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# Psychotherapy Dropout and Socioeconomic Status: A Qualitative Analysis of College Students

Emily Sophia Lavine
*Scripps College*

**PSYCHOTHERAPY DROPOUT AND SOCIOECONOMIC STATUS:
A QUALITATIVE ANALYSIS OF COLLEGE STUDENTS**

by

**EMILY SOPHIA LAVINE**

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**PROFESSOR PHIL ZUCKERMAN**
PITZER COLLEGE

**PROFESSOR SHEILA WALKER**
SCRIPPS COLLEGE

**PROFESSOR JENNIFER MA**
SCRIPPS COLLEGE

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Abstract

This qualitative research study explores the correlation between socioeconomic status and factors of psychotherapy dropout among college students who have prematurely terminated therapy while attending college. Twelve female-identifying college students were interviewed in a semi-structured design. It was predicted that socioeconomic status moderates the impact of financial and logistical barriers to access, mental health stigma, and perceived lack of socioeconomic status competency among practitioners on the decision to leave therapy prematurely, such that these factors have an amplified effect for students coming from lower socioeconomic status backgrounds. Findings indicate that logistical barriers to access are experienced across the socioeconomic spectrum, but with low socioeconomic students having fewer treatment options and an additional step of securing external funding. Results pertaining to identity competency did not indicate a socioeconomic status moderation or the specific need for socioeconomic status competence. Stigma was not found to be related to dropout. Other results are discussed. Further research should apply the present findings and recommendations to intervention-based pilot programs to investigate ways in which dropout can be reduced.

*Keywords*: psychotherapy, socioeconomic status, dropout, access, stigma, competency

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Psychotherapy Dropout and Socioeconomic Status:

A Qualitative Analysis of College Students

College is a formative milestone in the lives of many. Ideally, the experience is challenging but rewarding. It is a time to expand academic abilities, meet new people, and build a foundation of knowledge, skills, and friendships to support one in their post-graduate life. However, college can also be a time of overwhelming stress, isolation, lack of support, and emerging or worsening mental illness. In fact, over 20% of college students report experiencing so much stress that they have either considered or attempted committing suicide (Liu, Stevens, Wong, Yasui, & Chen, 2018). Just over 22% of adults aged 18-24 have a diagnosed mental illness, and although their mental illness rates are higher than that of the 26-49 and 50+ age groups, significantly fewer of them receive treatment (Substance Abuse and Mental Health Services Administration, 2017). In other words, college students may not be receiving the care they need to live successful, happy, and healthy lives.

Many schools, such as the Claremont Colleges, the setting of this study, provide on-campus resources for students in addition to the option of local therapists. The present research focuses on the students who have recognized they need help, started seeing therapists or counselors, and then stopped going before achieving desired outcomes. However, barriers to accessing or sustaining treatment may impact individuals differently. Specifically, being in a college setting may more substantially hinder the accessibility of treatment for low socioeconomic status individuals. Low-income students comprise a substantial and increasing portion of the national collegiate student body; in 1975, 31.2% of low-income high school graduates were enrolling in college, in

comparison to 65.4% in 2016 (National Center for Education Statistics). However, as of 2015, there is a 14% college graduation rate for students classified as low socioeconomic status, compared to a 60% graduation rate for high socioeconomic status students (Kena et al., 2015). Although more low-income students are going to college, barriers to their graduation remain.

These numbers and, more importantly, these students cannot be ignored. Lack of access to mental health treatment should not be another obstacle standing in the way of success. For this reason, it is critical that researchers, administrators, and practitioners understand the ways in which socioeconomic status interacts with psychotherapy dropout rates in a college context. Yet we must go further, asking *why* these variables interact in the way they do, and what can be done to alleviate disparity in consistent access to mental health services. In this study, I examine why students drop out of therapy, what must be done to create truly sustainable and effective systems of care, and how socioeconomic and demographic factors come into play. I explore general trends of therapy dropout and the way in which these trends interact with the specific sociological context of the Claremont Colleges.

**Therapy dropout among college students**

In a 1993 meta-analysis of therapy dropout across the United States, Wierzbicki and Pekarik found a national psychotherapy attrition rate of 46.86%. Due to the initial attention brought to the topic by their foundational research, therapy dropout has been the subject of a growing body of research. Swift and Greenberg (2012) aimed to reassess and update Wierzbicki and Pekariak's initial findings, performing a meta-analysis in 2012

that found the national dropout rate to have substantially decreased to 19.7%. However,

across the 669 studies that Swift and Greenberg analyzed, it was found that of the

treatment settings investigated (inpatient, outpatient: hospital, outpatient: private,

outpatient: public, research/specialty clinic, and university-based clinic), university-based

clinics were found to have the highest dropout rate of 30%. Although the attrition rate has

decreased in this way, it persists, particularly on college campuses, and researchers are

still working to uncover its contributing factors.

**Socioeconomic status**

One of the contributing factors to psychotherapy dropout is socioeconomic status.

Using data from the 2002 National Survey on Drug Use and Health, Ojeda and

Bergstresser (2008) investigated the role of socioeconomic status, among other

participant factors, in their analysis of barriers to mental health care access. The

researchers found an inverse relationship between family income and self-reporting an

unmet need for mental health care, such that a significantly greater percentage of those

with the lowest family income per year reported more unmet need than those from

families in the higher income brackets measured. Inextricable from income is the

accessibility of quality health insurance, or health insurance, period. In a survey of 2,785

college students, Eisenberg, Golberstein, and Gollust (2007) found that both being of a

low socioeconomic status and lacking health insurance significantly predicted not

receiving mental health services. Two years after this initial study, Zivin, Eisenberg,

Gollust, and Golberstein (2009) re-surveyed 763 of the initial respondents. Both the

baseline survey and the follow-up found that over one-third of respondents self-reported a

mental health problem (35.3% and 36.79%, respectively). For students who reported having a mental health problem in both surveys, only 25.94% received treatment during those two years. These results parallel Wierzbicki and Pekarik's (1993) foundational research finding that being of a minority race, low level of education, or low socioeconomic status were all significant predictors of psychotherapy dropout.

Some research has additionally suggested that lower socioeconomic status individuals have less successful outcomes in the treatment of their mental health. Sloane, Staples, Cristol, Yorkston, and Whipple (1976) found higher socioeconomic status patients demonstrated greater improvement by the end of psychotherapy treatment. Further, in a longitudinal study, Falconnier (2009) examined the relationship between outcomes and attrition rates for three forms of depression treatment – cognitive behavioral therapy, interpersonal therapy, and pharmacotherapy – and socioeconomic status, measured using the Hollingshead Index of Social Position (Hollingshead, 1975), education and family income measures. Although the analysis revealed a non-significant effect of socioeconomic status on attrition rates, when measured by the Hollingshead Index of Social Position, being of a lower socioeconomic was associated with poorer treatment outcomes. Falconnier's research further demonstrated a link between therapy success and socioeconomic status while revealing a potential weakness in correlational evidence investigating socioeconomic status, as results appear to be dependent on what measure is used. As Falconnier explains, his results could indicate that standardized, composite measures of socioeconomic status like the Hollingshead Index of Social Position may yield more reliable, valid, and significant results. Many different socioeconomic status measures are utilized throughout the existing body of literature,

some standardized, some individual to the study, some composite, and some based on an individual proxy variable. Falconnier makes the point that findings from these studies may not be speaking to the impact of socioeconomic status but rather the impact of whichever type of measure is used. Swift and Greenberg (2012) cited similar concerns of socioeconomic status measurement type acting as a factor for attrition rates, potentially calling into question the validity of previous findings, and necessitating more nuanced research to account for the complexities of socioeconomic status as a construct. In light of this information, it is critical that researchers, including psychologists, sociologists, and economists, work together to construct more complete, standardized measures of socioeconomic status that truly measure what they intend to measure.

More recent empirical research, however, has not had as much of a focus on socioeconomic status in relation to therapy dropout. In fact, Cooper and Conklin (2015) cited a lack of available data in their 54 study meta-analysis as justification for an inability to draw conclusions about the relationship between socioeconomic status and attrition. In other words, it appears researchers are not in the practice of collecting or analyzing socioeconomic data, resulting in a dearth of this information. Furthermore, not all research about this particular relationship concludes with similar findings. For example, Edlund et al. (2002) found income to be a non-significant predictor of premature therapy dropout, and as mentioned before, Falconnier (2009) found none of his three measures of socioeconomic status to correlate with attrition from any of his three depression treatments. This conclusion diverges from much of the existing body of literature, potentially bringing a previously unexplored nuance to the surface or demonstrating a flaw with his, or others' methodology.

Overall, the current body of research on the relationship between therapy dropout and socioeconomic status reveals conflicting findings, inconsistent measurements of socioeconomic status, and limited available data. However, looking at past research can uncover patterns to be mindful of when moving forward. As such, three prevailing themes from existing studies – financial and logistical access; mental health stigma; and perceived practitioner socioeconomic competency, or lack thereof – were the guiding force of the present research.

**Financial and logistical access**

College students, and particularly low-income college students, are in a precarious situation in terms of financial and logistical access to mental health services. Seeking therapy requires not only having the means to access care, but it may necessitate working a job to afford treatment, balancing treatment with schoolwork, and budgeting time and money for transportation, bringing many additional burdens come into play. This burden, in addition to keeping on top of course work and attending classes, could seem insurmountable. In fact, Ojeda and Bergstresser (2008) found that 29.5% of their participants cited having personal experience with access barriers to mental health services, and 44.5% identified financial barriers. However, besides this mention of access barriers, there is no other research available speaking to logistical accessibility of therapy. This gap warrants a deeper investigation into what it takes to access treatment and how logistical hoops to jump through may differ across class lines.

Ojeda and Bergstresser's findings in regards to financial barriers are, however, corroborated throughout existing research. Xiao et al. (2017) found an inflated likelihood

of dropout among those who characterized their current financial situation as "always stressful" in comparison to "rarely stressful" or "never stressful." A stressful financial situation can make it difficult to obtain quality health insurance, and lacking quality health insurance can make it difficult to access quality and affordable mental health treatment. Consulting firm Penn, Schoen & Berland also found that among potential reasons to not seek needed mental health care, 87% of respondents cited lacking insurance coverage, and 81% of respondents cited financial concerns (as cited in American Psychological Association, 2004).

The financial stability prerequisite to mental health treatment can be seen in the 2012-2013 National Health Interview Survey (Centers for Disease Control and Prevention, 2015) which found that among adults aged 18-34 who had spoken to a mental health professional in the previous year, the number of respondents with insurance was more than twice that of uninsured respondents, with the same trend persisting in older age groups. This disparity, while potentially the result of not initially seeking out treatment, is at least in part due to dropout, as Edlund et al. (2002) finds that lacking insurance is one of the greatest predictors of dropout from therapy.

It is important to note that access to therapy and insurance coverage frequently operate differently among college students in comparison to the general population. Colleges can equire students to be insured, either through their parents or through a school-sponsored health insurance program. Yet coverage for mental health treatment can vary. Further, colleges and universities across the country will frequently provide mental health services on campus, supposedly increasing logistical access to treatment, and potentially financial access. Yet the specifics of navigating mental health treatment as a

college student, and data on the quality and availability of care, are largely absent from available literature on therapy dropout.

**Stigma**

Stigma is another factor that has been linked to therapy dropout. Goffman (1963) conceptualized stigma as the way in which the reaction of others "spoils" and thereby socially discredits one's identity and self. Goffman explains, "We believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents…" (p. 16). A more contemporary definition comes from Link and Phelan (2001), who describe stigma as the interaction between labeling and stereotyping, which results in status loss, discrimination, and societal separation or isolation.

