**Acknowledgements**

This project was made possible by an Honors Thesis grant facilitated by the UNC-CH Honors Program, The Gump Family Undergraduate Research Award. I would especially like to thank my primary advisor, Dr. Karen Booth, for her constant support and brilliance. Dr. Rebecca Kreitzer, my advisor in Public Policy, provided crucial insights and was generous with her time. Dr. Cassandra Davis has been a qualitative research hero of mine during this school year. Thanks to Dr. Candis Smith for sharing about her work and for giving me the life-saving tip to get my interviews transcribed. Thank you to Evan Johnson, who advocated for me when I needed it most. I have been inspired by the life-affirming teaching of so many of my professors, including but not limited to Dr. Michele Berger, Dr. María DeGuzmán, and Dr. Ariana Vigil. I could not have been successful, either in life or in this thesis, without the solidarity and humor of my sister and lifelong friend, Isabel. I owe endless thanks also to C and R for late night studying, crying, and “questioning everything” sessions. To L, I am so excited for what’s in store for us. To F, thank you for seeing me. To Aspen, I am endlessly grateful for your genius ability to support me from a distance. To Alex, you have shown me a kind of care I never thought was possible. My families, both biological and chosen, make the work doable.

“I started to see queerness as a rupture point. As this break that showed the problems in the underlying system in the first place. Queerness not as an exception, but the thing that showed that the rule was broken.” – F

This project is positioned at the intersection not only of my research interests but also of some of the most important facets of my existence. As someone who is both mentally ill and queer, my experience of being a student at a large research university has at times been alienating, frustrating, and even dehumanizing. Yet, it is here that I’ve gained the tools to name experiences of oppression. It is here that I’ve discovered myself in others. Being in community has allowed me to imagine new ways of being. As a reflection of this, my research centers on the knowledge and lived experiences of my own political and personal communities: how do queer students navigate and interpret their encounters with mental health resources on campus?

While I write as a student of both Public Policy and Women’s and Gender Studies, it is my Women’s and Gender Studies curriculum that has given me the way of seeing that informed this paper. Qualitative research methods are one component of this ethic. Though Public Policy as a field should be and is informed by both quantitative and qualitative research, my experience of the Policy major at UNC is that the curriculum is biased towards quantitative methods as more objective. My frustration with the Policy curriculum motivated this project, and I wished to distance myself from the insistence on numerical proof of oppressive experiences, which are collectively known and lived by marginalized communities.

I first learned of the social processes which privilege the scientific notion of objectivity from my Women’s and Gender Studies coursework, and specifically from reading Donna Haraway’s “Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective” (Haraway, 1998). In this foundational feminist theory text, Haraway argues that the traditional scientific notion of objectivity insists upon the researcher as an unbiased observer, who holds “the view from nowhere” (Haraway, 1998, p. 578). Yet, as Haraway insists, the very act of seeing entails a body, and all bodies experience the world based on their social locations (Haraway, 1998). Those whose bodies are socially “marked” do not have the privilege of being understood as objective witnesses to reality. As a person whose body is visibly and invisibly marked by my femininity, my queerness, and my mental illness, I am familiar with this phenomenon. My academic interests, which stem from my lived experiences, are often dismissed as unimportant, unscientific, or overly political. However, I consider these lived experiences a valuable contribution to my expertise as a researcher who interrogates power.

Haraway argues that a “feminist objectivity” entails the valuing of situated knowledge. The concept of situated knowledge understands people as products of their social locations, and positions the researcher as an active participant in the research, who cannot observe others apolitically (Haraway, 1998). In other words, situated knowledge encounters and articulates how power is at work both in the individual lives of the observer and the observed, and in their relationship. In this project, I privileged situated knowledge over what I consider an abstract notion of objective, quantifiable reality. I positioned myself within the research, and I chose several strategies that might traditionally be dismissed as “too subjective.” I interviewed many of my close friends, and allowed my lived experiences to inform my analysis. I relied on encounters told both firsthand and secondhand as meaningful, if different sources of data. I interrogated my position of power as a researcher and as a result created an extensive informed consent process, which included sending my analysis to every participant for their feedback before the final draft was published.

