (Beck et al., 1988). This study included the BAI to measure graduate counseling students self-reported symptoms of anxiety. Internal consistency reliability is .92 with a test-retest reliability over one week of .75 (Beck et al., 1988). The scale was validated in a sample of 160 psychiatric outpatients with various anxiety and depressive disorders, diagnosed with the Structured Clinical Interview for DSM-III (Beck, Steer, Ball, & Ranieri, 1996).

The BAI is a 21-item instrument assessing anxiety symptoms using a four-point Likert scale (0 = not at all, 1 = mildly but it didn’t bother me much, 2 = moderately, it wasn’t pleasant at times, 3 = severely, it bothered me a lot). Respondents were asked to rate how much each of these symptoms bothered them in the past week. The total scale score has a minimum of 0 and a maximum of 63, and is determined by finding the total sum of the 21 items. Total scale scores can determine anxiety severity from low (0 – 21), moderate (22- 35), and severe (greater than 36) (Beck et al., 1988).

**Beck Depression Inventory, Second Edition (BDI-II).** This study included the BDI-II to measure graduate level counseling students self-reported symptoms of depression. The BDI-II assesses depressive symptoms present over the previous two weeks (Beck, Steer, & Brown, 1996). The BDI-II has an internal consistency reliability of .893 and a convergent validity based on strong positive correlations with other measures such as the Hamilton Depression Rating Scale (r = 0.71) (Erford et al., 2016; Hamilton, 1960). A meta-analysis of the BDI-II reviewing 144 studies between 1996 and 2013 found it to have internal consistency of .89, test–retest reliability of .75, along with high convergent validity and structural validity (Erford et al., 2016).
The BDI-II is a self-report 21-item instrument using a four-point Likert scale, which ranges from 0 (symptom not present) to 3 (symptom very intense). The BDI-II is used to assess severity of depression based on the *Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV)*; American Psychiatric Association, 1994). Total score is calculated by finding the total sum of the 21 items. Total score scales indicate the severity of depression from minimal (0 to 13), mild (14 to 19), moderate (20 to 28), and severe (29 to 63) (Beck, Steer, & Brown, 1996).

**Perceived Stress Scale-10 (PSS).** The PSS-10 measures the degree to which situations in an individual’s life are appraised as stressful (Cohen & Williamson, 1988). This study included the PSS-10 to measure graduate level counseling students’ self-reported perception of stress. It is a 10-item questionnaire rated on a five-point Likert scale ranging from 0 (never) to 4 (very often). Cohen et al. (1983) reported Cronbach’s $\alpha$ between .84-.86, and test-retest reliability .85 for the PSS. The PSS-10 is a validated instrument with .52-.76 correlation of the PSS to other similar measures (Cohen et al., 1983). The PSS showed adequate reliability and, as predicted, was correlated with life-event scores, depressive and physical symptomology, utilization of health services, and social anxiety.

Items in the scale are designed to see how unpredictable, uncontrollable, and overloaded respondents find their lives in relation to stress. In order to score the PSS-10, you must calculate the sum of the 10 items; four of these items are reverse scored (questions 4, 5, 7, & 8). Scores on the PSS-10 range from 0 to 40, with higher scores indicating higher perceived stress. Scores indicate the severity of perceived stress ranging from low (scores ranging from 0 to 13) moderate (scores ranging from 14 to 26) and high (scores ranging from 27 to 40) (Cohen et al., 1983).
Data Collection

Participants were notified of the study by CACREP program coordinators. Coordinators sent an informative email to potential participants asking them to voluntarily and anonymously participate in the research study. Upon receipt of the recruitment email, potential participants were able to decide whether or not they wanted to participate in the survey. Counseling graduate students who volunteered to participate in the research study followed a link embedded in the recruitment email directing them to an online Qualtrics survey.

Participants were required to read through the informed consent, which provided a description of the study, potential risks, privacy measures, investigator contact information, and mental health resources. Graduate counseling students who elected to participate in the study were then asked to complete the demographic questions of the survey. Potential participants not eligible to participate were screened through the demographic questionnaire at the beginning of the Qualtrics survey, and during initial data analysis.

Following the completion of the demographic questions, participants were then asked to answer questions regarding symptoms of depression, anxiety, and stress retrieved from the Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck et al., 1988), and the Perceived Stress Scale (PSS; Cohen, Kamarck, & Mermelstein, 1983).

The survey concluded with open ended questions about help seeking behaviors. Completion of the survey was expected to take no more than 30 minutes. No additional follow-up with individual participants was necessary. Data collection occurred between the dates of August 1, 2016 and August 1, 2017. Contact information to national hotlines for suicidal
thoughts or behaviors, and graduate student stress were provided at the conclusion of the survey to ensure safety of participants following the study.

**Data Analysis**

**Variables**

**Independent Variables**

The independent variables of this study included: help seeking behaviors, counseling specialty area, and length of time enrolled in counseling program.

**Help Seeking.** There were three groups examined in the help seeking variable named (1) Self-Help, (2) Type of Help, and (3) Source of Help. Graduate level counseling students’ mental health help seeking behaviors were examined in these groups using the responses from three questions included in the demographics section of the survey.

**Self-Help.** Self-help was defined as those participants who indicated they did not seek help from any outside source. The group of self-help was measured using the responses from question two (survey question 67), asking participants whom they usually talk to about their stress, anxiety, and/or depression. Responses are sorted and coded into twelve help groups of: 0) no one, 1) spouse/significant other, 2) friend, 3) classmate, 4) parent/family member, 5) mental health professional, 6) advisor/supervisor/teacher, 7) sponsor/mentor, 8) doctor, 9) co-worker, 10) religious leader, 11) higher power, 12) everyone.

This variable was further divided into a dichotomous variable labeled Self-Help. Participants who indicated they sought help from “no one”, were categorized in the “no” group. All other responses were included in the “yes” group, indicating they sought help from some outside source.
**Type of Help (Informal Help).** The group of informal help was measured using the responses from question two (survey question 67), asking participants whom they usually talk to about their stress, anxiety, and/or depression. Responses were sorted and coded into twelve help groups of: 0) no one, 1) spouse/significant other, 2) friend, 3) classmate, 4) parent/family member, 5) mental health professional, 6) advisor/ supervisor/teacher, 7) sponsor/mentor, 8) doctor, 9) co-worker, 10) religious leader, 11) higher power, 12) everyone.

The twelve possible sources of help were further divided into three help groups named Formal, Informal, and Other. Formal help seeking was defined as “assistance professionals who have a legitimate and recognized professional role in providing relevant advice, support and/or treatment” (Rickwood & Thomas, 2012, p. 175). The Formal help group included mental health professional, doctor, and advisor/supervisor/teacher.

Informal help seeking was defined as assistance from casual or informal social networks that were personal rather than professional in nature (Rickwood & Thomas, 2012). The Informal help group included spouse/significant other, friend, classmate, parent/family member, co-worker, and sponsor/mentor. The Other help group included responses that did not fit into the presented definition of formal or informal help, these responses included: no one, higher power, and everyone. This variable was further divided into a dichotomous variable labeled Informal Help. Participants who indicated they sought informal help, were categorized in “yes” group. All other responses were included in the “no” group.

**Source of Help (Professional Help).** The group of professional help was measured using the responses from question one (survey question 12) asking whether or not participants had received professional counseling services on or off campus since enrolling in their current
graduate program. Professional help was determined based on whether or not participants sought counseling services.

**Source of Help (Faculty Help).** The group of faculty help was measured using the responses from question three [survey question 68], asking whether or not participants had previously gone to their advisor/chair or another faculty member to discuss their stress, anxiety, and/or depression. Faculty help was determined by whether or not participants sought help from advisor, chair, or faculty member.

**Counseling Specialty.** The independent variable of counseling specialty specifically examined those participants identified in three groups of unspecified, clinical mental health counseling, and counseling in educational settings. These groups were identified from responses to an open-ended question on the survey asking participants their degree. Responses were organized, coded, and grouped into the three specified specialty areas of unspecified, clinical mental health counseling, and counseling in educational settings.

**Time Enrolled.** The independent variable of time enrolled in current counseling program was measured using the responses from an open-ended question on the survey asking participants how many semesters they had been enrolled in their current program. Responses were organized, coded, and grouped into four-time frames: 1) less than one to one semester, 2) two to five semesters, 3) six to nine semesters, 4) ten or more semesters enrolled.