Stigma with regards to mental health has established measurable impacts on the way in which those with mental illness are viewed. Link, Phelan, Bresnahan, Stueve, and Pescosolido (1999) found that there persists a strong perceptual association between mental illness and violence. Specifically, 33% of participants reported beliefs that violent behavior is either somewhat or very likely for someone labeled and described as having major depression, and 61% for someone labeled and described as schizophrenic, in comparison to only 17% for someone described as "troubled" without being diagnostically labeled. Such perceptions work to substantially impact the way in which those with publically known mental illnesses are treated or allocated resources and opportunity. For example, Corrigan (2005) found that stigma associated with mental

illness, particularly a belief that individuals with mental illness are dangerous, results in patterns of employment discrimination, and even discrimination in the quality of medical care one receives. And although Parcesepe and Cabassa (2013) found that seeking mental health treatment is generally viewed positively by the American public, with attitudes even improving over time, their research indicates that the association between mental illness and dangerousness has increased over time.

Public stigma also has concrete impacts on mental health. Fearing that one may be looked down upon or discriminated against due to mental illness creates a form of treatment stigma, making those who may need treatment less likely to access it due to the possibility that they will be discovered (Vogel, Wade, & Hackler, 2007). Ojeda and Bergstresser (2008) found that of those indicating an unmet need for mental health services, 24.14% identified that stigma avoidance was a deterrent to accessing treatment and 30% of those surveyed by the American Psychological Association in 2004 reported that they would be concerned should others find out they spoke to a mental health professional.

This type of treatment stigma and resistance to mental health treatment has been found to operate differently across race and ethnic lines. Data from the US Department of Health and Human Services (2001) shows that Black Americans seek mental health treatment less frequently than White Americans, although the two groups experience mental illness at a similar rate (Kessler et al., 1994). Whaley (2001) explains these racial differences to be the result of cultural mistrust, stemming from a history of racism within the field of psychology. In regards to college students, Masuda et al. (2009) found that in comparison to White Americans, African American and Asian American students were

less likely to seek professional mental health services, had less favorable attitudes about help-seeking, and held more stigmatizing attitudes of people diagnosed with psychological disorders.

Experiencing stigma from the public can additionally worsen symptoms and patient outcomes, as illustrated by Hirsh, Rabon, Reynolds, Barton, and Chang's (2017) examination of the relationship between stress, depression, suicidal behavior, and mental health stigma. The researchers found mental health stigma to be a significant moderator of the relationship between both stress and depression on suicidal behavior such that those with depression and perceived stress were more likely to demonstrate suicidal behavior when experiencing perceived mental health stigma in comparison to when no sigma was perceived.

Link and Phelan (2001) additionally explain that within the construct of stigma, mental health stereotypes, associations, and shame can be internalized, impacting not only the way someone is viewed and treated by outsiders, but also impacting the way one views themselves. In this way, not only may individuals fear the reaction of others learning about their mental illness and treatment, but they can also internalize stigmatizing attitudes, creating an additional, internal barrier to getting help. Luoma, Kohlenberg, Hayes, Bunting, and Rye (2008) apply this concept of self-stigma, or the internalization of shame for being a part of a stigmatized group, to the context of mental health treatment, particularly for substance abuse. The researchers evaluated the effectiveness of a substance abuse treatment intervention focusing on combating self-stigma. The results indicated that those in the treatment condition that targets self-stigma experienced significant decreases in internalized shame and internalized stigma,

improved results of a general health questionnaire, increased perceived social support, and increased self-esteem. These findings demonstrate the ways in which decreasing stigma can create a more positive context for healing with greater perceived support.

This type of positive context is critical. Corrigan, Larson, and Rusch (2009) established that self-stigma can be demoralizing and demotivating. When faced with public stigma, associated discrimination, and narratives of lack of worth, a "why try" effect can take place, creating a learned helplessness due to internalization of stigma and acting as a further barrier to accessing treatment. Eisenberg, Downs, Golberstein, and Zivin (2009) also found an association between accessing treatment, or even thinking one needs treatment, and self-stigma. The researchers evaluated over 5,000 college students across 13 universities to investigate the relationship between help-seeking (thinking about accessing or actually accessing psychotropic medication, psychotherapy, or non-clinical forms of support), and both perceived public stigma, and personal stigma (to be thought of as the equivalent of self-stigma). The results indicated that personal stigma is negatively correlated with help-seeking behaviors. However, no association between perceived public stigma and help-seeking was found. This outcome perhaps demonstrates the elevated power that self-stigma may relative to public stigma. Wu et al. (2017) additionally found that within a national sample of college students, those characterized as having both high self-stigma and high public stigma were less likely to display help-seeking behavior for mental health services. Eisenberg et al. (2009) further found that personal stigma in regards to mental health is higher for those who come from poorer family backgrounds, suggesting that those who are of lower socioeconomic status may be more vulnerable to internalizing stigma and any associated treatment seeking tendencies.

While stigma within mental health treatment has been extensively researched, there is limited information in the existing literature on the specific relationship between stigma and socioeconomic status within the context of mental health treatment. It is not fully clear to what degree stigma exists on-campus and among students, and whether or not it operates in the same way as it does for the general public.

**Practitioner competency**

One way in which researchers and practitioners have attempted to facilitate positive therapeutic relationships, and thus reduce dropout, is through the development competent therapy practices, particularly practices that are culturally competent with respect to the unique situations of marginalized racial and ethnic groups. Sue, Arredono, and McDavis (1992) define a culturally competent therapist as one with awareness of a client's culture and beliefs and of the impact of the therapist's own values and biases on a client and the therapeutic relationship; knowledge of the client's experiences, including cultural background, perspectives, and expectations; and skills to provide relevant and culturally sensitive treatment.

Owen, Tao, Leach, and Rodolfa (2011) found that a client's perception of their therapist's multicultural orientation – defined as the application of competency knowledge, awareness, and skills into practice – was positively correlated with a strong therapeutic alliance, client and practitioner interpersonal relationship, and client psychological functioning. Anderson (2015) found both low perceived cultural competence and a weak client-practitioner alliance to be significant predictors of client attrition from therapy, and a survey conducted by Anderson, Bautista, and Hope (2018)

found that having a therapist perceived as having low levels of cultural competence was a risk factor for therapy dropout. A meta-analysis of 76 culturally adapted mental health interventions revealed that culturally competent treatment methods resulted in significantly greater client outcomes and that interventions were four times more effective when targeted at a specific cultural group in comparison to a culturally diverse client pool (Griner & Smith, 2006). Without competency or understanding, practitioners may not only be less effective, but they could also contribute to a client's experience of stigmatization. Wang, Link, Corrigan, Davidson, and Flanagan (2018) found that perceptions of a practitioner holding a stigma or negative affect towards a user of treatment and perceptions of distance are positively associated with the user feeling disempowered in a treatment context.

The research on cultural competency and its impact on therapeutic alliance, outcomes, and dropout is vast. Gounded in this body of literature, Chu, Leino, Pflym, and Sue (2016) put forth a theoretical model of cultural competency, outlining the mechanisms by which these components of awareness, knowledge, and skills work. The researchers found that cultural competence is effective because it fosters an understanding of a client's culturally-based external realities, including stigmas or familial dynamics; an awareness of the way in which culture shapes the therapeutic relationship between the client and practitioner; and a client's sense of validation and being understood.

Unfortunately, the current cultural competency training may not be sufficient to create cultural competence in practice. Benuto, Casas, and O'Donohue (2018) systematically reviewed 1,230 studies about psychotherapy cultural competency training

programs, finding that such programs increase knowledge of other cultures, with inconclusive evidence for their impact on practitioner awareness, attitudes, and concrete skills. Only one of the studies in the review included patient satisfaction as an outcome variable, finding that patients were more satisfied when working with clinicians who had undergone cultural competence training. In response to these findings, Benuto, Casas, and O'Donohue argue that cultural competence training may have to be rethought to address its shortcomings, but first, there must be more research assessing exactly where and how the current curricula fall short. These findings demonstrate the critical need for clients to feel not only connected to, but also culturally understood and respected by their practitioners in order to remain motivated to continue seeking treatment. In sum, the importance of a strong client-provider alliance, and the established benefits of client comfort and feelings of being understood requires intentionally competent therapeutic practices.

Sue, Arredono, and McDavis (1992) explain that the term culture could be interpreted broadly, it is often constricted to refer to "visible racial ethnic minority groups" (p. 66) so as to not dilute the saliency of race and ethnic experiences. However, individuals of lower socioeconomic status backgrounds additionally face unique life circumstances that can be debilitating and all-encompassing. In order to address this, the idea of competency could be more actively extended into the realm of income and class, making socioeconomic status competency an additional construct necessary to assess when evaluating therapy dropout and outcomes.

**Broader impact of socioeconomic status**

There is already an existing foundational body of knowledge demonstrating the impact of socioeconomic status on outcomes across life domains. Evans and Kantrowitz (2002) provide evidence that those from lower socioeconomic status backgrounds are more likely to be exposed to hazardous waste, ambient and indoor air pollutants, and other toxins. Rekker et al. (2015) found that children ages 7-18 with unstable familial socioeconomic statuses were more likely to engage in delinquent behavior during lower socioeconomic status periods. This pattern of entering and leaving delinquency in tandem with socioeconomic status fluctuations demonstrates that such delinquent behavior is largely a product of socioeconomic context, not individual character. Luo and Waite (2008) found childhood and adult socioeconomic statuses to be positively correlated with one another. This indicates that children from wealthier, more educated families with higher occupational prestige are more likely to experience consistent economic privilege throughout their lives, as opposed to children from lower socioeconomic status backgrounds who are less likely to experience the upward mobility necessary to put them at the same level as their high socioeconomic counterparts. Luo and Waite additionally found high childhood socioeconomic status to be strongly associated with higher self-reported general health, lower functional limitations, fewer chronic conditions, fewer depressive symptoms, higher self-rated memory, and higher cognitive functioning.

If socioeconomic status were to be shown to impact therapy dropout factors and access to therapy, it would simply be another finding bolstering the existing pattern of the impact of socioeconomic status on life chances. Yet, if students are served effectively, college campuses could be a place where disparity is addressed head-on. The state that

one is in when entering college is largely the product of their social context up until that point, and experiences that one has in college will continue to shape their social context. The type, quality, and fit of resources and opportunities made consistently accessible to them during this critical life period could have a lasting impact.

**Need for further research**

Overall, there is a sizable existing body of literature that addresses factors of therapy dropout. However, there exists several gaps in the understanding of how such factors interact with socioeconomic status, specifically in a college context. Socioeconomic status measures vary, if measured at all. There are conflicting findings regarding the relationship between socioeconomic status and therapy dropout in general, and it is unclear how school health insurance programs or on-campus treatment centers impact accessibility, both in terms of cost and logistics. The way in which stigma operates on college campus and can impact dropout, particularly across the socioeconomic spectrum, is not yet fully understood, and the importance of practitioner socioeconomic status competency has yet to be assessed. Furthermore, the existing research is predominantly quantitative in nature, unable to capture the humanity and complexity behind that which is being investigated. By having in-depth conversations with those who are most impacted, the present research aims to uncover the nuanced nature and causes for disparate rates of therapy dropout and overall imbalances in access to mental health treatment. I address the ways in which these general factors and trends of therapy dropout manifest in the specific social context of the Claremont Colleges.

**Study overview**

The present study consisted of semi-structured, in-depth interviews with 12 female-identifying college students at the Claremont Colleges who self-reported premature termination of psychotherapy since the start of college. Demographic information pertaining to socioeconomic status was assessed prior to the interviews. In this correlational design, it was hypothesized that financial and logistical barriers to access; perceived mental health public stigma and experienced self-stigma; and lack of perceived socioeconomic status competency of practitioners impact the decision to drop out of therapy differently across the socioeconomic spectrum such that these factors have an amplified impact on the decision to drop out for students coming from a lower socioeconomic status background. The interviews additionally served an exploratory purpose, investigating the nuances and emerging themes of college student therapy dropout factors that may not have been uncovered in previous research.