Carol Hanisch’s foundational essay, “The Personal Is Political,” articulated the notion that seemingly-unrelated interpersonal experiences (which often take place in the “private sphere,” such as in a therapy office), when taken together, often reveal a political truth and expose patterns of oppression (Hanisch, 1969). She considers the sharing of these experiences within a marginalized group to be “political therapy” (Hanisch, 1969). Similarly, F, one of my interviewees, notes that they see their queerness as a “rupture point,” their queer identity as being inherently political. Being in community made them realize that their own experience is not an exception, but rather evidence that the “rule” is “broken.” It is my goal, as a researcher, to always consider how the very act taking part in my study can benefit the participants. I felt that many of the conversations I had with my interviewees were cathartic for both of us, and revealed common experiences of oppression that were now revealed to be political. It is my hope that reading this thesis might be an act of “political therapy” for fellow queer-identified students navigating an institution that does not support their mental health.

**Introduction: Queer Students and the “Mental Health Crisis”**

Conversations about mental health - its importance in the modern world, the value of “self-care,” the stigma associated with mental illness - are on the rise in various discursive spaces, including formally in academic and medical institutions and informally on social media. Though the necessity of mental health for a well-lived life is generally agreed upon, the definition of the phrase itself is more nebulous, and conceptions of well-being vary. The prevalence of mental illness, however, is not up for debate. That mental illness disproportionately impacts queer people, particularly youth, is also indisputable.

While queer youth face a higher likelihood of mental illness and more threats to mental well-being, their access to mental healthcare is mediated by a multitude of social and political barriers. These barriers are particularly important to consider in the university setting, which has been characterized as a site of “mental health crisis” (Kadison & DiGeronimo, 2004). In this site of crisis, marginalized students navigate complex, bureaucratic and under-resourced infrastructures to gain mental health support, with varying degrees of success.

This paper explores the ways that nine (ten, including the researcher) queer-identified UNC-Chapel Hill undergraduate students characterize their relationships to university-provided mental health resources, known as CAPS. I analyzed data from these nine interviews and conclude that the way interviewees speak about their experiences reveals their perceptions of CAPS as an authoritarian structure, and as largely ill-equipped to respond to queer students’ mental health needs. I begin with a brief review of existing literature, followed by descriptions of how students understood the concept of “mental health,” which is at odds with their experiences at CAPS and their meanings, which are laid out in the next section. I end with preliminary recommendations for the improvement of CAPS as a mental health resource for queer students, which include, but are not limited to: further research about the relationship between CAPS and queer students, increased transparency about what queer competent or queer specific services CAPS is able to provide, educational and cultural sensitivity training for CAPS providers regarding queer student experiences and appropriate language, and increased accommodation of queer and mentally ill students in the university at large.

**Mental Health: An Entry Point for Understanding Queer Oppression on College Campuses**

In 2018, public health experts and queer theorists agree, by and large, that lesbian, gay, bisexual, transgender, and questioning youth navigate a uniquely oppressive social and political landscape (Kelleher, 2009). Queer youth face not only the normal pains of adolescence, but must cope with stressors such as stigma, threats of violence, discriminatory legislation, unsupportive or abusive family members, fear of isolation from cultural communities, negative portrayals in media, and unavailability of resources tailored to their experiences (Bouris et al., 2016; Vaccaro & Mena, 2011; Balsam et al., 2011). As they maneuver the social contexts in which they are marginalized, queer young people encounter mental health concerns of varying severities, including but not limited to psychiatric and substance abuse disorders, psychological distress, and suicidality. Queer youth face significantly higher risk of experiencing each of these conditions when compared to non-queer identified youth. For example, in contrast with approximately 8% of their heterosexual peers (O’Brien et al., 2016), 29% of lesbian, gay, and bisexual high school students have attempted suicide (Kann, 2011). Though unfortunately less data exists about the experiences of transgender youth, recent a study out of Canada suggests that up to 37% of transgender youth have attempted to end their lives (Saewyc & Veale, 2016).

The college campus is a site of unique threat to queer mental health. According to a 2017 study published in the Journal of Adolescent Health, queer young people are not only more likely to be faced with mental health challenges before coming to college, they also “find typical developmental processes (e.g., identity development and burgeoning independence) more stressful than heterosexual peers during college” (Dunbar et al., 2017). College environments confront queer students with new dangers – queer students face elevated risk of experiencing sexual assault on campus, for example (Coulter & Rankin, 2017) – and force them to grapple with sites of queerphobic aggression and cisheteronormativity, such as fraternities, dorms, bathrooms, and even off-campus housing (in which one of my interviewees was trapped with hostile housemates, but isolated from potential campus support systems, for example) (Vaccaro & Mena, 2011).