**Dependent Variable**

The dependent variable of this study was psychological distress and was measured by participants’ symptoms of anxiety as measured by the BAI, symptoms of depression as measured by the BDI-II, and level of stress as measured by the PSS-10.
**Beck Anxiety Inventory.** The BAI is a 21-item instrument assessing anxiety symptoms using a four-point Likert scale (0 = not at all, 1 = mildly but it didn’t bother me much, 2 = moderately, it wasn’t pleasant at times, 3 = severely, it bothered me a lot) (Beck et al., 1988). The sum of the participant responses to the 21 items were calculated to identify severity of anxiety experienced by participants.

**Beck Depression Inventory.** The BDI-II is a self-report 21-item instrument using a four-point Likert scale, which ranges from 0 (symptom not present) to 3 (symptom very intense) (Beck, Steer, & Brown, 1996). The sum of the participant responses to the 21 items were calculated to identify severity of depression experienced by participants.

**Perceived Stress Scale-10.** The PSS-10 is a 10-item questionnaire rated on a five-point Likert scale ranging from 0 (never) to 4 (very often) (Cohen et al., 1983). The sum of the participant responses to the 10 item questions were calculated with responses to questions 4, 5, 7 and 8 reverse scored. Scores on the PSS-10 indicated participants’ level of perceived stress.

**Statistical Analyses**

Three hypotheses were analyzed to address the research questions: What is the relationship between graduate level counseling students’ mental health help seeking behaviors and self-reported symptoms of psychological distress of depression, anxiety, and stress?

- **Hypothesis 1:** There is no statistically significant relationship between self-help and length of time enrolled in a counseling program.

- **Hypothesis 2:** There is no statistically significant difference in self-reported symptoms of psychological distress based on help seeking behavior of type of help sought or source of help received.
• Hypothesis 3: There is no statistically significant relationship between self-reported symptoms of psychological distress of depression, anxiety, and stress and help seeking behaviors.

The statistical tests of Chi-Square test of independence, Analysis of Variance (ANOVA) and multiple regression were employed to analyze the data received from the survey.

**Chi-Square Test of Independence**

**Hypothesis Statement 1.** The first hypothesis examined if there was a statistically significant relationship between self-help and the length of time enrolled in a counseling program. In order to test this hypothesis, a Chi-Square of independence test was performed on the self-help variable and four time frames of enrollment: 1) less than one to one semester, 2) two to five semesters, 3) six to nine semesters, 4) ten or more semesters enrolled.

**Chi-square of Independence.** The Chi-square of independence test was used to examine this hypothesis. It is appropriate to use when trying to determine whether two categorical variables are independent. The Chi-Square test assumption of adequate cell size requires all cells to have expected values greater than zero, and 80% of cells to have expected values of at least five (McHugh, 2013). Cell size impacts validity of the p-value calculated for Chi-Square tests. In the case adequate cell size was violated, a Fischer’s exact test was used.

**Analysis of Variance (ANOVA)**

**Hypothesis Statement 2:** The second hypothesis examined if there was a statistically significant difference in self-reported symptoms of psychological distress based on help seeking behavior of type of help sought or source of help received. ANOVAs were used to examine both parts of the second hypothesis. The ANOVA is appropriate to use when a goal of research is to determine if there are statistically significant differences in means of variables between three or
more groups (Leedy & Ormrod, 2016). In order to test this hypothesis, ANOVAs were performed on help seeking behaviors type of help (informal help) and source of help (no one, faculty, professional, both faculty and professional).

**ANOVA Assumptions.** The assumptions of normality, homogeneity of variance, and independence were assessed. The normality assumption requires the residuals of the ANOVA to follow a normal distribution. Shapiro-Wilk test of normality was run and scatter plots examined to test for normality. To test the homogeneity of variance, Levene’s test of homogeneity of variances was used to make sure all groups had equal variances. The homogeneity of variance assumption requires the variance of the dependent variable to be equal within each independent group. Homogeneity was also assessed by examination of scatter plots. If the assumptions of the ANOVA were violated the Kruskal-Wallis test was used.

**Multiple Regression**

**Hypothesis Statement 3:** The third hypothesis examined if there was a statistically significant relationship between psychological distress and help seeking behavior (type of help) while length of time and counseling specialty were considered. A multiple regression analysis determined the statistical significance of the third hypothesis to explain the variance of the dependent variable based upon information available on two or more predictor variables. The final hypothesis examined if any predictive factors existed between self-reported symptoms of psychological distress of depression, anxiety, and stress and help seeking behaviors of graduate level counseling students.

Variables included in the regression model included: (1) participants level of anxiety as measured by Beck Anxiety Inventory (Beck et al., 1988); (2) symptoms of depression as measured by Beck Depression Inventory, Second Edition (Beck, Steer, & Brown, 1996); and (3)
level of perceived stress as measured by Perceived Stress Scale-10 (Cohen & Williamson, 1988). Participants’ help seeking behavior of type of help (Noone, Faculty, Professional, BothF&P) was used. Variables were also included in the multiple regression to test for interactions among groups. These variables included counseling specialty areas consisting of: (1) unspecified, (2) clinical mental health counseling, and (3) counseling in educational settings; and time enrolled consisting of time frames of: (1) less than one to one semester, (2) two to five semesters, (3) six to nine semesters, and (4) ten or more semesters.

**Regression Assumptions.** The assumptions of multiple regression of linearity, normality, homoscedasticity, and no multicollinearity were assessed. Normality assumes the residuals of the regression model follow a normal distribution. Shapiro-Wilk test of normality and scatter plots were used to test normality. Homoscedasticity assumes that scores are normally distributed about the regression line, meaning the variance of the dependent variable to be equal within each independent group. Linearity assumes the line of best fit through the data points is a straight line. Linearity was assessed by examination of scatter plots. The absence of multicollinearity assumes that independent variables don’t have any linear relationships between each other and was assessed using Variance Inflation Factors (VIF). VIF values over 10 will suggest the presence of multicollinearity, which could lead to Type-II error.

**Summary**

Chapter 3 outlined the planned methodology for the proposed study. The purpose of the proposed study was to expand on the existing research and examine the relationship between mental health help seeking behaviors and psychological distress in graduate level students enrolled in CACREP accredited counseling programs throughout The United States.
This study examined factors related to mental health help seeking behaviors among graduate level counseling students by looking at the relationship between help seeking behaviors of graduate level counseling students and self-reported symptoms of psychological distress (i.e., depression, anxiety and stress), counseling specialty, and length of time enrolled in CACREP accredited counseling program. This study also examined factors related to mental health help seeking behaviors among graduate level counseling students in order to further the knowledge and understanding of graduate counseling students’ mental health and help seeking.
Chapter 4: Results

This chapter presents the statistical analysis for each of the research hypotheses. This chapter begins by reporting descriptive statistics and demographic information of participants and psychological distress scales. The examination of Chi-Square test of independence, Analysis of Variance (ANOVA) and Multiple Linear Regression assumptions are then reported. A discussion of research hypotheses will be presented, following assumption testing. Hypothesis testing and analysis findings will then be discussed. The analyses conducted for hypothesis testing included, parametric tests of ANOVA and Multiple regression, as well as, nonparametric analyses of Kruskal-Wallis and Fishers exact tests. A brief presentation of the chosen analyses and a discussion of results will conclude this chapter.

Descriptive Statistics

Participants responded to survey questions that collected data on both demographic information, and psychological distress symptoms of depression, anxiety, and stress. Demographic information gathered included: gender, age, race, enrollment status, degree, graduate assistant or teacher assistant position, employment status, time enrolled, and specialty area. The psychological distress scales that measured depression, anxiety, and stress included the Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996), Beck Anxiety Inventory (BAI; Beck et al., 1988), and Perceived Stress Scale-10 (PSS-10; Cohen & Williamson, 1988). Descriptive statistics of frequencies, measures of central tendency, and standard deviations of demographic information and psychological distress scales are presented below.
Descriptive Statistic for Demographics

Respondents were asked to complete several multiple choice and open-ended questions on the survey to obtain demographic information. A total of 270 respondents were identified as being enrolled in a CACREP accredited counseling program. Participants ranged between 21 and 61 years of age, with an average age of 30.8 years. The most frequently observed category of gender was female \((n = 235, 87.0\%)\), followed by male \((n = 34, 12.4\%)\), with a single participant preferring not to disclose gender.