**Method**

**Participants**

The population of interest for the present study is college students from a wide range of socioeconomic backgrounds who have attended and prematurely terminated psychotherapy at some point while attending college. The sample consisted of 12 college students who self-reported having prematurely terminated therapy attendance while enrolled at the Claremont Colleges. Participants were not excluded if they were in therapy at the time of their interview seeing as returning to therapy does not invalidate a prior dropout. Such participants were thought to be able provide additional insight into

what can be done to bring students back into treatment. Because of the limited time frame of the study, participants were limited to those who self-identify as female in order to reduce the number of cross-cutting identities that had to be be taken into account during data analysis. This form of methodological control was intended to allow for clearer patterns to emerge.

In the final study sample, half of the participants came from low socioeconomic status families, one was middle status, three were high status, and two declined to state. Four were White (of that, one specified being Jewish), three were Asian (of that, two specified being of South Asian descent, and one did not specify region), two were Latinx (both specified being Mexican), two were Latinx and Middle Eastern, and one was Black. Students from three of the Claremont Colleges participated, with the majority coming from Scripps. There was representation from across class years, with half of the participants being in their senior year. Participant demographic information is outlined in Table 1. It should be noted that although each participant self-identified as female, two of the participants are gender-nonconforming and use "they/them" pronouns. At the time the interviews were conducted, I knew one participant well, seven were acquaintances, and four I had never met. Of the participants that chose to disclose the diagnosis, symptoms, or event(s) that brought them to therapy, examples cited include general anxiety and depression from a heavy college workload; diagnosed attention deficit hyperactivity disorder, obsessive compulsive disorder, post traumatic stress disorder, generalized anxiety, panic disorders, chronic pain; substance addiction; and trauma from sexual assault and/or abuse.

Table 1

*Demographics of the Study Sample*

| Characteristic | Category | *n* |
|---|---|---|
| Socioeconomic status | | |
| | Low | 6 |
| | Middle | 1 |
| | High | 3 |
| | Declined to state | 2 |
| Race/ethnic identity | | |
| | Asian | 3 |
| | Black | 1 |
| | Latinx | 2 |
| | Latinx and Middle Eastern | 2 |
| | White | 4 |
| College | | |
| | Claremont McKenna College | 1 |
| | Pomona College | 4 |
| | Scripps College | 7 |
| Class year | | |
| | First-year | 1 |
| | Sophomore | 2 |
| | Junior | 3 |
| | Senior | 6 |

The Claremont Colleges, sometimes referred to as the 5Cs, are a consortium of five undergraduate liberal arts colleges – Claremont McKenna, Harvey Mudd, Pitzer, Pomona, and Scripps. The consortium is located approximately 35 miles east of Los Angeles, California. All five colleges are generally considered to be "elite" institutions, with 2018 acceptance rates ranging from 24.1% at Scripps to 6.96% at Pomona (Ding, 2018). According to the 2017-2018 Common Data Sets for the individual colleges

(Claremont McKenna College, 2018; Harvey Mudd College, 2018; Pitzer College, 2018; Pomona College, 2018; Scripps College, 2018) supplemented by the Claremont McKenna College website section on "Costs and Payments" (Claremont McKenna College, 2019), the schools have a combined student body of 6,081, with combined first-year tuition, fees, and room and board costs ranging from $69,260 at Scripps to $72,478 at Harvey Mudd annually, not including additionally required student fees, books, supplies, transportation, and other expenses. Of the 2,958 total full-time undergraduate students across the Claremont Colleges who applied for need-based financial aid in 2017-2018, 2,658, or 89.96% were determined to have a financial need, and 2,656 were awarded some form of financial aid (Claremont McKenna College, 2018; Harvey Mudd College, 2018; Pitzer College, 2018; Pomona College, 2018; Scripps College, 2018). Of those who were awarded financial aid, 100% of their determined need was met through grants, loans, and work-study jobs. It should be noted that need is calculated by colleges according to government algorithm, not by student and family self-reports (US Department of Education, 2019). The largest racial cohort at each school is of domestic White students, ranging from 52.9% at Scripps to 33.9% at Harvey Mudd (Harvey Mudd College, 2018; Scripps College, 2018). The gender breakdown is approximately even at each of the institutions, excluding Scripps, which solely admits students who "report that the sex currently listed on their birth certificate is female" or "self-identify as women," and will award a degree regardless of gender identity, according to a 2014 "Admissions Policy update" (Scripps College, 2014). The consortium additionally comprises two additional institutions – Claremont Graduate University and Keck Graduate Institute – which were not included in this study.

Participants were recruited through posts on class- and school-wide Facebook pages, and a mental health Facebook page. This convenience sample was supplemented through purposive snowball recruitment, whereby participants of demographics under-represented in the sample were encouraged to reach out to peers of similar demographics that may be interested in being interviewed, providing them with my contact information.

**Materials**

**Interview protocol.** A detailed list of 37 questions was compiled as the basis of the interviews (see Appendix A). This interview protocol as a whole addressed the experience of therapy at the Claremont Colleges, therapy dropout, access, stigma, and practitioners; reasons for prematurely terminating therapy; and ideal therapy contexts. The questions were self-generated, and not based in or sampled from the existing literature. The interview protocol was the same for each interview. However, the questions were addressed in varying orders and depth depending on the flow of the conversation, and additional follow-up questions and questions not listed on the interview protocol were asked depending on the answers provided by the participants.

**Socioeconomic status and demographics.** Participants were asked to self-report demographic information by answering nine questions on a post-interview demographic questionnaire (see Appendix B). The questionnaire includes three proxy measures for family socioeconomic status: 1) combined family household annual income, 2) parental education level, and 3) parental occupations. Income was divided into status brackets based on the US Census' 2017 medium income finding (as cited in Rothbaum, 2018) and Pew Research Center's (2015) definition of middle class. The adapted annual combined

family income brackets are as follows: low income (<$40,000), middle income ($40,000-$120,000), and high income (>$120,000). In addition, parental education was ranked on an 8-point scale (see Appendix C) and parental occupational prestige was ranked on a 10-point scale (see Appendix D) in accordance with the Hollingshead (1975) Index of Social Position. Income was used as the primary indicator of socioeconomic status, categorized as "low," "medium," or "high" socioeconomic status. If income was close to the border between two brackets, parental education and occupation were taken into account. Qualitative information that arose during the interview (e.g., a participant revealing a need to work during the school year to support their family or a lack of financial support from family) was also taken into account when interpreting findings.

**Procedure**

After participants made initial contact with me, we agreed upon a time comfortable location at which to meet. Once at the interview location, I explained that the purpose of the study is to investigate the role that social, cultural, and economic factors play in the decision to leave therapy. I did not specify the focus on socioeconomic status so that it would be less likely for participant responses to be primed or altered by knowledge of the specific research question, thus reducing the possibility of artificially magnifying any impact of socioeconomic status in the hypothesized therapy dropout model. I next explained the basic information on the informed consent document, allowed participants time to read through the document, and obtained physical signatures of participation consent. A recording device was then turned on, and the in-depth interview commenced based on the predetermined interview protocol. The interviews were semi-

structured, allowing for related topics brought up by participants to be fully addressed, even if they were not included in the official interview protocol. Interviews lasted between approximately 25 minutes to 1.5 hours. After interviews were completed, participants were asked to complete the demographic questionnaire. They were then debriefed, compensated, and thanked for their time.

**Ethics**

Participation in the present study was completely voluntary and did not involve protected populations or deception. For their time, interviewees were given $15 as compensation in order to make participation more accessible regardless of financial means. Not only were participants able to potentially contribute to the greater body of knowledge and impact the way in which therapy dropout is understood and addressed on college campuses, but also they were also able to have their stories heard. This study prioritized these first-hand narratives, putting the voices of those who have prematurely terminated psychotherapy at the forefront. Participants may have even enjoyed the opportunity to confidentially process their therapy experiences. However, due to the stigma of mental illness and therapy attendance, it is not always easy to speak fully and honestly about such topics. In addition, speaking about one's own experiences with mental illness and treatment can be challenging, and potentially poses a risk of emotional distress. Particularly because interview questions focused on reasons for leaving therapy, unpleasant memories could have arisen. However, in order to fully understand therapy dropout, asking such questions was unavoidable.

To make sure that any emotional and confidentiality risk for participants was limited, and did not rise above a minimum, exhaustive steps were taken. Interviewees were presented with a detailed informed consent form electronically directly after contacting me to participate. A physical copy of the informed consent form was additionally presented to participants prior to the start of the interview, and participants were given a third copy to take with them for future reference. The informed consent included participant rights within the study, specifying that if at any point they prefer to not answer a question, stop answering a question once they have begun, or end the interview prematurely, they would be able to do so. The informed consent further alerted the participant that the questions they would be asked are related to therapy and reasons for premature therapy termination so that these questions would not have come as a surprise. It was specified that I am not a trained psychologist or mental health professional and that the interview should not be viewed as therapy, but rather is purely a time for data collection purposes for a psychological and sociological study. The interview protocol additionally was shaped such that questions only asked about relevant content to therapy experiences, dropout, and ideal therapy contexts. No questions were asked about diagnostic, symptom, or trauma history, yet participants were free to provide this information if they desired. Questions were framed such that sensitive and emotionally distressing responses are possible, but not required for the question to be answered. Both prior to the interview and during the debriefing, participants were informed of the benefits of their participation for the greater body of knowledge on therapy dropout, which might be used in turn to improve therapy access and outcomes.

These measures were taken in attempts to allow the benefit of participation to outweigh emotional distress that may have been experienced during or after the interview.

In the case that emotional distress did arise, I was closely observing participant behavior throughout the interview, watching for signs of discomfort and unease, and was prepared to remind participants that they could take breaks, not answer questions, or discontinue the interview at any point. Additionally, in both the informed consent and debriefing forms, participants were provided with contact information for on-campus counseling services and external support resources which they were encouraged to contact if needed.

In order to protect participant confidentiality, all documents with participant information were scanned and saved on a password-protected computer. Online communications took place over Facebook Messenger and/or email through a password-protected account, and interview recordings were saved on an iPhone with a passcode before they were transcribed and saved on a password-protected computer. Interviewee names were excluded from the recordings and any documents that contained participant information and responses. Documents with participant information were stored in separate computer folders from interview transcriptions. All identifying information that participants offered during the interview including name, home city, and college major was altered or omitted to protect participant confidentiality. Further, participants were asked both before and after the interview whether they would like to specify additional identifying information to be omitted. Overall, because of the extensive efforts that were taken to protect the emotional wellbeing of participants during interviews and participant confidentiality in light of disclosing sensitive information, the potential benefits of

increased understanding of therapy dropout through first-person accounts are believed to have outweighed the potential risks.

**Data analysis**

After I transcribed the interviews, participant responses to the interview protocol and additional questions were assessed during the level-one coding phase. This type of data analysis involves closely reading interview transcriptions and indicating sections and quotes in which participants speak about certain predetermined codes, which can be thought of categories, ideas, or topics. The three initial hypothesized factors of therapy dropout – financial and logistical access; perceived public and experienced self-stigma; and perceived practitioner socioeconomic status competency – were used as the predetermined codes for level-one coding. Additional, non-hypothesized ideas that arose during the interview process were analyzed during the level-two coding, in which I used single words or short phrases to note significant quotes and points descriptively (descriptive coding), indicate values that underpin participant responses (values coding), identify how participants explain that they interact with their social context (dramaturgical coding), mark conflicts and dichotomies (verses coding), and highlight direct quotes from the participant that stand out as critical to their narrative (in vivo coding; Saldaña, 2011). These level-two codes were not predetermined, but rather entirely based on the participants' accounts. I then grouped these level-one codes and level-two codes into broader themes of understanding, both of the manifest and latent meanings of the participants' narratives (Saldaña, 2011). The level-one codes, level-two

codes, and overarching themes were qualitatively assessed across participants in order to identify both repeated patterns and unique experiences.