Queer students are not a monolith, and experiences of violence and marginalization vary based on social categories and identities that intersect with queerness, including but not limited to race, class, gender, and ability. The framework of intersectionality, first articulated by

Black feminist scholar Kimberlé Crenshaw, understands these identities as impossible to separate from one another in interrogating the functions of oppression (Crenshaw, 2005). Queer theorist Roderick Ferguson discusses how racism and heterosexism can intersect, citing sociology’s measurement of the success of African American families and individuals “in terms of their adherence to the norms of a heterosexual and patriarchal nuclear family model” as one example of how racial identity and sexual orientation are inseparably intertwined (Ferguson, 2004).

Returning specifically to the college environment, a 2011 study of queer college student activists of color notes the unique stressors queer students of color face on university campuses, citing specifically how respondents felt alienation from both queer social groups and communities of color (Vaccaro & Mena, 2011). Other stressors for queer students of color might include fears of criminalization and police brutality, experiences of racism in dating relationships, experiences of racism in white-dominated queer spaces, and, in UNC’s case, fears that the university will not address legacies of and ongoing white supremacy (Balsam et al., 2011, Cooper et. al., 2004, Quillin, 2018).

For all students, the presence of a heavy workload and the pressure of a “fast-paced” academic environment may either exacerbate existing mental health issues or fan the flames of emergent mental illnesses, of which queer students are more likely to experience even aside from these factors.

Campus mental health resources face increased demands as more students than ever before report depression, anxiety and psychological distress, and the percentage of students seeking counseling increases (Center for Collegiate Mental Health, 2018, Watkins et al., 2011). Yet, the literature regarding campus mental health services suggests that college counselors have a unique opportunity to both identify and provide assistance to students who are experiencing elevated stress, psychiatric disorders, and other mental health concerns (Vescovelli et al., 2017). Campus counseling services most often provide treatment for existing mental health conditions and operate on the premise of preempting potential psychiatric disorders by providing talk therapy to university students, which is standard for university counseling resources (Vescovelli et al., 2017).

The intended purpose for the provision of counseling resources varies from university to university, but common among each of these stated missions is the role of these services in facilitating academic success. A study by Schwitzer et al. in the Journal of College Student Development suggests that students concerns “fall within the mental health domain” when a student’s daily health is interrupted or when the “the student experiences distress or difficulties in functioning in important areas of college adjustment” (Schwitzer et al., 2018). Studies examining the correlation between college counseling experiences and students’ academic success suggest that receiving effective therapy can both bolster students’ general mental health and improve academic outcomes (Schwitzer et al., 2018). Thus, college counseling services operate with multiple goals, including not just improving the general well-being of students, but pre-empting the onset of psychiatric disorders and bolstering students’ ability to achieve academic success.

The research is not as clear regarding how college counseling benefits specifically queer-identified students. According to the Dunbar et al. study, though lesbian, gay, bisexual, and queer-identified college students are more likely to report use of mental health treatment, they are less likely to feel that their treatment needs have been met (Dunbar et al., 2017). A 2017 study published in the College Student Journal about the competence of campus providers in treating transgender students found that while, according to the study, college mental health clinicians largely believe they have a “professional duty” to support and understand “gender identity issues,” overall competency and preparedness was “moderate” (Couture, 2017). A 2011 content analysis of college counseling center websites found that fewer than one third of websites discussed counseling for LGBT students at all, even less had group counseling opportunities, and less than 6% included an informational page or flyer that had compiled a list of resources for LGBT students (Wright & McKinley, 2011).

Yet, at this juncture of increased need, queer students report significant barriers to accessing mental healthcare, including fears of being discriminated against, fears of being outed, and difficulty locating queer-friendly and queer-identified providers. Campus mental healthcare facilities operate under conditions of real or imposed scarcity, under which decisions must be made about how to allocate finite resources, and to whom (Sood & Martel, 2015). According to the Dunbar et al. study, though lesbian, gay, bisexual, and queer-identified college students are more likely to report use of mental health treatment, they are less likely to feel that their treatment needs have been met (Dunbar et al., 2017).