The racial makeup for participants was primarily White \((n = 226, 83.7\%)\) followed by African American \((n = 23, 8.5\%)\), Hispanic \((n = 8, 3.0\%)\), and Asian \((n = 4, 1.5\%)\). Nine respondents \((3.3\%)\) preferred not to disclose their race. Approximately one-third \((n = 82, 30.4\%)\) of participants noted holding either a graduate assistantship or a teaching assistantship position. Nearly 70 percent \((n = 188)\) indicated not holding a graduate assistantship or teaching assistantship position. During the time of the survey, approximately two-thirds \((n = 165, 61.1\%)\) of participants were employed outside of GA or TA position, with the remaining 39.1 percent \((n = 105)\) not employed.

Most of respondents indicated their enrollment status as full-time \((n = 216, 80\%)\), with only 20 percent \((n = 54)\) reporting part-time enrollment. The majority of respondents were degree seeking students \((n = 267, 98.9\%)\), with those seeking a master’s degree being the highest representation \((n = 225, 83.3\%)\). The length of time enrolled in the counseling program varied, with those in two to five semesters \((n = 135, 50.0\%)\) being the largest. The most frequently observed category of counseling specialty was clinical mental health \((n = 139, 51.48\%)\), followed by counseling in educational settings specialty \((n = 71, 26.2\%)\). Frequencies and percentages for degree, counseling specialty, and time enrolled are presented in Table 1.
Table 1

Frequency Table for Nominal Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master's</td>
<td>225</td>
<td>83.33</td>
</tr>
<tr>
<td>Doctorate</td>
<td>41</td>
<td>15.19</td>
</tr>
<tr>
<td>Specialist</td>
<td>2</td>
<td>0.74</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0.74</td>
</tr>
<tr>
<td>Counseling Specialty</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td>60</td>
<td>22.22</td>
</tr>
<tr>
<td>Clinical Mental Health</td>
<td>139</td>
<td>51.48</td>
</tr>
<tr>
<td>Counseling in Educational Settings</td>
<td>71</td>
<td>26.30</td>
</tr>
<tr>
<td>Time Enrolled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one to one semester</td>
<td>66</td>
<td>24.44</td>
</tr>
<tr>
<td>Two to Five semesters</td>
<td>135</td>
<td>50.00</td>
</tr>
<tr>
<td>Six to Nine semesters</td>
<td>61</td>
<td>22.59</td>
</tr>
<tr>
<td>Ten or more semesters</td>
<td>8</td>
<td>2.96</td>
</tr>
</tbody>
</table>

Descriptive Statistic for Psychological Distress Scales

Participants completed three assessment inventories to measure symptoms of psychological distress of depression, anxiety, and stress, as measured by the Beck Depression Inventory, Second Edition (BDI-II; Beck, Steer, & Brown, 1996), Beck Anxiety Inventory (BAI; Beck et al., 1988), and Perceived Stress Scale-10 (PSS-10; Cohen & Williamson, 1988). The descriptive statistics for these measures of central tendency, standard deviations, and frequencies are presented in Table 2.
### Table 2

*Summary Statistics Table for Interval and Ratio Variables*

<table>
<thead>
<tr>
<th>Psychological Distress</th>
<th>$M$</th>
<th>$SD$</th>
<th>$n$</th>
<th>$SE_M$</th>
<th>Min</th>
<th>Max</th>
<th>Skewness</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI-II</td>
<td>9.99</td>
<td>7.63</td>
<td>270</td>
<td>0.46</td>
<td>43.00</td>
<td>1.44</td>
<td>2.86</td>
<td></td>
</tr>
<tr>
<td>BAI</td>
<td>11.61</td>
<td>9.82</td>
<td>270</td>
<td>0.60</td>
<td>47.00</td>
<td>1.07</td>
<td>0.63</td>
<td></td>
</tr>
<tr>
<td>PSS</td>
<td>16.03</td>
<td>6.41</td>
<td>270</td>
<td>0.39</td>
<td>35.00</td>
<td>0.22</td>
<td>-0.18</td>
<td></td>
</tr>
</tbody>
</table>

### Examination of Assumptions

Chi-Square test of independence, ANOVA, and Multiple regression assumptions were run to ensure the validity of results prior to hypothesis testing. The Chi-Square test of independence requires all cells to have expected values greater than zero, and 80% of cells to have expected values of at least five (McHugh, 2013). ANOVA assumptions require data to be normally distributed, for all groups to have equal variances, independent of observations, and there to be no extreme outliers. Multiple Regression assumptions require linearity between variables, data to be normally distributed, needs to show homoscedasticity, and must not show multicollinearity. A discussion of assumption testing is presented, along with procedures taken when assumptions are not met.

### Chi-Square Test of Independence

The assumption of adequate cell size requires all cells to have expected values greater than zero, and 80% of cells to have expected values of at least five (McHugh, 2013). Cell size impacts validity of the p-value calculated for chi-square tests. P-value of Chi square test is based on large samples (data where the expected values are at least 5 for each cell), so if cell sizes are too small, valid p-values cannot be calculated. The assumption of adequate cell size was not met.
as one cell had an expected frequency of zero, and 62.50% of the cells had expected frequencies of at least five.

A Fisher's exact test was conducted to produce more reliable results. The Fisher’s exact test compares the observed frequencies to expected frequencies of two variables, and is appropriate to used when looking at the relationships between two categorical level variables. This test calculates the exact p-value which is used to evaluate the results, with alpha value of 0.05 indicating statistical significance. Fisher's exact test was used to produce more reliable results since Chi-square assumptions were violated. Fisher’s exact test does not require cell size assumptions to be met.

ANOVA Assumptions

An examination of the ANOVA assumptions of outliers, normality, and homogeneity of variance was assessed prior to hypothesis testing to ensure validity of results. A single observation was observed to be just over three standard deviations from the mean for BDI-II, with a score of 4.32. This observation was not removed from further analysis, as it represented participants’ experience and only slightly diverged from the standard deviation threshold of minimum score of -22 and maximum score of 41.

Normality

Shapiro-Wilk tests were conducted to determine whether the distributions of BDI, BAI, and PSS were significantly different from a normal distribution. PSS scores ($W = 0.99, p = .147$) did not significantly differ from normality based on an alpha of .05. However, BDI ($W = 0.89, p < .001$) and BAI ($W = 0.90, p < .001$) variables had distributions which significantly differed from normality, indicating the assumption of normality was not met. Howell (2013) reports that violations of normality are not problematic when the sample size exceeds 50 cases. Since the
sample size of the study was 270, it is not a concern that BDI-II and BAI scores were not normally distributed.

**Homogeneity of Variance**

Homogeneity of variance was conducted for the scale variables of BDI-II, BAI, and PSS by the two independent variables of Type of help sought (Informal Help) and Source of help sought (Noone_Faculty_Prof_BothFP). Results of Levene’s test of homogeneity of variance found the data met the assumption of homogeneity of variance for BDI-II by \( F(3, 266) = 1.30, p = .273 \), BAI by \( F(3, 266) = 0.71, p = .547 \), and PSS by \( F(3, 266) = 1.12, p = .340 \) for the independent variable of Source of help sought. However, the results of Levene's test of homogeneity for psychological distress scales by Type of help (Informal Help) were violated for BDI-II \( F(1, 268) = 4.20, p = .041 \) and BAI total scores \( F(1, 268) = 5.88, p = .016 \). PSS total scores by informal help \( F(1, 268) = 3.59, p = 0.59 \).

**Regression Assumptions**

An assessment of the regression assumptions of multi-variant outliers, normality, linearity, homoscedasticity, and multicollinearity of was conducted prior to hypothesis testing to ensure accurate interpretation of results. The results of the test of normality were presented in the previous ANOVA assumption discussion. Mahalanobias distance result identified no significant multivariate outliers. Multicollinearity was also not of concern, as none of the Variance Inflation Factors were greater than 10 (VIF=1.02).