This method of data collection analysis allows for results to be substantially grounded in participant narratives and experiences, not simply in the pre-conceived notions of researchers. Participant responses steered the direction of interviews, and although coding and theming were initially based on concepts from existing literature, the bulk of data analysis was focused on the information that emerged throughout the interview. Using qualitative methodology and analysis in this way created space for in-depth conversations to result in in-depth understandings. The aim of the present study was to uncover the *why* of therapy dropout among college students, which is anything but simple. In order to do justice to participant experiences and effectively uncover the nuances of the decision to leave therapy before treatment is complete, a semi-structured interview design with qualitative data analysis, was determined to be most appropriate.

## Results[1]

It was hypothesized that among other factors, financial and logistical access barriers, perceived public mental health stigma and self-stigma, and perceived lack of practitioner socioeconomic status competency have an amplified impact on the decision to prematurely drop out of therapy for students of lower socioeconomic status background compared to students of higher socioeconomic status background.

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[1] Transcribed quotes were edited for readability and flow by removing sentence fragments, words like 'um' and 'like,' and improving grammar. Italics indicate a participant's emphasis, and ellipses indicate time between when quotes were stated, not pauses in speech.

The on-campus therapy services at the Claremont Colleges were found to have a generally poor reputation, which has discouraged some students from accessing it. Interviewees appreciate the convenient physical location of on-campus treatment centers, but session restrictions, long wait times, and therapist inconsistency act as barriers to steady, effective treatment. Some were told their circumstances required more intensive or specialized treatment and were referred to off-campus treatment, armed with varying degrees of financial and informational support. Among those turned away from on-campus services, low socioeconomic status participants were more likely to drop out as a result. Those who utilized off-campus therapy reported similar challenges, in addition to difficulty physically getting to their treatment location, finding accurate information, and securing adequate funding. Financial inaccessibility of quality treatment contributed to dropout, predominantly among participants of a lower socioeconomic status; however, anxiety associated with the expense of treatment impacted participants of high, middle, and low socioeconomic status. In regards to therapeutic alliance, having a therapist with incompatible or harmful treatment practices and a lack of practitioner identity competency were all associated with client discomfort and dropout, regardless of socioeconomic status. Public stigma, including culturally-based stigma, was commonly cited by participants across the socioeconomic spectrum, and several participants mentioned internalizing stigma. However, no participant cited stigma of any type as a factor of dropout or resistance to treatment. Claremont Colleges were reported as being generally accepting of mental health, which was attributed to a culture of open communication. Some found college administrations to be helpful, while others were unhappy with inconsistent and confusing information, lack of follow through, and a

perceived lack of prioritization for mental health. While family and peers were often cited as helpful, there was an overall concern of being too much of a "burden" on these sources of support. Lastly, many explained feeling unable to leave unhealthy or unhelpful therapy situations for various reasons, and the experience of dropping out was explained to bring about feelings of guilt, hopelessness, freedom, healing, and loss of momentum.

**On-campus mental health services**

Monsour Counseling and Psychological Services (MCAPS), commonly referred to just as Monsour, is an on-campus mental health resource shared among all seven of the Claremont Colleges. The center offers free but limited counseling appointments to students in addition to online resources and psychiatric services (MCAPS, 2019a).

**Reputation.** Almost every interviewee who brought up or was asked about Monsour mentioned its not-so-stellar reputation. Prior to Camille's[2] first year of college, her mother was warned by a parent of a Claremont Colleges student at the time to have Camille avoid Monsour due to their long wait times, therapist shortages, and poor quality of service. Other interviewees also mentioned hearing overwhelmingly negative reviews of Monsour from peers, particularly in regards to long wait times, and a lack of ethnic, cultural, and experiential diversity among the counseling staff. Devi has heard these concerns, but she believes many of the students expressing "aren't students that have actually used Monsour. And like a lot of people who have used Monsour are like, 'Well it's not their fault, they just don't have money.'" Paola, however, who has been to Monsour, and even found her therapist there to be extremely knowledgeable and kind,

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[2] Participant names listed are pseudonyms.

agrees with the overarching critiques of Monsour, attributing them to lack of funding and understaffing. Lauren and Alisha feel similarly. But regardless of why, there appears to be a general consensus that Monsour is not effectively meeting student needs. For interviewees like Camille, Jazmine, and Alisha, this reputation was enough to dissuade them from seeking treatment on campus altogether.

Although Monsour's reputation stems in part from real student experiences, some information, specifically about the number of sessions offered, is simply inaccurate. Several of the interviewees said they were not sure how many free sessions Monsour offers, and others stated a number that was incorrect, such as 10 sessions per year or 8 sessions per semester. Only after calling into the center was I able to confirm that Monsour offers students eight free counseling sessions every academic year. This number is not listed on their website.

**On-campus logistical access.** Accessibility of on-campus treatment at the Claremont Colleges is largely impacted by location, policy regarding appointment restrictions, number of available staff, wait times, and consistency of therapists.

*Convenient location.* Even though college-based treatment centers will never be able to accommodate all students' needs, particularly at smaller colleges, there is an undeniable convenience to being able to receive treatment at an on-campus location. Nikita expressed that the accessible location of Monsour was critical to making therapy seem like more of a realistic option. For those with disabilities relating to mobility and for those without cars, on-campus treatment centers may be their only option, particularly when accounting for the time and expense associated with public transportation. For

Marie, having treatment within walking distance can make or break her decision to seek

treatment for mental or physical health:

> Marie: Most people I know wouldn't even like go see a
> doctor outside of the colleges.
>
> Interviewer: Really? Why do you think?
>
> Marie: Yeah! I mean it's definitely not convenient. And it
> ends up being something you put off for a long time. And
> like, for me I'm having like physical issues right now and
> like the only reason I can address those is because I have
> the on-campus resource.

Camille, however, brought up the unique perspective that she prefers to only see

off-campus therapists specifically for the purpose of compartmentalizing therapy and

school. After being treated by an on-campus school psychologist during high school, she

believes it is better for her to work with someone there will be no risk she will see during

her school day or who will know the students and her friends at school.

*Session restrictions.* Monsour's system of "brief therapy" aims to treat student's

specific needs efficiently, within eight sessions annually. To put that in perspective,

school at the Claremont Colleges is in session approximately six and a half months out of

the year. The current session allotment would thus allow for an average of just over one

appointment monthly. Due to this restriction, Clara explained that she has had to "ration"

her appointments, sacrificing consistent treatment just in case she needed emergency

support. She thinks this session limit stifles the ability to form a positive therapeutic

alliance with practitioners. Cutting down on time spent together naturally cuts down on

the ability to get to know each other and build trust and understanding. For Devi, this

restriction was a direct factor of dropout. She wanted to continue therapy, and she was

recommended to do so, but she explained, "We only get eight free sessions so I was just

like 'There's no point [in returning] for just like four sessions and then not doing it ever

again.' So I just never went back to it."

***Wait times.*** Wait times, sometimes over a month, were frequently mentioned as a

barrier to consistent treatment. Interviewees who cited this issue at Monsour brought up

that on top of the obvious problem that these long wait times delay treatment, they

increase the likelihood that a student's schedule will fill with unavoidable school or work

commitments that may need to be prioritized over a therapy appointment. Marie and Devi

both said that scheduling their first appointments went smoothly, but due to short-staffing

at Monsour, finding times for follow-up appointments that worked both for them and for

their therapists was a challenge. Ana told me that the majority of her calls to schedule

appointments at Monsour were not even returned. Clara and Paola both reported that their

therapists frequently canceled or called out sick, encroaching further on treatment

consistency. For Devi and Paola, the long wait times made it so they were not able to use

their full eight appointment allotment per year. Devi explained that by the time she would

get a chance to talk to her therapist, often the issue she was struggling with when she

made the appointment would have already felt like old news. She explained, "[My

therapist] always wanted me to come prepared with things to talk about but I'd be like,

'Oh this happened like two weeks ago, we can't really talk about that now.'" She said

that such spaced out appointments were "better than nothing," but she was still in need of

more consistent treatment. The long wait times at Monsour would have prevented Skye

from seeing a therapist as frequently as they need to, prompting their choice of off-

campus therapy.

***Therapist inconsistency.*** Long wait time at Monsour and the short-staffing of

therapists can impede therapist consistency. For Marie, this challenge in scheduling

follow-up appointments meant sacrificing the ability to build a relationship with a single

therapist:

> Marie: So I went twice and there was like a little bit of
> follow up, but it was mostly me like repeating myself.
>
> Interviewer: Was it the same therapist both times?
>
> Marie: No, it was two different therapists. And then after
> talking to the school, they like sent me back to Monsour for
> a third session before I like transitioned [to off-campus
> therapy]. And it was like kinda the same, just like repeating
> exactly what happened, or like what was going on. And
> yeah it was just repetitive.
>
> Interviewer: What was that process like emotionally for
> you?
>
> Marie: Um I mean, it's kind of draining to keep re-hashing.
> Like, you're saying the same thing and also not like seeing
> any progress.

The lack of therapist consistency both stood in the way of forward progress and added

another layer of emotional hardship to her healing process. In addition, Jazmine explains

that therapist inconsistency prevents students from sharing experiences with peers in

order to recommend or warn against certain practitioners:

> Jazmine: There's a lot of like switching around and
> switching around so there can be like no basis in credibility
> formed.
>
> Interviewer: What do you mean basis of credibility?
>
> Jazmine: Like 'this person is consistently good. Go to this
> person.' Like my off-campus therapist, everyone knows
> about her and everyone loves her she has a lot of credibility
> whereas like Monsour it's like who are these people they're
> constantly like shuffling in and out.

**"We can't help you."** Several interviewees reported being turned away from Monsour entirely. Because Lauren did not have a specific reason for seeking treatment, but rather she was in need of general support, the therapist told her that Monsour could not help her, but that they could provide her with a stress management toolkit instead. This reaction is in line with a description on the Claremont College's website, explaining that Monsour utilizes "brief therapy," which is "short-term and focused on helping a person to resolve or effectively manage a specific problem or challenge, or to make a desired change. The sessions are more geared towards here-and-now aspects of the problem than on exploration of historical material" (MCAPS, 2019b). Not only did being turned away prevent Lauren from accessing services, but she explained that the experience made her feel "silly for even going." She understood that Monsour needs to prioritize the highest risk people, but she felt invalidated. She told me:

> I feel like I might have liked [the therapist] and have gotten
> more out of the experience if I had kept going. But I think
> because I felt invalidated by the experience and I got the
> sense of like Monsour being more for like emergencies and
> crisis and 'high risk' people, whatever that means, they like
> didn't want me there.

Interestingly though, when Skye went to Monsour for crisis services during an extreme low-point in their mental health, they remember being told that if they were not a present danger to them self or others, Monsour was not equipped to help them.

But being "too general" is not the only reason that students reported they were turned away. The Monsour section of the Claremont Colleges website states, "Students who would benefit from long-term treatment are referred to pre-screened, qualified clinicians in the community. Students must make financial arrangements for therapy

outside of MCAPS, but often clinicians accept health insurance or a sliding payment

scale" (MCAPS, 2019a). How this has played out in practice is that students with

therapeutic needs too great or specific are referred to off-campus therapists, whether or

not they are able to pay. For example, during their intake appointments at Monsour, both

Paola and Eden were recommended to find an off-campus therapist that specializes in the

specific issues they were struggling with. And it is not just Monsour that makes these off-

campus referrals. According to Marie, her college's deans understood that her need could

not be met by Monsour so they provided her with information to aid in her search for an

off-campus therapist.