Seeing as existing literature suggests elevated risk and rates of mental illness and unique threats to mental health for queer students, difficulty accessing competent care, and complex relationships to university life, as well as strained resources on the part of college counseling facilities, studying the relationships between queer-identified students and campus mental health institutions seems a natural and necessary step. By interrogating the differences between how students describe their own notions of what it means to be mentally healthy, and the ways they describe encounters with hegemonic notions of mental health at CAPS, this study understands UNC’s Counseling and Psychological Services (CAPS) as a unique point of rupture, where queer experiences with mental health resources can be understood.

**Methods**

*Participants*

My sample consisted of nine queer-identified undergraduate students enrolled at the University of North Carolina at Chapel Hill. This study received IRB approval on October 27, 2017.[[1]](#footnote-1) I chose queerness as an entry point for understanding how marginalized students navigate mental health resources, and my own experience as mentally ill undergraduate who identifies as bisexual and genderqueer informed this approach. I chose the word “queer” as it most accurately reflects and encompasses all the identities of my interviewees and myself, both in terms of sexual orientation and gender identity, and as a broader political identity. At the time the interviews were conducted, two students were sophomores, two juniors, and five were seniors, and all were between the ages of 19 and 22. Six interviewees identify as White, one interviewee identifies as Black, one interviewee as Asian-American, and one interviewee described themself as Arab. One participant described her socioeconomic standing as “lower class,” another described himself as “lower middle class,” and a third mentioned that their family didn’t have a lot of money. Other interviewees did not provide this information explicitly, although many described money as a source of stress. Seven participants identify as cisgender, and two identify as gender non-conforming. Of the seven cisgender participants, five identify as women and two as men. One interviewee identified as “homosexual,” one used the word “lesbian” to describe herself, three used the term “pansexual,” two participants identified as “bisexual,” and two preferred simply the word “queer” to describe their sexual orientations. In addition, two participants described themselves as survivors of sexual violence (though this was not an interview question). One participant mentioned that she was chronically ill. Participants also described identities like scientist, artist, and empath. Four participants were regularly seeing a therapist at the time of the interview, two were not, one was looking for a therapist, and two did not mention whether they were in therapy.

*Procedure*

I solicited interview participation by asking friends and acquaintances who are “out” to me whether they would be interested in being interviewed, either via text message or in person. I described my research questions and the purpose of the project, and gave them time to consider whether they wanted to be involved, getting back in touch either through text message or in-person conversation. I recruited nine participants and conducted their interviews over a four-month period. Interviews were semi-structured and consisted of three sections. In the first section, I asked each participant broadly to disclose personal/social identities that shape how they experience the world to understand how they might both uniquely perceive and experience oppression. After this broad question, I asked more specifically about gender identity and sexual orientation. In the following section, I asked participants how they conceived of the terms “self care,” and “mental health,” because I was interested in learning how students defined these socially and politically loaded, and often nebulous terms. I asked both for their “free associations” with these terms and for their definitions of them. Then, in the third section, I asked about students access to different on campus and off campus resources, including queer and other identity based student groups, friend groups, and Counseling and Psychological Services on campus, because I was interested how different support systems functioned in my interviewees’ lives. In regards to CAPS, I asked interviewees both about their own experiences and experiences they had heard from their friends. Though rich answers to each of these questions were provided, answers about CAPS stood out as particularly meaningful for analysis because of their potential policy implications and because the experiences were so commonly negative. Thus, this paper mainly explores students’ relationships with CAPS.

*Informed Consent*

To protect their privacy, I solicited verbal consent from participants rather than written. At the time of the interviews, which were face-to-face, I informed each person that I would not attach their real name to any of their interview data. I solicited consent to record our conversation, and told my interviewees that I would change the pitch of the recording before sending it to be transcribed so that their voice would not be identifiable. Interviews were transcribed by GMR Transcription. I also told participants that they could stop the interview at any time, and that if later, they decided they didn’t want to participate in the research, I would destroy any interview data and not include our conversation in my analysis. I solicited consent again before proceeding to each new section of the interview. For information revealed in the interviews that I deemed very personal (though not identifiable) and wanted to include in the analysis, I asked the participant directly. Finally, after writing my analysis, I sent it to each participant to make sure they were comfortable with the way I represented their quotes.

**Queer Students Challenging Dominant Notions of “Mental Health”**

The World Health Organization defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (Herman et al., 2005). Other elements of the dominant or stereotypical understanding of “mental health” in the United States include that it simply the absence of mental illness (as defined by Wikipedia), that one definition of mental health can be applied to all individuals and every culture (USDHHS, 2001), that mental health is the norm and illness therefore abnormal (Powell, 2015), and, taking the WHO’s definition to the extreme, that mental health is a completely individual experience, unrelated to or at least not directly correlated with social and economic conditions such as oppression.