An examination of the normal P-P plot of standardized residuals presented in Figure 1 indicated the data met linearity assumptions. Further, the random pattern on the scatterplot of standardized residuals of the predicted values indicated that the data met the assumption of homoscedasticity was met for BDI-II, BAI, or PSS.
Figure 1

P-P Plots and Scatter Plots of Standard Residuals

(a) BDI-II P-P Plot of Standard Residuals

(b) BDI-II Scatter Plot of Standard Residuals

(c) BAI P-P Plot of Standard Residuals

(c) BAI Scatter Plot of Standard Residuals

(e) PSS P-P Plot of Standard Residuals

(f) PSS Scatter Plot of Standard Residuals
Analyses

Parametric and nonparametric analysis methods for analyzing data between variables were included in this study. Parametric statistical procedures rely on assumptions about the shape of the distribution and form of parameters on means and standard deviations (Hopkins et al., 2018). On the other hand, nonparametric statistical procedures rely on very few assumptions regarding the shape or parameters of the data. These tests can handle both ordinal and categorical data, unlike most parametric statistics (Eddington, 2015). However, some disadvantages of nonparametric tests are that they are less precise, and not as powerful as parametric analyses, and interactions between independent variables are unable to be observed (Sheskin, 2011).

Parametric tests are most often preferred over nonparametric analyses (Eddington, 2015; Hopkins et al., 2018; Sheskin, 2011). If assumptions of parametric test are not met, results of the test can lead to incorrect conclusions. If one or more assumptions of the proposed parametric test have been significantly violated, it is recommended that a nonparametric test be used as it will provide a more reliable analysis of the data (Sheskin, 2011).

Parametric tests are typically used when interval or ratio data are evaluated, and data meets shape and parameter assumptions. While nonparametric tests are used with ordinal and categorical data, as well as, when data does not meet assumptions of parametric tests. The parametric analyses used in this study include ANOVA and Multiple regression tests. The nonparametric tests used in this study include Kruskal-Wallis and Fisher’s exact test. A discussion of results from statistical analyses are presented below.

Hypothesis One: Relationship Between Self-Help and Counseling Program

Hypothesis one stated: There is no statistically significant relationship between self-help and length of time enrolled in a counseling program. A Chi-Square test of independence was
originally conducted to examine whether time enrolled and self-help were independent. The assumption of adequate cell size was not met as one cell had an expected frequency of zero, and 62.50% of the cells had expected frequencies of at least five.

A Fisher's exact test was conducted to produce more reliable results. The Fisher’s exact test compares the observed frequencies to expected frequencies of two variables, and is appropriate to used when looking at the relationships between two categorical level variables. This test calculated the exact p-value which is used to evaluate the results, with alpha value of 0.05 indicating statistical significance. Fisher's exact test was used to produce more reliable results since Chi-square assumptions were violated. Fisher’s exact test does not require cell size assumptions to be met. The results of the Fisher exact test were not significant based on an alpha value $p = .680$. Results suggested that seeking self-help and time enrolled in a counseling program were not independent. The observed frequencies were not significantly different than the expected frequencies. Results of the Fisher's exact test are presented in Table 3.

<table>
<thead>
<tr>
<th>Time-Enrolled Variable</th>
<th>Observed</th>
<th>Expected</th>
<th>Observed</th>
<th>Expected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than one to two semesters</td>
<td>3</td>
<td>3.42</td>
<td>63</td>
<td>62.58</td>
</tr>
<tr>
<td>Two to five semesters</td>
<td>6</td>
<td>7.00</td>
<td>129</td>
<td>128.00</td>
</tr>
<tr>
<td>Six to nine semesters</td>
<td>5</td>
<td>3.16</td>
<td>56</td>
<td>57.84</td>
</tr>
<tr>
<td>Ten or more semesters</td>
<td>0</td>
<td>0.41</td>
<td>8</td>
<td>7.59</td>
</tr>
</tbody>
</table>

*Note: $p = .680$*
Hypothesis Two: Informal Help and Source of Help

The second hypothesis stated: There is no statistically significant difference in self-reported symptoms of psychological distress based on help seeking behavior of Type of help sought (Informal Help) or Source of help received (Noone_Faculty_Prof_BothFP).

Informal Help Results

As ANOVA assumptions were not met for the interaction of psychological distress and Type of help sought, a nonparametric test was conducted to test the hypothesis. The Kruskal-Wallis test is a non-parametric alternative to the one-way ANOVA that does not require distributional assumptions (Conover & Iman, 1981). It is appropriate to use when the purpose of research is to assess if a difference exist on one ordinal or continuous dependent variable by an independent variable with two or more groups. No assumptions had to be met to perform the Kruskal-Wallis test. Three Kruskal-Wallis tests were run on BDI, BAI, and PSS scores using Informal Help and Source of help sought as the independent variables.

BDI Kruskal-Wallis. Results of the Kruskal-Wallis test found a statistically significant difference in BDI-II scores between Informal Help groups, $\chi^2(1) = 5.28, p = .022$, with a mean rank score of 152.01 for the No group, and 128.30 for the Yes group. The median for No ($Mdn = 10.00$) was significantly larger than the median for Yes ($Mdn = 8.00$). Participants who sought informal help had lower levels of depression compared to those who did not.

BAI Kruskal-Wallis. Results of the Kruskal-Wallis found a statistically significant difference in BAI scores between Informal Help groups, $\chi^2(1) = 8.34, p = .004$, with a mean rank score of 156.26 for the No group, and 126.44 for the Yes group. Participants who sought informal help had lower anxiety levels compared to those who did not.
PSS Kruskal-Wallis. Results of the Kruskal-Wallis test revealed a statistically significant difference in PSS scores between Informal Help groups, $\chi^2(1) = 6.38, p = .012$, with a mean rank score of 153.66 for the No group, and 127.58 for the Yes group. Participants who sought informal help had lower levels of stress than those who did not.

Source of Help Results

Analysis of Variance (ANOVA) tests were run for the independent variable of Source of help received (Noone_Faculty_Prof_BothFP), and the BDI-II, BAI, and PSS scores as the dependent variables.

BDI-II ANOVA. The ANOVA result for BDI was significant ($F(3, 266) = 2.88, p = .036$), with approximately 3% of the difference explained by who participants sought help from. A Tukey HSD post-hoc analysis found a statistically significant difference in one pair: No one and Faculty. The mean of BDI-II for No one ($M = 8.72, SD = 6.55$) was significantly smaller than for Faculty ($M = 12.62, SD = 8.34$). Participants whom sought help from faculty had higher levels of depression than those who received no help at all. No other pairs were statistically significant.

BAI ANOVA. The ANOVA result for BAI was significant ($F(3, 266) = 5.47, p = .001$), with approximately 6% of the variance explained by who they sought help from. A Tukey HSD post-hoc analysis found a statistically significant difference in two pairs: (1) No one and Faculty, and (2) No one and Both Faculty/Professional. The mean of BAI for No one ($M = 9.39, SD = 9.09$) was significantly smaller than for Faculty ($M = 14.76, SD = 11.02$), $p = .021$. Findings also indicated that the mean of BAI for No one ($M = 9.39, SD = 9.09$) was significantly smaller than for Both Faculty/Professional ($M = 15.35, SD = 9.96$), $p = .004$. No other significant effects were found. Participants who received no help had lower anxiety scores than both those who sought
help from a faculty member and those who sought help from both faculty and counseling professional.

**PSS ANOVA.** Results of ANOVA for the PSS scale found no significant differences in perceived stress symptoms based on source of help seeking groups \((F(3, 266) = 2.28, p = .079.)\)

Table 4 presents a recap of the findings of source of help seeking for the three scores.