**Off-campus therapy**

Students who opt for off-campus treatment, whether it is to avoid long wait times

at Monsour to seek more specialized care, or any other reason, report similar issues as

those in on-campus treatment. Just like at Monsour, session limits can also be present in

off-campus therapy if one's college subsidizes copays. In order to manage this session

restriction, Jazmine reported rationing of appointments similarly to the rationing reported

by Clara at Monsour. Many interviewees also cited long wait times and difficulties

securing appointments. When asked about what the logistical process of accessing an off-

campus therapist looks like, Alisha described:

> You call like eight people and maybe one of them gets back
> to you. And like two of them have moved and are no longer
> practicing near you. So you call the one that gets back to
> you and you're like 'okay when's your soonest
> appointment?' and it's usually in like three months. And
> then you wait the three months and then you go to see if
> you like them.

She estimates that she can sometimes spend around five hours doing research and contacting therapists to get one call back. Lauren's comparatively shorter wait time of only two weeks to see an off-campus therapist still felt unmanageable, particularly when her symptoms were becoming all-consuming. She told me "at the time, two weeks just feels so long." When Paola reached out to an off-campus clinic to try group therapy, she never got a call back. On top of this setback, her mental illness acted as another barrier to contacting the clinic again, as she explained, "Because I have anxiety, I have trouble with phone calls. And because I have trouble with phone calls, I can't get treatment for my anxiety." Skye's mental illness additionally compounded the difficulty of accessing treatment, as they were searching for a therapist while simultaneously struggling with the resurfacing of past traumas, making the process even more emotionally burdensome.

Nikita ran into roadblocks when information listed on therapists' websites was not accurate. She thinks that if insurance, location, and patient opening information were updated more frequently and publicized more clearly, the process would have been much less stressful and time-consuming. Skye and Alisha expressed similar experiences with lack of accurate and accessible information.

In regards to physically accessing treatment, Ana, who is of a low socioeconomic status, explained that one treatment center she had utilized while living on-campus one summer became entirely inaccessible once the school year started. She told me that public transportation was too time-consuming and expensive, forcing her to discontinue treatment. Eden, also from a low socioeconomic status, needed specialized treatment that Monsour could not provide, also found transportation to off-campus treatment to be a

challenge. Not having a car, and having a chronic physical illness that prevented her from comfortably using a bike greatly limited her treatment options.

Working with school administrations to access off-campus treatment also posed problems for interviewees. The consortium shares Monsour as a central mental health resource, but each college has individual policies and practices regarding subsidization and referral for off-campus therapy, which can result in confusion and misinformation. Devi remembers hearing about such a policy that allows students to be reimbursed for off-campus therapy copays, but she says when she asked about this option at Monsour, "they were like, 'Yeah we don't really know what's going on. All schools have different policies.' Like they were basically like, 'You can't really do that so just stick with Monsour.'" Jazmine utilized a subsidization program for off-campus therapy through their own college. Yet after a change was applied to this program, they have avoided it entirely. They felt it is too difficult to navigate, and the information surrounding the change is too convoluted for Jazmine to confidently know whether or not they will lose their reimbursement. The financial risk was simply not worth it. Skye and Nikita also mentioned the challenges of accessing reimbursements, and Clara' confusion over how to access this type of copay subsidy deterred her from seeking off-campus therapy entirely.

**School breaks**

Longer school breaks over the summer and winter pose additional logistical challenges to consistent treatment access. The Claremont Colleges run on a semester system, with semesters separated by summer break, lasting approximately three months, and winter break, lasting approximately one month. Many of the interviewees cited these

school breaks as times they had discontinued mental health treatment. For Camille, extended school breaks have been challenging as she usually returns home, away from the off-campus therapist she goes to during the school year. Although sometimes she returns to a therapist she saw in high school during these periods, when she returns back for the semester, she has had difficulty re-initiating contact with her therapist.

Some off-campus therapists offer phone or video chat service options for these temporary periods when students may be traveling or returning home. But Monsour is closed over these breaks and it does not offer such long-distance services. Admittedly, student participants reported that these long-distance treatment options are not ideal or even useful for all. Marie found her experience with phone therapy over an extended school break to be unsuccessful, finding in-person conversations to be more conducive to listening and focus. Camille has been hesitant to try long distance therapy at all, as she says she thinks it would feel "a bit more artificial." After trying phone therapy, Alisha feels it is "less personal."

Yet for Devi, therapy over school breaks was not possible, long-distance or not. Her parents do not support mental health treatment, so even though her therapist recommended she continue treatment over her summer break, she could not use her family's insurance or personally finance the expense out-of-pocket. During that particular summer break, Devi was even living on campus, but Monsour does not operate over break, so she truly had no way to access treatment. Devi was left demoralized, choosing to not return to her therapist after summer break.

**Financial accessibility**

Both affordability of services, and emotions surrounding the cost of therapy were related to dropping out of therapy, or reducing frequency of treatment.

**Affordability.** Being able to pay for therapy was cited as a determining factor of access for several low socioeconomic status participants. Jazmine, for example, only considered starting therapy because they discovered they could access it for free, and they only stopped due to the risk that it would no longer be covered by their college. Marie even expressed that she simply would not pay to seek treatment, medical or psychological, for an issue unless it was "really serious." There are free and reduced price options available to Claremont College students, both on- and off-campus; however, for students of a lower socioeconomic status, cost still poses an active barrier to access, particularly for quality and competent services. Alisha's only successful therapy experience was in high school, with a therapist who worked out of network, meaning she did not accept any insurance. Alisha believes that, unfortunately, most of the best practitioners operate in this way, making them financially inaccessible for many.

Clara, coming from a low socioeconomic status, single family income household, has never paid for therapy. She explained, "I have State insurance [Medicaid], so…you are very limited in who you can see." Since being in college, she has been on her school's insurance program, yet her options are still limited and she is still required to pay a copay, so she opted for the free, school-provided services instead. Paola similarly finds being of a low socioeconomic status to limit her treatment options, as she told me, "I think there are people who have the privilege of looking into mental health options, whereas I just have to take what I can get." Ultimately, Paola's lack of financial means

has made therapy completely inaccessible. She was told by a Monsour therapist that they would not be able to provide her the specialized care she needed. The therapist who told her this tried to find an off-campus option that would work for her, but was nothing found in her price range even after calculating in the maximum reimbursement her school could provide. The therapist offered Paola the option of continuing treatment at Monsour, but Paola thought it would be "futile" considering she would not be able to get the care she needed. Paola has received no professional care for her mental illness since this experience at Monsour, and told me "I just have no idea what to do now."

Skye's mental health care needs are also not able to be adequately addressed by on-campus services, so they rely on their school provided health insurance in addition to financial aid and reimbursements to afford therapy. However, balancing their academic workload with mental ill-health has been a struggle. Skye explained that they need to remain a full-time, high achieving student in order to keep their financial aid and school health insurance. In other words, Skye's success in therapy enables success in school, which is required for their ability to afford therapy. If one part of this equation goes wrong, it can all fall apart, which Skye explained results in an anxiety-producing "pressure to perform" in order to prove they can make it work.

**Cost anxiety.** The issue of cost extends beyond accessibility, impacting students' conceptions of treatment and mental illness itself. When asked what the impact of having access to less expensive or free mental health services of a quality that met her needs would be, Marie said, "I think I would treat it more as like, like just for my own health and not for like, not really like a luxury really." In regards to her experiences accessing off-campus treatment without financial support from her college, she said:

> Marie: Um, I mean, you know it's like for the semester you
> kind of have to like budget and like take care of everything
> that's going to like get you through the semester, and like
> factoring therapy into that because it's so expensive is
> really hard to do.

Skye elaborated that coming from a low socioeconomic status background has triggered a "financial trauma" that compounds the stress of budgeting and concern that they might not be able to afford treatment.

But cost anxiety does not appear to be limited to those from lower socioeconomic backgrounds, or from those who have their therapy costs fully covered by well-off parents. Although Lauren comes from a high socioeconomic household and her mom pays for her therapy, she says that if she had unrestricted access to less expensive or free therapy with a practitioner she felt comfortable with, she would be more likely to get treatment. Similarly, Alisha, who comes from an upper socioeconomic status household, has felt anxiety and guilt over the amount of money her family has spent on her health, even switching to bi-weekly appointments at one point to cut down on costs. Camille, also from an upper socioeconomic status background, brought up the additional worry that her subsidy may be taking financial resources away from other students who may need financial assistance more than she does.

**Therapeutic alliance**

Believing that the specific therapeutic practices used by a practitioner are effective and relevant, and feeling comfortable with and understood by a therapist were all cited by interviewees as ways to prevent therapy dropout.

**Style incompatibility.** A common reason that interviewees felt that their therapeutic relationship was not working is an incompatibility between the way the therapist practices and what the interviewee believes they need. Devi described her therapist as "pushy," often telling her what to do or giving her advice that she did not feel would work for her. Although she did not feel completely understood, she did think the experience was helpful, explaining, "I started feeling a lot better after." Despite this, she does wish she had more choice when picking out a therapist who would work for her, as opposed to being assigned to one based on availability. Conversely, Clara is more interested in getting advice than in talking through her thoughts and experiences with her therapist. She felt her therapist was not playing as active a role in her treatment as she wanted him to. After sticking with that therapist for a year, she did not see any results, and she terminated treatment.

Jazmine told me they liked their therapist on a personal level, but they felt their therapist's style was not working for them. Although they had to terminate treatment for financial reasons, had money not been a factor, Jazmine said they would have continued seeing her because "something is better than nothing." Paola additionally has had experiences working with therapists who she liked and felt comfortable with personally, but she sometimes thought that the techniques and skills they taught her were not personalized, or were the equivalent of what she would be able to find online. For this reason, she explained that it felt like it was "not as big of a deal" if she stopped going, as opposed to if she were receiving treatment that she "couldn't get elsewhere."

**Harmful treatment practices.** In addition to incompatible or unhelpful therapeutic style, sometimes treatment practices are truly harmful, at least from the

perspective of the client. Ana, for example, felt that the way one of her therapists spoke

with her about past traumas left her feeling "triggered," and Marie felt her off-campus

therapist "blamed" her for her past experiences, was not receptive, and did not facilitate

progress. When asked why she thought that was the case, Marie said, "I think it was just

because of just her personality." Not only was Marie not making forward progress with

this therapist, but she perceived her therapist was actively harming her by, at best,

implying blame, and, at worst, actually blaming Marie for traumatic experiences that

brought her into therapy in the first place.

   Camille's style incompatibility with one of her off-campus therapists also

inflicted true and lasting harm from her point of view. Camille felt this therapist was

invalidating and condescending, for example, telling her that her anxiety existed in

'anxiety land' not 'real land.' Camille explains why this strategy was deeply damaging:

> Camille: I think she like confirmed for me a lot of self-
> doubt that I have always had in my mental illness, and like
> in like how I interact with my anxiety and if it's actually
> legitimate enough. And she just kind of played straight into
> that.
>
> Interviewer: Wait can you clarify that? She played straight
> into what?
>
> Camille: Um I don't know, I feel like I've always been like
> not super confident and comfortable in actually saying that
> I have mental health issues and not just like saying 'I'm a
> stressed out person.' Especially because it is so common
> for high school and college women to deal with anxiety,
> and like for a while I was like 'this is just a phase.' But
> clearly like having gone to a good therapist, [I know] it's
> like a lifelong thing. It's been an issue. I'm just now like
> learning how to accept it. But…she treated the anxiety so
> much as like, 'We just need to figure out how to stop it.'
> Like that's not what you do with an anxiety disorder. Like
> that would be great, but that's like not why we're here. So
> her way of treating my anxiety like played into my

> tendency to like not take it seriously as a mental illness.
> And *it was bad* yeah. It was *really* bad.

Although this therapeutic strategy may be effective for some, it was clearly not for

Camille. She reported that it broke down her trust. Not only was it a major contributing

factor to her leaving that therapist, but it exacerbated a tendency, caused by her social

anxiety, that makes it difficult for her to reach out for help. For this reason, she explained

that after dropping out of therapy, only an undeniable flare-up of anxiety led her to seek

professional support, rather than her using therapy as a tool to foster consistent mental

health even outside of times of crises.