Although not every participant actively disavowed these dominant understandings of mental health, and their answers were not homogenous, interview responses taken as a whole overwhelmingly understood mental health as non-oppositional to mental illness, defined mental illness as “normal,” and particularly common in queer communities, and understood mental health as a response to social conditions like oppression. Other students rejected the idea that they could define a universally-applicable conception of mental health, saying they “wouldn’t know what a mentally healthy ‘someone else’ would look like.” Two passages stood out. In one, a student I’ll refer to as C describes a mentally person as “someone who has…found a way to process their oppression, in a way that’s – to where it is not impacting their overall happiness.” Another student, F, describes how closely they view mental health and freedom from oppression are linked, saying “to be mentally healthy, you have to eliminate the barriers of oppression.” Thus, largely students understood oppression, queer identity, and the ability to realize mental health to be related. They left definitions of mental health open-ended, unwilling to assert that diagnosis of mental illness precludes someone from being “mentally healthy,” and regarded people who cannot “cope with oppression” as being not at fault. Therefore, my interviewees understood mental health as a socially mediated and dynamic idea. They connected notions of “mental health” to understanding of social justice and the role of injustice in their lives, and felt that confronting oppression, if not the main strategy, was a necessary part of the pursuit of mental health.

**“I’ve Heard the Negative From My Queer Friends:” Personal and Secondhand Experiences with UNC’s Counseling and Psychological Services (CAPS)**

CAPS, or Counseling and Psychological Services, is a department of UNC-Chapel Hill’s Campus Health Services that “provides therapy, psychiatry, referral and academic intervention services for UNC Chapel Hill students and post-doctoral fellows” (CAPS Homepage, 2017). CAPS hosts both individual and group therapy sessions, as well as triage (walk-in) sessions from 9am to 12pm, and 1pm to 4pm, Monday through Thursday as well as 9:30 to 12pm, and 1pm to 4pm Friday. These sessions are generally fifteen minutes long. According to the CAPS website, in a triage appointment the provider first listens and responds to the student’s concerns and then makes a recommendation in the form of either a referral to outside mental health resources or to a therapist at CAPS (CAPS Homepage, 2017). Counseling services, except for medication management, are covered by the Student Health Fee paid as part of tuition and are available to any full-time student. CAPS also offers a variety of on location therapy groups, with themes including, but not limited to “Mindfulness,” “Emotional Wellness,” “Empowering Black Women,” and “Sexual Assault Recovery” (CAPS Current Therapy Groups, 2018). None of the available groups as advertised on the website as of April 2018 were specifically for queer-identified students.

Though CAPS often refers students to therapists outside of the university, these therapy sessions are not covered by the student health fee. According to the CAPS website, session limits were done away with “years ago,” and thus there is no defined limit on the amount of therapy sessions a student can receive through CAPS, although twenty was the highest number listed, and “most students” were characterized as being satisfied with three to six sessions (CAPS FAQ, 2018). An FAQ page says that the number of sessions a student can be seen at CAPS “depends on the type of concern identified in the initial session,” and that CAPS generally provides short-term counseling because it is “the most appropriate format” for most students. The same section reports that if “longer term therapy or specialized therapy” is needed, the student will be referred outside of CAPS. The website reports that the “vast majority” of students receive treatment on location, and that only thirty percent are referred (CAPS FAQ, 2018).

Though some interviewees mentioned utilizing other sources of mental health support provided by the university, participants were most familiar with and had most frequently used CAPS. All participants had either used CAPS themselves or had heard about a friend’s experience.

*Personal vs. Secondhand Experiences*

In this thesis, I strive to center my participants as the experts of their own experiences. My values as a researcher are to actively believe my interviewees’ accounts of racist, heterosexist, ableist, misogynist, classist, and transphobic oppression that has been enacted against them and their communities, and to value their lived experiences as an important source of knowledge. I include both firsthand and secondhand accounts of experiences had at Counseling and Psychological Services, because I believe the importance of the queer community’s “collective knowledge” about CAPS is significant even though, and especially as it blurs the distinction between perceptions of CAPS and how they actually operate. Both of these sets of data – perceptions of CAPS, and the “truth” of how they operate – are meaningful in understanding how and whether queer students can access campus mental health resources, especially when considering perceived discrimination as a significant barrier to mental healthcare access. However, it is important to note that this thesis focuses only on student perceptions of CAPS, and is not a study of CAPS itself, its policies, or its staff. In other words, this study evaluates how a group of students and their peers speak about their experiences at CAPS, but does not make claims about the “truth” of how CAPS operates or their policies.