**Table 4**

*One-Way ANOVA Results*

<table>
<thead>
<tr>
<th>Psychological Distress Scales</th>
<th>F</th>
<th>p</th>
<th>Tukey HSD</th>
<th>Help Seeking Source</th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI-II</td>
<td>2.88</td>
<td>.036</td>
<td></td>
<td>No one</td>
<td>Faculty</td>
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<td>1.464</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Professional</td>
<td>-1.545</td>
<td>1.116</td>
<td>.510</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Both FP</td>
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<td>Faculty</td>
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<td>Both FP</td>
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<td>1.762</td>
<td>.839</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Professional</td>
<td>No one</td>
<td>1.545</td>
<td>1.116</td>
</tr>
<tr>
<td></td>
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<td>Faculty</td>
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<td></td>
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<td>1.375</td>
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<td>Faculty</td>
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<td>.839</td>
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<td>Professional</td>
<td>.890</td>
<td>1.486</td>
<td>.932</td>
</tr>
<tr>
<td>BAI</td>
<td>5.466</td>
<td>.001</td>
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<td>No one</td>
<td>Faculty</td>
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<td>Both FP</td>
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<td></td>
<td></td>
<td></td>
<td>Faculty</td>
<td>None</td>
<td>5.374*</td>
<td>1.858</td>
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<td></td>
<td>Both FP</td>
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<td>2.236</td>
<td>.994</td>
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<td>1.416</td>
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<td>Faculty</td>
<td>-2.943</td>
<td>1.991</td>
<td>.452</td>
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<tr>
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<td></td>
<td>Both FP</td>
<td>-3.528</td>
<td>1.886</td>
<td>.243</td>
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</tbody>
</table>
One-Way ANOVA Results

<table>
<thead>
<tr>
<th>Psychological Distress Scales</th>
<th>F</th>
<th>p</th>
<th>Tukey HSD</th>
<th>Help Seeking Source</th>
<th>Mean Difference</th>
<th>Std. Error</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Both FP</td>
<td>None</td>
<td>5.960*</td>
<td>1.745</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Faculty</td>
<td>.585</td>
<td>2.236</td>
<td>.994</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Professional</td>
<td>3.528</td>
<td>1.886</td>
<td>.243</td>
</tr>
</tbody>
</table>

* Statistically significant at alpha > .05.

Hypothesis Three: Relationship Between Psychological Distress and Help Seeking

The third hypothesis stated: There is no statistically significant relationship between self-reported symptoms of psychological distress of depression, anxiety, and stress and help seeking behaviors. To examine the third hypothesis, three multiple linear regressions were conducted to assess how much variation in psychological distress scores is explained by help seeking, time enrolled, and counseling specialty. For the purpose of the multiple regression analysis, help seeking behaviors included the variables of Faculty Help and Professional Help. Demographic variables of Time enrolled and Counseling Specialty were also be considered in the regression model. Time enrolled variable considered the length of time participants had been enrolled in counseling program, based on semesters enrolled. Counseling specialty variable identified the specific concentration studied including, clinical mental health, counseling in educational setting, and unspecified. Three multiple regression analyses were conducted for BDI-II, BAI, and PSS scores, with the variables of Faculty Help and Professional Help as predictor variables, and Time Enrolled and Counseling Specialty as interaction variables.

BDI-II Regression

The regression model was significant \(F(5, 264) = 2.88, p = .015, R^2 = .05\), with approximately 5.18% of the variance in depression scores explained by the type of help sought,
time enrolled, and counseling specialty. The “yes” response of the variable FacultyHelp significantly predicted BDI-II scores ($B = 2.17$, $t(264) = 2.08$, $p = .038$), with those who sought faculty help having on average 2.17 higher levels of depression compared to those who did not. Enrollment in the counseling specialty area of counseling in educational settings (CES) significantly predicted BDI-II scores ($B = -2.46$, $t(264) = -2.22$, $p = .027$), with CES specialty having on average 2.46 lower levels of depression than CMH specialty. No other findings were significant.

**BAI Regression**

The regression model was significant ($F(5, 264) = 5.05$, $p < .001$, $R^2 = .09$), with approximately 8.73% of the variance in anxiety scores explained by the type of help sought, time enrolled, and counseling specialty. The “yes” response of the variable FacultyHelp significantly predicted BAI scores ($B = 4.39$, $t(264) = 3.34$, $p < .001$), with those who sought faculty help having on average 4.39 higher levels of anxiety than those that did not. Enrollment in the counseling specialty area of CES significantly predicted BAI scores of participants ($B = -3.36$, $t(264) = -2.40$, $p = .017$), with CES specialty having on average 3.36 lower levels of anxiety than CMH specialty. No other findings were significant.

**PSS Regression**

The Regression model was not significant ($F(5, 264) = 1.66$, $p = .143$, $R^2 = .03$), indicating the type of help, time enrolled, and counseling specialty did not explain a significant proportion of variation in PSS scores. Individual predictors were not further examined. Multiple regression results are summarized in Table 5.
### Table 5

**Summary of Multiple Regression Analyses**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>SE</th>
<th>95.00%CI</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
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</thead>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>(Intercept)</td>
<td>9.15</td>
<td>0.94</td>
<td>[7.30, 10.99]</td>
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<td>9.77</td>
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<td>0.98</td>
<td>[-1.76, 2.08]</td>
<td>0.01</td>
<td>0.17</td>
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<tr>
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<td>1.04</td>
<td>[0.12, 4.22]</td>
<td>0.13</td>
<td>2.08</td>
<td>.038</td>
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<tr>
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<td>[-4.64, -0.27]</td>
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<tr>
<td>(Intercept)</td>
<td>11.14</td>
<td>1.18</td>
<td>[8.81, 13.47]</td>
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<tr>
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<tr>
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<td>[1.80, 6.99]</td>
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<td>TimeEnrolled_Scale</td>
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<td>-0.97</td>
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<tr>
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<td>-0.15</td>
<td>-2.40</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Intercept)</td>
<td>15.09</td>
<td>0.80</td>
<td>[13.52, 16.65]</td>
<td>0.00</td>
<td>18.98</td>
<td>&lt; .001</td>
</tr>
<tr>
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<td>0.83</td>
<td>[-0.56, 2.70]</td>
<td>0.08</td>
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<tr>
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<td>1.23</td>
<td>.221</td>
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<tr>
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<td>[-2.75, 0.95]</td>
<td>-0.06</td>
<td>-0.96</td>
<td>.338</td>
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</table>

**Summary**

This chapter reviewed the statistical analyses and findings for each of the research hypotheses. Descriptive statistics were reported, as well as, results of assumption testing. Hypothesis testing and analysis findings were then discussed. The purpose of this study was to examine the relationship between mental health help seeking behaviors and self-reported symptoms of psychological distress in graduate level counseling students enrolled in a CACREP program.
accredited counseling program, while considering the influence of variables counseling specialty and length of time. The research question which guided this study asked, what is the relationship between graduate level counseling students’ mental health help seeking behavior and self-reported symptoms of psychological distress of depression, anxiety and stress? From the general research question three hypotheses were presented. Prior to testing the hypotheses, assumptions of Chi square of independence, ANOVA, and Multiple regression tests were examined to ensure validity of results.

The first hypothesis looked at the relationship between self-help and length of time enrolled. When Chi square of independence test assumption of adequate cell size was not met, a Fisher’s exact test was used to test the relationship between the two variables. Results of Fisher’s exact test were not significant.

The second hypothesis looked at the differences in self-reported symptoms of psychological distress based on the type of help sought (Informal Help), as well as, source of help received (Noone_Faculty_Prof_BothFP). ANOVA assumptions were not met for the interaction of psychological distress and Type of help sought, so the nonparametric Kruskal-Wallis test was used to test this aspect of the hypothesis. Results of the Kruskal-Wallis test found a statistically significant difference in depression, anxiety, and stress scores between Informal Help groups. Participants who sought informal help had lower levels of depression, anxiety, and stress compared to those who did not.

ANOVAs were run to assess the differences in self-reported symptoms of psychological distress based on the source of help received (Noone_Faculty_Prof_BothFP). ANOVA results found there to be a statistically significant difference in depression and anxiety scores between Noone_Faculty_Prof_BothFP groups. Tukey HSD post-hoc analyses found that participants
whom sought help from faculty had higher depression scores than those who received no help at all, and participants who received no help had lower anxiety scores than both those who sought help from faculty, as well as, those who sought help from both faculty and counseling professionals.

To examine the third hypothesis, three multiple linear regressions were conducted to assess how much variation in psychological distress scores is explained by help seeking, time enrolled, and counseling specialty. Regression model was significant for both depression and anxiety. Findings concluded that seeking faculty help, and enrollment in CES specialty area contributed to depression and anxiety scores.

A final chapter presents a brief discussion of methodology and research findings related to current literature as well as implications for action, future research considerations, and study limitations.
Chapter 5: Discussion

Chapter 1 introduced the proposed area of research, presented through a description of the research problem, research purpose, research question, and hypotheses. Chapter 2 reviewed literature related to the major study variables of psychological distress and help seeking to identify existing research, and support further investigation. Chapter 3 outlined the methodology for this study along with a description of participants including recruitment, the research design including survey instruments, data collection, and the methodology for data analysis. Chapter 4 presented the statistical analysis and findings for each of the research hypotheses. Chapter 5 discusses research findings’ relation to the theoretical framework and existing literature, implications for action, limitations of the study, and future research considerations.