By contrast, Camille believes her current therapist understands the nuances of her

mental illness, her behaviors, and her coping strategies and the way these interact with

her personality. She feels that her therapist respects her queer identity and views it in a

holistic, intersectional context, which Camille says is validating and comforting. At the

heart of her dynamic with her current therapist, Camille feels listened to. She does view

therapy as challenging and uncomfortable, but she believes that the element of discomfort

can be precisely why it works. This therapeutic style has prompted resistance to therapy,

but it is ultimately what keeps her coming back. Trust in the process and trust in her

therapist's experience, bolstered by feeling respected and listened to, has allowed Camille

to persevere.

**Identity competency.** Personal experience or competency with client identities

was cited across the board as critical for fostering a positive, comfortable therapeutic

alliance, feelings of validation, and positive outcomes. Lack of perceived identity

competency was a consistent factor of dropout. At Monsour, Clara was assigned to work

with a White male therapist. Because Clara is a person of Color, and she is from a town

bordering Mexico, she did not find her assigned therapist to be an ideal match:

> There are a lot of the issues that I have, and they like make
> sense within the context of my culture. It's just like, [I
> have] two literally completely different identities. Besides
> the fact that I speak two languages, I also - like I have a
> different personality over there than here. And like,
> different like I don't know, it's like a weird thing to
> juggle… especially like in college where people are like
> trying to figure themselves out. But that's not really
> something like a White dude from America can help me
> with… But again, I don't need someone from the next town
> over, but like, at least someone that was of a similar
> cultural background honestly.

Clara eventually transitioned to primarily seeing a counselor employed by and paid for

through her college. Her current counselor is a White woman, with whom Clara feels

comfortable and understood, partially because of her counselor's own experience with

similar issues:

> I mean she's still a woman first of all, and she also has like
> been down in the sleaze and so there's also like at least that
> connection, you know? We still have something in
> common, and so like that's really helpful, and I trust her.
> She's kinda like a mother figure, and she'll like encourage
> me to be better and kinda get after me without getting after
> me.

Camille, who identifies as bisexual, explicitly sought out an off-campus

practitioner with experience working with LGBTQ+ clients, finding a therapist with this

listed as a specialty on their website. Regardless, she did not feel her queer identity was

understood or respected in that space. Camille recounted that at one point when she

started dating a woman, her therapist asked, "You see yourself as ultimately settling

down with a man and having children, right?" This invalidation of Camille's queer

identity was the ultimate catalyst for her leaving this therapist. It should be noted that

Camille reported that she tried pushing back against her therapist's microaggressions on several occasions. Yet the therapist-client power dynamics present allowed for her therapist to brush her off, claiming that Camille's resistance was just a maladaptive coping mechanism.

In addition to incompatibilities with their therapist's style, Devi and Alisha did not feel their therapists understood the culturally-grounded family dynamics they have with their parents. However, Devi was not sure that having a therapist with a shared cultural identity would have been preferable:

> Interviewer: Do you think you would have preferred an [Asian] therapist?
>
> Devi: Maybe. But I don't know how open I would have been with like opening up to an [Asian] therapist. Just like because my experiences with family have always been like them not believing in mental health services, so I feel like I would have some sort of underlying stigma that like they wouldn't believe me or like know what I was going through.

Jazmine was able to find a therapist who specializes in working with students who share some of the identities most defining for Jazmine, explaining, "I really needed somebody to verbalize that what I'm feeling is making sense and that I'm not the only person to have felt that way." They told me that their therapist "could like really validate like, 'Yes what you are feeling is common. It's not your fault. It's due to like systemic issues in this country.' Jazmine avoided Monsour because they do not believe the therapists there would have the necessary experience with her identities. Yet Jazmine acknowledged that it is impossible to perfectly mirror their demographics and life experience, and they believe competency around issues facing certain populations and experience working with those types of clients is sufficient. In fact, like Devi, Jazmine is

concerned about having a therapist too similar to them self. If the practitioner is too closely aligned with Jazmine's demographics, Jazmine is worried that the practitioner might "project" experiences onto them. Skye similarly values having a practitioner who understands Skye's identities, and they particularly prefer working with therapists of Color. However, they explained not all therapists of Color can bring the identity-based understanding that Skye desires, as some can be "mouthpieces for the status quo."

Nikita's time in group therapy at Monsour sheds more light on the importance of practitioner identity competency. Nikita remembers her group being approximately half women of Color and half White men. She felt that the men in the room dominated the time and space, and spoke about race and gender in ways that made Nikita uncomfortable. She was disappointed and frustrated that the moderators did not intervene, only acknowledging the potential harm of the dynamic at the closing of the session. She felt "actively aggressed" in the room and remembers thinking, "I don't feel like my needs are being recognized here and I feel like the needs of people with terrible and harmful opinions are being actively centered." Although Nikita's experience improved when she tried individual therapy both on- and off-campus, she has only felt comfortable with her current therapist, a woman from a region close to where Nikita's family had immigrated from. It was only with this therapist did Nikita feel her therapy sessions were "rooted in [her] reality" due to their shared cultural perspective. Not only did her therapist's identity competency help Nikita feel more comfortable, but it made her more willing to engage in therapy and apply what is discussed in sessions to her day-to-day life.

Preferences for therapists of certain identities were also brought up for reasons other than a straight forward desire for identity competency. Eden gravitates towards working with younger therapists, however, she did not explain this preference in terms of competency for her experiences as a young person. Rather, she simply finds that younger therapists tend to be more candid and authentic in their emotional reactions. Additionally, Paola, a woman of Color, strongly disliked working with a White, brunet, male therapist while she was in high school for a reason she could not articulate or even understand herself. She did not cite her discomfort around him as stemming from a lack of identity competency or understanding, but she did tell me she has avoided similar practitioners ever since.

**Stigma**

Participants across the socioeconomic spectrum identified stigma as something that exists, but none identified stigma as a reason they had dropped out of therapy. Stigma has, however, made some interviewees hesitate to share their mental health experiences with peers. Lauren has not felt looked down upon per se, but she worries that people could make unfounded assumptions about her because she has struggled with mental health. Devi was concerned about encountering stigma, yet she acknowledges her concerns may be at least in part unfounded:

> Interviewer: Yeah, do you ever talk to your friends about therapy or mental health?
>
> Devi: A little. Definitely when I was going, I would like bring it up with the friends I was closest with, but it was always something I was a little uncomfortable doing.

> Interviewer: Why do you think you were uncomfortable with that?
>
> Devi: I mean like the stigmas around mental health. I wouldn't want anyone to judge me or see me as less for seeking therapy. But that's also like stupid because so many people see a therapist.

However, both Camille and Alisha say they have experienced stigma while at the Claremont Colleges. Alisha has felt looked down upon by administrators and college employees, in addition to witnessing a serious mental illness related act of prejudice committed by a professor that was ignored by the administration. These experiences have been troubling for Alisha, fueling her fear of future employment discrimination.

Although Paola feels that students at the Claremont Colleges have an open attitude towards mental health, she feels embarrassed for not being as high functioning as her friends, feels a "strong social stigma" about mental health, and sometimes feels regret when she thinks she has shared too much about her mental illness with peers. She mentioned that some of her peers in high school would use the fact that she went to therapy as a way to "discredit" her, which was "damaging to [her] confidence," and likely plays a role in her current shame surrounding the topic. Camille also thinks the Claremont Colleges are welcoming in regards to mental health, but she was once met with cricket chirps when she spoke openly in one of her classes about her experiences with panic attacks. She was quite impacted by this event, telling me "I didn't feel shame for like feeling like after having a panic disorder or anything, but I felt shame for sharing that." She explained that this experience and the reality of living on a college campus with students from all sorts of backgrounds have shaped the way that she feels when speaking with peers on campus about illness:

> Interviewer: What are some of the emotions that you've experienced while talking to peers or friends about mental health at the 5Cs?
>
> Camille: On the one hand a lot of like hesitation and fear because I don't know how it's going to be accepted. And I know that like people at the 5Cs are coming from a lot of different backgrounds, and they might not be coming from my background and like they might not have like the empathy or understanding. And like that's not a fun idea. But then also intimacy. Like I think it's a really intimate experience to be able to talk about that, and it can be really powerful if it's well received.

**Cultural stigmas.** In addition to general mental health stigma, numerous interviewees told me their experiences facing mental health stigma were rooted in their family's or community's culture. Clara, who identified as Latinx and Middle Eastern, explains that in her community, going to therapy is thought of as "weak." Clara suspects that even her mother, who has been relatively supportive of Clara's therapy and has anxiety herself, views Clara's need for therapy as a weakness. Ana, who identifies as Latinx, mentioned that there is a similar perception of therapy among Latinx women at the Claremont Colleges. She explains that in this community, although mental illness is acknowledged and understood to be a challenge, the culture of independence among Latinx women creates a pressure to "deal with it on your own."

Such cultural stigmas were reported to be prominent enough for interviewees to keep their therapy a secret from family members. One of the participants who does this, Devi, attributes her family's rejection of mental health treatment to cultural factors, as her parents are first-generation immigrants from a country in Asia. She explains, "In [my country] it's not normal for people to seek treatment for mental health, like depression.

You're just told to tough it out and deal with it." For this reason, she does not expect that

her family would be accepting of her going to therapy:

> Interviewer: What about your home community? How do
> you think people there feel about mental health?
>
> Devi: Well I mean my parents and extended family would
> not be supportive at all. For them like only people who are
> extreme, severe cases should be seeking therapy. And apart
> from that like, if I told them I was seeing a therapist they
> would be like, 'Why? You're fine. You don't need
> therapy.' But yeah I just don't think they would understand
> or like treat me fairly for it.

Nikita hides her therapy from her family for a similar reason. She fears their judgments of

her and worries that her parents would be concerned about the way their family would be

viewed if others found out. For Alisha, the stigma she felt from her extended family

became so severe that she at one point cut them out of her life. Despite the salience of

this cultural stigma, none of the interviewees connected these attitudes to their dropout

with the exception of participants whose families were not financially supportive of

therapy as a result of cultural stigma.

**Normalizing mental health on campus.** Although stigma exists, there is a

general consensus that campus culture at the Claremont Colleges is relatively open and

accepting of mental health and therapy. According to several interviewees, this

normalization been achieved through dialogue and disclosure of personal experiences

between students. For example, when a fellow student told Alisha about her own mental

health accommodations, Alisha felt more comfortable about her own mental illness and

going to therapy. She speaks to close friends about the topic, but for cultural reasons, she

chooses not to share more openly than that. Jazmin has a similar view of campus culture,

explaining that attitudes towards mental health are more accepting at the Claremont

Colleges in comparison to the United States in general due to a practice of more open dialogue. Devi has experienced the impact of this dialogue herself. She remembers coming to college with a mindset that therapy was only for "severe cases," but once she saw that others around her were seeing therapists, she became more open to the idea.

But attitudes about mental health at the Claremont Colleges are not completely ideal. Lauren believes that she has become more comfortable speaking about her own mental illness and experience with therapy over time, as it is openly discussed around her. However, when going through the timeline of therapists she has seen, she paused several times, laughed nervously, and apologized when she told me, "I'm trying to not get embarrassed." Although dialogue has contributed to diminished stigma, that stigma still exists and still carries weight. Clara maintains that there is a "superficial supportiveness" on campus, touting the importance of small acts of self-care while simultaneously perpetuating a mentality that academics and extracurricular involvement are paramount. Ana agrees that it is a problem that the conversation often ends at self-care. Alisha believes the schools' administrations need to do more to facilitate deeper, more meaningful dialogues. She wants there to be more administrative support for conversations on some of the harder questions: "How do you talk about depression? How do you tell a friend that you are feeling depressed without turning them into a therapist?" Nikita agrees that there is an overall prioritization of academic performance over mental health. She has also heard statements along the lines of, "Oh, you're in therapy? But you seem like you're doing fine," demonstrating a lack of understanding of the way in which mental illness manifests and an assumption that those in therapy are visibly and constantly in a state of crisis. Marie also indicated that therapy dropout itself may be left

out of the current conversation. At the very start of her interview, she voiced, "It just seems like there's not that many students that have had this experience…[of] not having success with therapy."