Study Findings

Mental health concerns have increasingly become more prevalent, with nearly one in five individuals experiencing mental health conditions in the U.S. (SAMHSA, 2016). Between January and September of 2020, the Mental Health America survey reported that over half a million participants indicated signs of depression and/or anxiety (Reinert et al., 2021). More specifically, graduate students in the U.S. have been seen to experience symptoms of emotional distress and/or meet criteria for a diagnosable mental health disorder at an increased rate (Eisenberg et al., 2013; Hyun et al., 2006; Winter et al., 2017). Graduate students are almost six times as likely to experience symptoms of anxiety and depression than the general population (Evans et al., 2018; Hyun et al., 2006).

Graduate level counseling students also experience symptoms of psychological distress (Byars, 2005; Smith et al., 2007). In fact, graduate level counseling students may experience these symptoms at an increased level, when compared to the general population (White &
Franzoni, 1990). Research has found that a low percentage of students actually seek help for mental health concerns while enrolled in graduate level programs (McCarthy et al., 2010; Salaheddin & Mason, 2016). Specifically in graduate level counseling students, some obstacles have been shown to include fear of stigma, time, affordability, and previous experience with seeking and receiving help (McCarthy et al., 2010; Troff, 2007).

Findings from this study revealed that a majority of the graduate level counseling students whom participated in the survey appear to experience low levels of depression (85%), low levels of anxiety (84%), and moderate levels of stress (59.3%). Less than half of participants sought professional help for mental health related concerns, supporting previous findings on the small percentage of students that seek help for mental health concerns (McCarthy et al., 2010; Salaheddin & Mason, 2016).

**Help Seeking and Time Enrolled**

The study’s first hypothesis sought to examine whether a significant relationship exists between the help seeking behavior of self-help, and the length of time enrolled in a counseling program. No significant association was found between the two variables. Results showed self-help and time enrolled in a counseling program to be independent of one another.

Strozier et al. (2003) found the length of time enrolled in program significantly correlated with psychological help seeking in masters level marriage and family counseling students, with increased service usage during the start of practicum placement. Hyun et al. (2006), found graduate students’ utilization of counseling services to be positively associated with the number of semesters enrolled in program. It is important to note that in this study a majority of participants identified as part of the “No” group (94.8%), indicating they typically seek help from a formal, informal, or both formal and informal source. Although no significant relationship
was found between help seeking and time enrolled in the presented study, participants enrolled in two to five semesters had the largest “No” ($n = 129, 95.6\%$) responses, supporting previous research of increased service use during what typically is the beginning of practicum placement.

**Psychological Distress and Help Seeking**

The study’s second hypothesis sought to examine if differences exist between psychological distress based on the type of help sought as well as the source of help received. Results found a statistically significant difference in depression, anxiety, and stress scores between informal help groups. A possible reason for these results is that participants whom need a higher level of care, to address psychological distress symptoms, are more open to seeking formal help, thus experience greater distress symptoms. Research has found that counseling students seek help at higher rate than the general population (McCarthy et al., 2010; Pfohl, 2010). However, it has also been found that despite the presence of symptoms, counseling students use of counseling services is actually fairly limited (Rummell, 2015).

The differences in psychological distress and informal groups may also be explained by factors contributing to mental health concerns, and potential help seeking barriers experienced by counseling graduate students. Some elements of graduate life that have been found to contribute to mental health concerns in graduate students include program pressure, expectations and academic demands (El-Ghoroury et al., 2012; Gruttadaro & Crudo, 2012; Rummell, 2015), financial stressors (Andrews & Wilding, 2004; El-Ghoroury et al., 2012; Hyun et al., 2006), and work–life balance (El-Ghoroury et al., 2012). Some barriers to graduate level counseling students seeking help include time (Dearing et al., 2005; Driscoll, 2020; McCarthy et al., 2009), the financial cost (Dearing et al., 2005; Driscoll, 2020; Farber, 2000; McCarthy et al., 2009),
concerns about confidentiality (Dearing et al., 2005; Farber, 2000), and fear of stigma (McCarthy et al., 2009).

A majority of participants in the present study indicated seeking informal help for psychological distress related concerns. This supports previous research indicating a majority of graduate level students report seeking help from some informal source, such as a family member, friend, or peer (El-Ghoroury et al., 2012; Offstein et al., 2014; Tompkins et al., 2016). Attribution Theory can aid in the explanation of participants decision to seek help and the kind of help sought. Internal or external attributes are assigned to the help seeking scenario, based on observed levels of consensus, distinctiveness, and consistency (Fiske & Taylor, 1991). Help is sought more often when the need for help is due to external rather than internal attributes (Tessler & Schwartz, 1972). The need for help being assigned to internal or external attributes may have contributed to the help seeking process.

This study also found a statistically significant difference in depression and anxiety scores between Noone_Faculty_Prof_BothFP groups. Participants who noted seeking no help had significantly lower levels of depression than those who sought help from faculty. Participants who received no help had lower anxiety scores than both those who sought help from a faculty member, and those who sought help from both faculty and counseling professional. These differences can be understood through the lens of attribution theory, as variances can be explained by the personally assigned attributes related to help seeking experiences. Based on the assumption of this theory, participants likely assign attributions, influenced by past and present experiences, surrounding the interaction that transpired, and cause of help seeking (Kelley, 1967). These attributes are assigned to help make sense of the situation and thus impacts thoughts and behaviors of participants (Kelley, 1967).
Psychological Distress and Help Seeking by Time and Specialty

The study’s third hypothesis sought to examine if a significant relationship exists between self-reported symptoms of psychological distress and help seeking behaviors by time enrolled and counseling specialty. The regression model found significance for both depression and anxiety, indicating that differences in help seeking can help explain differences in depression and anxiety scores. Findings concluded that seeking faculty help and enrollment in CES specialty area contributed to the variance in depression and anxiety scores.

Previous studies reported some barriers to help seeking in counselors in training to be fear of stigma and confidentiality concerns (Dearing et al., 2005; Farber, 2000; McCarthy et al., 2009; Sullivan & Mancillas, 2015). Further, Troff (2007) found a significant inverse relationship between stigma concerns of counselors in training and their attitudes toward counseling. Study participants possible fear of stigma and confidentiality concerns may have played a role in the outcome of their experience of help, thus impacting psychological distress symptoms.

Findings from the present study suggested that the variance in depression and anxiety scores were at least in part a result of help seeking behavior. Participants that sought faculty help exhibited higher levels of depression and anxiety symptoms. These variances may be in part explained through attribution theory. Recipients of help seek to know the intent and motive behind the helpers’ behavior, and in turn they attribute the helpers’ behavior to three possible motives (Fisher et al., 1983). These three possible motives include the following: (1) the helper acted from a place of genuine concern, (2) the helper acted for ulterior motives, or (3) the helper acted out of role responsibility (Fisher et al., 1983). The attributed motive assumed by the recipient of help, may have influenced the experience of psychological distress.
Findings from this study indicated that participants enrolled in CES specialty area had lower levels of depression and anxiety than those in CMH specialty. Javaheri (2017) studied psychological capital for coping with stressors in graduate level counseling students enrolled in CACREP programs. Findings of this study revealed that levels of both clinical and academic stressors, as measured by academic stress, clinical stress, PsyCap, and mental health, did not differ among the various counseling specialties (Javaheri, 2017).

**Implications of Findings**

This study expanded on the existing research of mental health and help seeking behaviors of graduate level counseling students. It examined the relationship between self-reported symptoms of psychological distress (i.e., depression, anxiety, and stress) and mental health help seeking behaviors of graduate level counseling students enrolled in CACREP accredited counseling programs. A secondary analysis of de-identified pre-existing data was assessed to examine the relationship between psychological distress and mental health help seeking in graduate level students enrolled in CACREP accredited counseling programs throughout The United States. From this study implications for research, teaching, and practice have been made.