**Systems of support**

Participants explained that generally, systems of support can be used to find and remain in therapy, whereas lack of support makes therapy less accessible and can contribute to dropout.

**Administration.** College administrations are one source of support that students can utilize on campus. However, Ana and Jazmine are frustrated with the college's handling of mental health issues, believing they do not sufficiently prioritize funding for services. Jazmine told me, "I'm like annoyed that there's this new art museum and the new gym but they cut the mental health funding which has like consistently been a problem." Skye also has felt that their mental health has been neglected by their college's administration. Skye had been relying on their off-campus therapy copay to be subsidized by their college. When the funding source for this subsidization program ended, the program did as well. Skye explained:

> I felt very let down. Kind of like the institution had given
> up on me… I was angry and tired, and I felt really
> defeated… I don't think people understand how visceral
> trauma is and how it can impact every area of your life. But
> that also means that getting proper care and treatment for it
> makes everything more manageable, and it just felt like that
> had been ripped away from me.

Clara has both been to Monsour and accessed services through her college's Dean of Students office. As a result of her own experience in conjunction with experiences she

has heard about, she told me, "I feel like the schools don't often tend to really care about you unless you are threatening to kill yourself, and I don't think even then because they care about you dying but because they care about how it would look on them if you died."

Nikita also recounted feeling let down when here college made an error that put her in jeopardy wither family. When seeing an off-campus therapist, she utilized her school's copay subsidization program, allowing her to be seen for free after she was reimbursed. Nikita did not disclose her family's socioeconomic status information. However, she did explain that she pays for therapy herself. She has chosen to not tell her parents both because of their stigma about mental health and because much of her treatment has revolved around a lesbian relationship about which she does not want her parents to know. To indicate its seriousness, she refers to keeping this secret a "security concern." The subsidization system bypassed her parents, however, because her college did not pay one bill on time; it was sent to her parents' house for them to pay. Nikita was able to make up an excuse, but in order to protect herself, she chose to stop seeing that therapist or other off-campus therapists.

**Family.** For interviewees who felt that their college's administration was helpful and for those who did not, families were also cited as sources for support. Camille's mother, for example, was so dedicated to ensuring her daughter was in therapy that she arranged intake appointments with numerous practitioners in the area for the week before orientation so that Camille could start college with a therapist secured. Marie and Lauren both reported being supported by family members in researching local therapists. Paola

also told me that her mother drives her to see therapists when she is home on school breaks, but she feels guilty for giving her mother this "burden," on top of feeling shame for making her mother "deal with a daughter who has anxiety."

**Peers.** Friends and classmates can also help provide one another with support and information. Marie feels comfortable speaking with friends about therapy in attempts to convince them to consider it themselves, while warning against the therapist she had a negative experience with. Camille explained that she is grateful for the support of her friends and has found having strong friendships to be a benefit to her mental health. But, she does not want to be a "burden" to those around her, which is why she makes therapy a priority. Skye also appreciates the support of friends, and they explain that they predominantly are friends with other mentally ill students. Although these friendships can be beneficial, Skye thinks there can be downsides to having a community of mentally ill friends support one another:

> A lot of us are very traumatized people, not getting the resources we need, and sometimes traumatizing each other. We just don't have the tools we need to properly process, so we kind of get stuck in like a feedback loop of like 'this is pointless, the college doesn't care.'… It can get to a point where it becomes [immobilizing].

## Emotional experience of dropping out

Leaving therapy can spark a range of emotions depending on the context in which treatment was terminated. When initially starting therapy during college, Clara was excited. She remembers having the mindset of, "Oh, therapy! You do it to better yourself and be healthier!" But after feeling "underwhelmed" by her outcomes, she decided to discontinue her treatment when returning to campus for her sophomore year, thinking

"Nah, I'm not going to bother going or signing up because it's not worth it." This

hopelessness was echoed throughout the participant pool. Alisha has seen only two local

therapists since coming to the Claremont Colleges, but she has met with several others to

see if they would be a good fit for her, without success. She told me, "I just feel like I

haven't really found a therapist in the area that really works for me. So like, I've given

up." Jazmine felt a similar disappointment, as they wanted to continue with treatment, but

the ability to do so was simply out of their hands after the off-campus subsidization

policy was changed.

For Camille and Ana, however, leaving negative therapy experiences left them

with a sense of "relief," and "healing," respectively. But for Camille, this relief did not

change the fact that she was still struggling with her mental illness, and she still needed

therapy. Yet she felt unable to seek out new therapists:

> I was really scarred from this other woman…I actually
> tried to find somebody who was going to be a good fit for
> me, and then I tried and I failed like *so badly*. So I was like
> 'I feel like maybe I'm just fine if I just stumble through on
> my own as opposed to like getting another therapist who's
> like that make me feel awful about myself.' So I think it
> was a lot of fear.

On top of Camille's general tendency to not contact therapists and to doubt her own

mental illness, her negative therapy experience and associated feeling of failure act as yet

another barrier to her initiating a therapeutic relationship. This dynamic brought out a

unique range of emotions that no other participant directly communicated. She expressed

that, "Part of me is really proud of it because I do think that there is like a lot of

vulnerability and going to therapy. And like I feel so awful like every time I stop and I

feel so dumb, but I do feel like I was really proud of myself when I get myself to go back."

**Feeling stuck.** Although providing consistent, effective, and accessible treatment is critical, sometimes dropout is necessary for various reasons. Unfortunately, part of the process of dropping out for several of the participants included feeling unable to drop out of therapy, or "break up" with their therapist. For Marie, the financial and time investment made her resistant to removing herself from a therapeutic relationship that she found unhelpful, and at times harmful:

> Marie: In therapy, you have to invest so much into finding a therapist who works for you. And so on top of like how inaccessible it is otherwise, that finding a therapist, it's just like not feasible.
>
> Interviewer: Yeah, can you tell me like what the process is like for you to find a therapist?
>
> Marie: Um, I think you definitely have to go to like at least three or four sessions. And that's costly itself. Like if you don't like a therapist – I mean like once you've invested that much you feel like you need to stay with the same therapist. But if that therapist is not working for you, you either have to like get out of there quickly or you're gonna be stuck for a while. I don't know, that's kinda what happened because I didn't like my therapist kinda like off the bat. But it was so expensive, and there weren't that many other options.

Ana, who is from a low socioeconomic status family, felt a similar need to stay with unhelpful, or harmful therapists because of their flexibility about costs. Alternatively, when working with a therapist who she felt was "belittling and dismissive," Eden felt that the expense was a justification for her to discontinue treatment. Coming from a low socioeconomic status background, Eden told me that staying with a therapist that did not work for her was "not worth [her] time or money."

For others, the experience of "feeling stuck" stemmed from a dislike or anxiety

around confrontation. Alisha told me, "I have a problem with confrontation, so even

though I knew it wasn't the perfect fit, I didn't really want to break up with her." On the

one hand, this mentality kept Alisha in treatment, yet, on the other hand, the treatment

she was given did not align with the treatment she needed. Camille similarly tends to

evade confrontation, in part due to her social anxiety, keeping her in therapy with a

practitioner who invalidated her sexual identity and made her actively uncomfortable:

> Camille: I'm not a confrontational person, so I was just like
> 'I'm just gonna suck it up and keep on going to her. It was
> like almost the end of the semester, so I'm just like I'm
> going to go to her for the rest of the semester, and then like
> never contact her again. So that's what I did!
>
> Interviewer: What was preventing you from just stopping at
> that point?
>
> Camille: I have a really weird relationship with therapy in
> like, in stopping and starting it. And I feel like to some
> extent I like don't want to inconvenience my therapist. So I
> think that's why I was like - like dumbly I don't want her to
> know that she like did this to me. And I don't want her to
> feel bad. So I'm just going to suck it up, go for a couple
> more weeks, and then just like spend the summer with my
> home therapist trying to fix everything that she did to me.
>
> Interviewer: Do you know why you view your relationship
> with your therapists in that way?
>
> Camille: I think it's a lot of like my social anxiety that plays
> into like the need to please others and make others
> comfortable before myself… I like kind of have this grin
> and bear it attitude, like we'll just get through the
> discomfort. Because like I do know that ultimately therapy
> is beneficial for me and really good.

**Loss of momentum.** Dropping out of therapy for whatever reason can clearly be

an emotional experience. Part of that emotional experience can include resistance to

returning to treatment in the future or with a different practitioner. Devi explains that "then after three months of no therapy, it was hard to get started again, so I just never made that call." Devi does not see therapy in her future, at least for a while. She explained to me that she had gotten comfortable with her therapist, and as someone who finds it very difficult to open up about her emotional experiences, she felt she was simply unable to restart the formation of a therapeutic relationship with someone else. Alisha agrees this process is a challenge, adding the point that going through your history with a new therapist can be "emotionally draining," working against the overall aims of therapy. For these interviewees, dropping out of therapy is a factor of therapy dropout in and of itself.

**Discussion**

Although each of the participants in this study has had vastly different experiences accessing treatment, several trends have emerged. Unfortunately, finding definitive patterns along demographic lines is not possible with a sample size of just 12. However, the data collected is nonetheless valuable as a preliminary exploration into therapy dropout among college students, and at the Claremont Colleges. In line with what was hypothesized, socioeconomic status has a moderating impact on financial accessibility of therapeutic services, even within a social context that provides free, although limited, mental health services. Being of a low socioeconomic status was consistently shown to hinder accessible, affordable options for interviewees, making it difficult for students with specific needs or needs that could not be met by on-campus therapy options. Only participants classified as low socioeconomic status dropped out of treatment due to expense. The convoluted process of accessing reimbursements through

one's academic institution compounds this inequity, making access even more difficult for low socioeconomic students who cannot afford off-campus treatment without financial support. Regardless of socioeconomic status, however, lack of financial support for therapy impacted accessibility and options in a way that mirrored the reality of being from a low socioeconomic status family.

Interestingly, stress about paying for therapy and guilt around spending on therapy was reported by interviewees regardless of socioeconomic status. As seen from participant interviews, this cost anxiety can be enough to interfere with regular therapy attendance, indicating that although affordability may uniquely impact low socioeconomic students (and students who are effectively of a low socioeconomic status due to lack of parental financial support), students from across the socioeconomic spectrum are susceptible to cost anxiety factoring into dropout.

For on-campus therapy, logistical barriers to access – long wait times, therapist inconsistencies, and session restrictions – are experienced by participants across the socioeconomic spectrum. Accessing therapy off campus expands options for students with more specific or intensive needs, although it also carries similar logistical hazards, experienced differently depending on socioeconomic status. For low socioeconomic students, attempting to secure subsidized funding adds another layer of logistical burden, not felt by high socioeconomic status students. In the case of the Claremont Colleges, that logistical burden is convoluted and overwhelming enough to trigger dropout. In addition, the logistical burden of physically accessing off-campus therapy was only cited by low socioeconomic status participants who could not afford efficient transportation. In this way, the added hoops to jump through required of low socioeconomic students whose

needs are not met by on-campus services are indeed factors of dropout. And again, the choice between off-campus or on-campus therapy primarily exists for students of a high socioeconomic status who enjoy financial support for their therapy from their parents.

Although stigma is a part of several interviewees' stories around mental health, whether it be internalized, from peers and acquaintances, or family members, it was not indicated as a factor of dropout. Regardless, breaking down whatever stigmas continue to persist on college campuses is a critical piece to the process of normalizing therapy and making it seem like a legitimate option. Even though stigma was not reported to trigger dropout, openness, acceptance, and dialogue around mental health were all credited with contributing to more comfort in trying therapy for the first time and in talking about it with peers.

Results pertaining to identity competency did not indicate a socioeconomic status moderation. Identities that were cited as being microaggressed or misunderstood by practitioners – being of a certain cultural background, having an undocumented immigration status, being a part of the LGBTQ+ community, etc. – were held by participants in all socioeconomic status categories. Regardless, it is clear from interviewee stories that identity competency in therapists is crucial to the creation and maintenance of strong therapeutic alliances, and lack thereof is a significant factor of therapy dropout across the board.

In contrast to what was hypothesized, socioeconomic status competency was not cited as relevant or necessary by any participant in the context of therapy. However, due to the disproportionate logistical barriers faced by lower socioeconomic status students in attempts to access treatment, it would perhaps benefit college administrators and directors

of on-campus therapy services to possess an understanding of the experiences of low socioeconomic status students. In this way, colleges can be better equipped to produce policies and pathways to facilitate accessible and effective services for all.

Extending beyond hypothesized results, the data collected also serves an exploratory purpose, shedding light on more nuanced and context-specific themes relating to therapy dropout. It is likely that the poor reputation of mental health services on campus is a barrier in and of itself to accessing those services. Yet based on interviews with students who have accessed services there, that bad reputation is reflective, at least in part, of reality. Each of these components – confusing or incorrect information, being turned away, having a limited number of sessions, inaccessibility over school breaks, short-staffing resulting in long wait times and therapist inconsistencies, and lack of diverse or identity competent staff – contribute to therapy dropout as well.

**Conclusion**

On-campus treatment centers are the home-base for mental health services at colleges and universities. If these centers are not running smoothly, it hurts students and disproportionately impacts lower socioeconomic students who cannot afford to be treated elsewhere. Although off-campus services can carry similar challenges that contribute to dropout, accessing therapy outside of a college treatment center allows for a greater variety of options in practitioners, therapeutic styles, and specialties. Supporting students both financially and with clear and correct information can create equitable access to treatment that works.

It must be asked, is the current system of mental health care available to college students, specifically students at the Claremont Colleges, truly "better than nothing"? On one level, the resources provided are not accessible to all in need. But looking deeper, it becomes clear that the content and quality of the resources that are accessed can also be a cause of dropout, and the response of terminating treatment and the emotions surrounding that decision can act as a further barrier to accessing treatment later in life. The services available, despite their flaws, have brought some students into the world of therapy and has scared others away.

**Limitations**

Due to the short time frame, the sample size was severely limited. Data saturation is the ideal for qualitative research based in-depth interviews, requiring sufficient depth of inquiry and breadth of participant experiences to get to the point that all categories, patterns, codes, and themes that will arise have already emerged. This is generally achieved with approximately 45 interviewees. However, the time frame for the present study only allowed for 12 participants to be interviewed, which is not a sufficient sample size to ensure data saturation, and therefore the findings may not be fully generalizable to the target population. For this reason, the decision was made to interview solely female-identifying students at a single batch of collegiate institutions. In addition, the Claremont Colleges have a relatively economically homogeneous and affluent student body, creating a context of wealth within which lower-income students operate. This atmosphere could have altered the way in which socioeconomic status correlates with student behavior in comparison to more economically diverse university settings. Having the capacity to

study a greater number of participants from a wider range of backgrounds, identities, and campuses could work to uncover broader patterns that exist across populations, or unique experiences within specific identity and background categories. In addition, simply having a larger sample size in and of itself would allow for greater finding generalizability.

Apart from the limited time frame, the sensitivity of the topic could have posed limitations as well. It can be difficult to talk about the personal subject of mental illness and treatment without a pre-established bond or trust formed between the interviewer and participant. Steps were taken to meet in comfortable and private settings, establish a positive rapport early on, and ensure that identifying would remain confidential. However, the sensitive nature of the content likely impacted the participants' willingness to reveal potentially relevant information.

Lastly, I attempted to create a more nuanced, comprehensive measure of socioeconomic status, using both proxy measures and qualitative information to categorize participants. However, my measure relied on an outdated scale created over 40 years ago, and subjective analysis of participant explanations, making it far from ideal. Methods for computing socioeconomic status must continue to be improved.

**Recommendations**

In the hopes of keeping what works and improving what does not, I recommend several concrete ways in which the Claremont Colleges, colleges across the country, and independent mental health care providers can create more accessible and effective options for students. In order to ease logistical access of treatment, service providers

should keep their information, including the location of the practice, whether or not they are accepting new patients, insurance information, cost, and specialties, updated and available online. Treatment centers should employ case managers equipped with this accurate and up-to-date information to assist students in navigating the process of finding a therapist both on and off campus.

The number of staff at on-campus treatment centers should be commensurate with student need, therapists should be diverse in identities and experiences, and trainings should be ongoing and based in trauma-informed and identity competent curricula. Crisis counseling should be made available to students regardless of whether or not they are suicidal, or otherwise a danger to themselves or others. Referring students to alternative, more specialized treatment centers should be done with care in attempts to prevent invalidation, and should be paired with concrete options that work for a student's price range, accessibility needs, and treatment specialization needs.

 Session restrictions should be expanded, ideally allowing for one appointment per week throughout the school year. If on-campus treatment centers are not equipped to meet student needs, colleges should provide funding for off-campus treatment, especially if on-campus treatment centers cannot provide sufficient services. Information about this funding must be transparent, clear, and accessible, and the process of accessing such funding should be streamlined. Treatment centers should provide students with resources and long-distance therapy options during extended school breaks, and check in with students after such breaks to encourage re-starting treatment if necessary.

In light of the benefits that come from on-campus dialogue and inter-personal, revelatory conversations, continuing such a culture of communication is likely to foster

more openness to accessing treatment in the first place. Colleges should encourage and sponsor programming around topics of mental health, both with the aim of normalizing the topic and providing students with necessary tools to care for themselves and one another.

**Future directions**

The transcripts from the interviews in this study are rich with information, only some of which could be addressed in this thesis. Other demographic trends and social contexts can be investigated, and more participants can be interviewed to bring patterns to the surface. This study also only focuses in on the experiences and perceptions of students, independent of that of college administrators and practitioners. With an added analysis of these other points of view in addition to a more in-depth review of funding policy and management of on-campus treatment centers, a more complete picture of therapy dropout causes, experiences, and solutions could emerge.

Although understanding what factors into the decision to terminate psychotherapy and why provides a clear academic function, research in this area can be applied in order to have a tangible social impact. Instituting pilot interventions for college students and measuring outcome and dropout rate is a way to use the body of knowledge to which the present study could contribute to examine therapy dropout in a real-life context.

College students are struggling, and the current system of care is not sufficient. Tearing down barriers to consistent access of treatment for all must be a priority. Knowledge about why some students leave therapy can pave the way for concrete changes in the way mental health care is provided to college students, offering competent

and informed services, and striving for mental health outcome equity across the

socioeconomic spectrum. The interviewees in this study point towards concrete ways in

which their experience as students struggling with mental health on campus can be

improved. All we have to do is listen.

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Appendix A

Interview Protocol

**Therapy and dropout**

1. Keeping in mind that I am not asking about your specific symptoms or diagnoses, can you tell me about the first time you saw a mental health practitioner or therapist?

2. How many therapists or mental health practitioner have you seen?

3. What was the most recent motivation for you to not return to therapy?

4. What have past motivations been for not returning to therapy if there have been other occurrences of dropout?

5. What emotions accompanied your decision process and eventual decision to discontinue treatment?

6. What would have made previous therapy experiences not result in you feeling the need to discontinue treatment?

7. What would make you consider revisiting therapy or counseling in the future, if anything?

8. What could be done on an institutional level at the Claremont Colleges to combat any of the reasons that have led you to terminate treatment in the past?


**Financial access**

9. How has expense factored into your thoughts around accessing treatment, if at all?

10. How would accessibility of less expensive or free therapy impact your decision to

attend therapy, if at all?

**Logistical access**

11. Have you ever accessed or tried to access on-campus mental health services at

    Monsour?

12. Have you ever accessed or tried to access off campus mental health services in the

    surrounding area?

13. Have you ever accessed or tried to access virtual mental health services (ex.

    phone, text, video chat)?

14. What was involved in the logistical process of accessing mental health services

    while attending the Claremont Colleges?

15. Have the logistics of accessing therapy or mental health treatment ever been a

    deterrent to you continuing treatment? If so, how?

16. What would improve your ability to logistically access treatment?

**Stigma**

17. How do you feel about the fact that you have accessed mental health services?

18. Do you have conversations with friends about your experiences in therapy?

19. If you do have conversations with friends about therapy, what is the content of

    such conversations?

20. If you do have conversations with friends about therapy, what emotions

    accompany such conversations?

21. How did you feel about entering therapy when you first decided to go?

22. What are your emotions accompanying telling others in your life that you have attended therapy?

23. How do you think you would feel if someone found out you have attended therapy without you telling them?

24. How do you generally view the portrayal of mental health treatment in the media?

25. Have you ever felt looked down upon by others due to their knowledge of your mental health status? If so, in what way?

26. Have you ever felt looked down upon by others due to their knowledge of your therapy attendance? If so, in what way?

27. How would you characterize the general attitude towards mental health at the Claremont colleges? If so, in what way?

28. How would you characterize the general attitude towards mental health in your hometown?

29. How would you characterize the general attitude towards mental health in places you have lived in the past?

**Practitioner competency and relationship**

30. How have you gotten along with your previous therapist(s)? Tell me more about that.

31. Have you found your previous therapist(s) to be helpful? Tell me more about that, but remember I am not asking about your symptoms or diagnoses.

32. Have you found your previous therapist(s) to be understanding of you and the context you were coming from? Tell me more about that, but remember I am not

asking about your symptoms or diagnoses.

33. What could your previous therapist(s) have done to prevent your decision to leave therapy, if anything?

**On-campus services**

34. What do you think about Monsour from personal experience?

35. What do you think about Monsour from hearing about it from others?

36. What could Monsour do to prevent your decision to leave therapy, if anything?

37. What do you want out of your on-campus mental health service provider?

Appendix B

Demographic Questionnaire

1. Indicate your school: PO, SC, PZ, CMC, MUDD

> Pomona
>
> Scripps
>
> Pitzer
>
> CMC
>
> Mudd

2. Number of semesters at the Claremont Colleges, including the current semester:

3. Racial/ethnic identity:

4. What is your family's current annual income? Try to be as accurate as possible:

   $_____ per year

5. Do you receive need-based financial aid from your college or from independent

   scholarships?

   > Yes
   >
   > No

6. What are your parental figures' highest level of education AND current

   occupation?

   a. Parental figure 1:

   b. Parental figure 2:

   c. Parental figure 3:

7. If there is anything you would like to elaborate on from above, please do so here:

Appendix C

Educational Attainment Rating Scale (Hollingshead, 1975)

7 = graduate/professional training

6 = standard college or university graduation

5 = partial college, at least one year of specialized training

4 = high school graduate

3 = partial high school, 10th or 11th grade

2 = junior high school, including 9th grade

1 = less than 7th grade

0 = not applicable or unknown.

Appendix D

Occupational Prestige Rating Scale (Hollingshead, 1975)

9 = higher executive, proprietor of large businesses, major professional

8 = administrators, lesser professionals, proprietor of medium-sized business

7 = smaller business owners, farm owners, managers, minor professionals

6 = technicians, semi-professionals, small business owners (business valued at $50,000-70,000)

5 = clerical and sales workers, small farm and business owners (business valued at $25,000-50,000)

4 = smaller business owners (<$25,000), skilled manual laborers, craftsmen, tenant farmers

3= machine operators and semi-skilled workers

2 = unskilled workers

1 = farm laborers, menial service workers, students, housewives, (dependent on welfare, no regular occupation)

0 = not applicable or unknown