**Implications for Research**

Increased interest, yet limited research has been done on both psychological distress and help seeking behaviors of counselors in training. This study found that counseling students exhibit increased levels of psychological distress, as exhibited by self-reported symptoms of depression, anxiety, and stress. This study also found there to be a significant relationship between source and type of help seeking behavior, and the experience of psychological distress in participants. Our limited knowledge of both the mental health and help seeking behaviors and
experiences of counselors in training is a problem as their emotional wellbeing impacts both them and the individuals they work with as helpers. This problem is significant as it is the ethical duty of both educators and counselors in training to monitor, recognize, and seek/direct services when an impairment is present in mental, physical, or emotional areas of functioning (ACA, 2014; CACREP, 2016). Continued research is not just suggested to expand on the knowledge and understanding, but urged as it is in part our ethical responsibility as counselor professionals and educators.

**Implications for Teaching**

**Role confusion**

As counseling faculty members are first therapists and second counseling educators, one might consider the experience of role confusion in the student faculty relationship a contributing factor to these results. When students come to faculty with mental health concerns, faculty members may unintentionally slip into the role of counselor, providing emotional support to the student. This could potentially lead to confusion as to the nature of the relationship, and result in unintentional unmet expectations and harm.

One way this could cause harm is by faculty providing support and understanding when information is disclosed, then quickly reverting back into the role of educator outside of that interaction. Truell (2001) found confusion in the role dynamics of the teacher student relationship to be a contributing factor to stress during the learning process of counselors in training. These perceived roles may impact student mental health as feelings of shame, fear, and loneliness arise due to the inconsistent, confusing nature of the relationship. The findings from this study did not reveal any significant differences in stress scores based on the type or source of help sought by participants.
**Ramifications**

Waight and Giordano (2018) noted that students who disclosed information to faculty experienced an increase in distress symptoms. Participants expressed feeling supported by faculty upon sharing, yet feeling forgotten and dismissed soon after (Waight & Giordano, 2018). After disclosing vulnerable and personal information, such as mental health challenges, students may be fearful of the ramifications that might follow, thus contributing to the experience of increased symptoms. Dyrbye et al. (2015), reported that some students expressed having concerns over possible repercussions from program faculty regarding disclosing mental health concerns. Participants were fearful of how sharing such information might impact their academic and future professional careers (Dyrbye et al., 2015). Although findings from the current study do not assume cause, results indicate there is a relationship between seeking faculty help, and depression and anxiety scores. Participants who sought faculty help had higher scores on both depression and anxiety scales, supporting previous research findings.

Results suggest a need for faculty to be mindful of their interactions with students, as well as the role they are playing within those interactions. Implementing appropriate boundaries, as well as, communicating them to students that bring such concerns, may provide greater understanding to the nature of the relationship, and more clarity to expectations and responsibilities of each role. The hope is that in this mindful interaction faculty help will be experienced as a positive influence of student mental health.

**Normalization**

Attribution theory suggests that individuals are more likely to seek help when it is normalized to do so, and the need for help is more easily attributed to external rather than internal causes (Tessler & Schwartz, 1972). Witmer and Granellos’ (2005) chapter on wellness
in counselor education and supervision, they spoke on the importance of a saturation approach to wellness within counseling programs to help imprint pervasive long lasting healthy lifestyle changes in counselors and trainees. I propose an extension of this idea to the saturation and normalization of seeking and receiving help for mental health related concerns in counseling graduate programs. As a positive correlation has been found between students’ perception of faculty attitude and value of seeking help, and student’ help seeking behavior (Dearing et al., 2005; Farber, 1999). Perceived social norms impact graduate level students’ willingness to seek help (Farber, 1999). Thus, it is important that the normalization of help seeking is intentionally promoted within counseling programs.

**Implications for Practice**

**On the Surface**

The relationship between psychological distress and help seeking may also exist because students that are going to faculty or counseling professionals for mental health related concerns are actually addressing them. Increasing self-awareness and bringing issues and concerns to the surface, thus experiencing the emotional depth and breadth of them more fully. Rather than the possible alternative of minimizing and avoiding the experience of mental health concerns, thus not connecting to the actual experience of the emotion. The increase in self-awareness can contribute to feelings of uncertainty, anxiety, and other existential related concerns (Pierce, 2016). Practicing counselors can acknowledge and normalize this process thus aiding in the experience of growth and change, and the emotional experience.

**Faculty stress**

Faculty members also experience their own stressors related to both their work and personal life (Gmelch et al., 1986; Hart & Cress, 2008). The ever-increasing workload and demands
placed on faculty in higher education settings have been associated with burnout, work-related stress, and mental health concerns (Fontinha et al., 2019; Johnson et al., 2019). A portion of the variance in depression and anxiety scores found in this study could be explained by faculty help seeking. Faculty members were experiencing symptoms of burnout and stress during time of help seeking, could have influenced students experience of help and intensity of their psychological distress symptoms. Counselor educators must also be thought of and cared for, as their interactions and relationships with students are vital in the personal and counselor development process.

**Limitation of Research**

One limitation of this current study is the nature of the questionnaire, it relied on participants to respond honestly to presented questions. In an effort to not appear like they are struggling, respondents may have not answered questions honestly. This may have impacted scores on psychological distress tests. In addition to the possible influence of perception, the timing of data collection was another limitation of this study. The survey was open to participants from September 2016 to February 2017, the bulk of data was collected in September 2016, which was the start of the semester. It is possible that the timing of data collection influenced the intensity of self-reported symptoms of depression, anxiety, and stress being that participants had just returned from summer break.

Another limitation of this study was the design of help seeking questions. More direct and concrete questions could have been used to address more targeted and specific research questions. Having more direct and specific survey questions could have provided fewer group options, with larger group sizes. This would have allowed for more reliable hypothesis testing, and reduced the need for modifications.
The data was collected in the Fall of 2016 and Spring 2017 semester. The time of collection was a limitation to this study because the COVID-19 pandemic transpired between the time of data collection and the current research study. This is an important limitation to note because during the pandemic many programs had to switch to a format where community, communication, and courses were held in a virtual setting. These changes may have greatly impacted help seeking behaviors, as well as the intensity of mental health symptoms in graduate level counseling students.

**Recommendations for Further Research**

There has been an increased interest in understanding the experience of graduate level students. In terms of help seeking, the rate of seeking help (McCarthy et al., 2010; Pföhl, 2010), the use of services (Rummell, 2015), predictors of help seeking attitudes (Civan & Haskan Avci, 2021; McCarthy et al., 2010; Pföhl, 2010; Sullivan & Mancillas, 2015; Troff, 2007), and barriers to help seeking (Dearing et al., 2005; Driscoll, 2020; Farber, 2000; McCarthy et al., 2009) have been minimally studied in graduate level counseling students. Researchers have also begun to take interest in the psychological distress of graduate counseling students, including their experience (Byars, 2005; Parker, 2014; Rummell, 2015), and the impact of mental health concerns alliance (Drabowicz, 2017; Gnilka, 2010; Gnilka et al., 2012; Smith et al., 2007). In order to add to the increasingly growing body of knowledge on help seeking and psychological distress of graduate level students, continued research is recommended.

One suggestion for future research is to explore specific demographic variables and their relationship with psychological distress and help seeking behaviors. In this current study we examined the relationship between the help seeking behaviors, self-help, and time enrolled. No significant relationship was found. The self-help variable was created from open ended
responses, and consisted of a small group size. Future research that specifically studies self-help of counselors in training, with a larger group size, may uncover different relationships between self-help and time enrolled.

The data from this study was collected at a single point in time. Pre/posttest design is recommended for future research as to collected psychological distress measure before and after help is sought. To study the cause-and-effect relationship between help seeking and psychological distress in graduate level counseling students.

To expand on the current study, research on the reasons contributing to increased psychological distress symptoms in graduate level counseling students, based on the type and source of help sought, is recommended. The purpose would be to explore the phenomenological experiences of those who sought various types of help. This would provide increased knowledge on how to best support and care for students, as well as, clarity on experiences that may cause harm.

**Summary**

The present study expands on the current research and understanding of the mental health and help seeking behaviors and experience of counselor trainees. The purpose of this study was to examine the relationship between mental health help seeking behaviors and self-reported symptoms of psychological distress of depression, anxiety, and stress in graduate level counseling students enrolled in CACREP accredited counseling programs, while considering the influence of variables counseling specialty and length of time. To conclude this study, this final chapter discussed research findings and literature, implications for action based on findings, limitations of the presented study, and future research considerations.
Research findings were grouped based on the three hypotheses. Significant research findings were presented for each hypothesis, along with previous research findings from existing literature as supporting evidence. Support of study findings through the lens of theoretical framework was also discussed. Implications for research, teaching, and practice were presented as possible modifiable factors that can be made based on study findings. Limitations of study including participant bias, survey design, and time of data collection were discussed. Finally, recommendations for future research were presented, to support the continued expansion of literature and understanding of the mental health and help seeking of graduate level counselors in training.
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Appendix A

Institutional Review Board Approval Letter

Institutional Review Board
Division of Research and Innovation
Office of Research Compliance
University of Memphis
315 Admin Bldg
Memphis, TN 38152-3370

May 5, 2022

PI Name: Katherine Haaga
Co-Investigators:
Advisor and/or Co-PI: Stephen Zanskas
Submission Type: Admin Withdrawal
Title: A Secondary Analysis of Help Seeking Behaviors and Psychological Distress of Graduate Level Students Enrolled in CACREP Accredited Counseling Programs
IRB ID: PRO-FY2022-431

From the information provided on your determination review request for “A Secondary Analysis of Help Seeking Behaviors and Psychological Distress of Graduate Level Students Enrolled in CACREP Accredited Counseling Programs”, the IRB has determined that your activity does not meet the Office of Human Subjects Research Protections definition of human subjects research and 45 CFR part 46 does not apply.

This study does not require IRB approval nor review. Your determination will be administratively withdrawn from Cayuse IRB and you will receive an email similar to this correspondence from irb@memphis.edu. This submission will be archived in Cayuse IRB.

Thanks,

IRB Administrator
Division of Research and Innovation
Office of Research Compliance
315 Administration Building
Memphis, TN 38152-3370
P: 901.678.2705
F: 901.678.4409
Appendix B

The Beck Depression Inventory II

1. Sadness
0 I do not feel sad.
1 I feel sad much of the time.
2 I am sad all of the time.
3 I am so sad or unhappy that I can't stand it.

2. Pessimism
0 I am not discouraged about my future.
1 I feel more discouraged about my future than I used to be.
2 I do not expect things to work out for me.
3 I feel my fortune is hopeless and will get only worse.

3. Past Failure
0 I do not feel like a failure.
1 I have failed more than I should have.
2 As I look back I see a lot of failures.
3 I feel I am a total failure as a person.

4. Loss of Pleasure
0 I get as much pleasure as I ever did from the things I enjoy.
1 I don’t enjoy things as much as I used to.
2 I get very little pleasure from the things I used to enjoy.
3 I can’t get any pleasure from the things I used to enjoy.

5. Guilty Feelings
0 I don’t feel particularly guilty.
1 I feel guilty over many things I have done or should have done.
2 I feel quite guilty most of the time.
3 I feel guilty most of the time.

6. Punishment Feelings
0 I don’t feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7. Self-Dislike
0 I feel the same about myself as ever.
1 I have lost confidence in myself.
2 I am disappointed in myself.
3 I dislike myself.

8. Self-Criticisms
0 I don’t criticize or blame myself more than usual.
1 I am more critical of myself than I used to be.
2 I criticize myself for all of my faults.
3 I blame myself for everything bad that happens.

9. Suicidal Thoughts or Wishes
0 I don’t have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10. Crying
0 I don’t cry anymore than I used to.
I cry more than I used to.
I cry over every little thing.
I feel like crying, but I can’t.

11. Agitation
0 I am no more restless or would up than usual.
1 I feel more restless or would up than usual.
2 I am so restless or agitated that it’s hard to stay still.
3 I am so restless that I have to keep moving or doing something.

12. Loss of Interest
0 I have not lost interest in other people or activities.
1 I am less interested in other people or things than before.
2 I have lost most of my interest in other people or things.
3 It’s hard to get interested in anything.

13. Indecisiveness
0 I make decisions about as well as ever.
1 I find it more difficult to make decisions than usual.
2 I have much greater difficulty in making decisions than usual.
3 I have trouble making any decision.

14. Worthlessness
0 I do not feel I am worthless.
1 I don’t consider myself as worthwhile and useful as I used to.
2 I feel more worthless as compared to other people.
3 I feel utterly worthless.

15. Loss of Energy
0 I have as much energy as ever.
1 I have less energy than I used to have.
2 I don’t have enough energy to do very much.
3 I don’t have enough energy to do anything.

16. Changes in Sleeping Patterns
0 I have not experienced any change in my sleeping pattern.
1 I sleep somewhat more/less than usual.
2 I sleep a lot more/less than usual.
3 I sleep most of the day.
   I wake up 1-2 hours early and can’t get back to sleep.

17. Irritability
0 I am no more irritable than usual.
1 I am more irritable than usual.
2 I am much more irritable than usual.
3 I am irritable all the time.

18. Changes in Appetite
0 I have not experienced any change in my appetite.
1 My appetite is somewhat greater/lesser than usual.
2 My appetite is much greater/lesser than usual.
3 I crave food all the time or I have no appetite at all.

19. Concentration Difficulty
0 I can concentrate as well as ever.
1 I can’t concentrate as well as usual.
2 It’s hard to keep my mind on anything for very long.
3 I find I can’t concentrate on anything.

20. Tiredness or Fatigue
0 I am no more tired or fatigued than usual.
1 I get more tired or fatigued more easily than usual.
2. I am too tired or fatigued to do a lot of the things I used to do.
3. I am too tired or fatigued to do most of the things I used to do.

21. Loss of Interest in Sex
0. I have not noticed any recent change in my interest in sex.
1. I am less interested in sex than I used to be.
2. I am much less interested in sex now.
3. I have lost interest in sex completely.

Client Score ______________________
Appendix C

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Not At All</th>
<th>Mildly but it didn’t bother me much.</th>
<th>Moderately - it wasn’t pleasant at times</th>
<th>Severely – it bothered me a lot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness or tingling</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling hot</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Wobbliness in legs</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unable to relax</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Fear of worst happening</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Dizzy or lightheaded</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Heart pounding/racing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unsteady</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Terrified or afraid</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling of choking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hands trembling</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Shaky / unsteady</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Fear of losing control</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Difficulty in breathing</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Fear of dying</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Scared</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Indigestion</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Faint / lightheaded</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Face flushed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Hot/cold sweats</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Column Sum**

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here ____________.

**Interpretation**

A grand sum between 0 – 21 indicates very low anxiety. That is usually a good thing. However, it is possible that you might be unrealistic in either your assessment which would be denial or that you have learned to “mask” the symptoms commonly associated with anxiety. Too little “anxiety” could indicate that you are detached from yourself, others, or your environment.
A grand sum between 22 – 35 indicates moderate anxiety. Your body is trying to tell you something. Look for patterns as to when and why you experience the symptoms described above. For example, if it occurs prior to public speaking and your job requires a lot of presentations you may want to find ways to calm yourself before speaking or let others do some of the presentations. You may have some conflict issues that need to be resolved. Clearly, it is not “panic” time but you want to find ways to manage the stress you feel.

A grand sum that exceeds 36 is a potential cause for concern. Again, look for patterns or times when you tend to feel the symptoms you have circled. Persistent and high anxiety is not a sign of personal weakness or failure. It is, however, something that needs to be proactively treated or there could be significant impacts to you mentally and physically. You may want to consult a physician or counselor if the feelings persist.
Appendix D

Perceived Stress Scale-10

For each question choose from the following alternatives:
0 – Never
1 – Almost Never
2 – Sometimes
3 - Fairly often
4 - Very often

_____ 1. In the last month, how often have you been upset because of something that happened unexpectedly?

_____ 2. In the last month, how often have you felt that you were unable to control the important things in your life?

_____ 3. In the last month, how often have you felt nervous and stressed?

_____ 4. In the last month, how often have you felt confident about your ability to handle your personal problems?

_____ 5. In the last month, how often have you felt that things were going your way?

_____ 6. In the last month, how often have you found that you could not cope with all the things that you had to do?

_____ 7. In the last month, how often have you been able to control irritations in your life?

_____ 8. In the last month, how often have you felt that you were on top of things?

_____ 9. In the last month, how often have you been angered because of things that happened that were outside of your control?

_____ 10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?