CAPS was described, by almost every participant, as a “mixed-bag,” meaning that even if an individual had what they described as a “good experience” with CAPS, they had heard about a friend’s bad experience. This inconsistency manifested itself in a variety of ways, with negative experiences including discussions of CAPS’ tendency to refer students to outside mental health resources rather than providing services on-site, and the marketing of CAPS as a “safe space” for queer and otherwise marginalized students despite this not always being true in their experiences. The following section will discuss how interviewees described their own and their peers’ encounters with Counseling and Psychological Services, divided into two major themes. The themes are as follows: student agency (or lack thereof) in the CAPS referral process, and the inconsistency of CAPS as a resource tailored for queer students.

*Referred or not? Agency denied either way in the referral process*

Students described a variety of contrasting experiences with the referral process – some felt that CAPS focused on referral exclusively in their first appointment rather than addressing their emotional crisis, many recounted how they felt ushered out of CAPS after only a few sessions of weekly therapy, and one person even felt that CAPS should have referred their friends and did not, preventing them from receiving necessary mental healthcare. Common in each described experience, despite their wide variety, interviewees felt that CAPS did not prioritize what students desired out of their own mental healthcare. CAPS counselors were experts, and according to their descriptions, students were simply patients, rather than agents.

Seven out of nine participants directly mentioned an experience that either they or a friend had with the referral process at CAPS. Of these seven experiences, six involved referrals being given and one described referrals being withheld from several of her friends. Four of the mentioned referrals were directly experienced by the interviewee (the interviewee was the “primary source”), and three were experiences they’d heard about either from a friend directly or through their peer networks. In my analysis, I differentiate these experiences, but include them both. I will call retold experiences for which the interviewee is the primary source “lived,“ and experiences participants described their friends having “secondhand.” I believe both types of data are important to understanding students right to access mental healthcare, especially when considering that perceived or potential discrimination is a well-understood barrier to mental healthcare (Stepanikova & Oates, 2017), and thus perceptions of CAPS can inhibit students right to receive care.

In the following pages, I will provide several quotes that shed light on distinct encounters with the CAPS referral process, and how students describe this process as denying their ability to self-determine their mental healthcare. As discussed above, though these experiences vary in referral outcome, they reveal a similar pattern in how students and their peers perceive they are being treated by CAPS. Below, I provide three quite different descriptions of outcome with referral (or lack thereof), the first of which I call “the referral reflex,” the second as the “quick fix,” and the third “the exception.”

1. *The Referral Reflex*

The first example is a lived experience from a sophomore I’ll refer to as T:

“I went yesterday and it was not what I was expecting…I just went in and filled out this survey thing. And then they took me into the room. And I was like, ‘I just need some help and also I might want to go see someone off campus.’ And they were like, ‘So, I heard you want to go see someone off campus.’ And I was like, ‘But I also need help. Please help me.’ They didn’t...but they were very nice and did give me a lot of different people to look into. And gave me this sheet with how exactly to contact people.”

T went in for a triage appointment the day before our interview. She felt that the CAPS staff heavily prioritized sending her to someone off campus over “helping” her. She had mixed feelings about this experience because she was glad that she was able to schedule an appointment off campus, but felt that her emotional needs had been neglected on site.

Another interviewee I’ll call D recounted a similar experience he heard secondhand. Unlike the first example, this interviewee’s friend was not seeking referral when they went to CAPS, but they were told to go to an outside therapist, even though it would cause them financial difficulty:

“I have another friend who used it, and they said it really didn’t help at all, and they were – I think they were advised to – they were a senior at the time, and they were advised to go to an outside counselor, which I think was a good suggestion. But at the same time, it didn’t really consider their financial place. So, yeah, I – I feel like – or if I remember correctly, they felt that they were abandoned by CAPS.”

D acknowledges that, while he thinks that seeing an outside counselor may have been a “good suggestion” for the average student, his friend was left without help because their own material situation conflicted with what CAPS provided, which was not tailored to their financial needs.

V, a junior, recounted how, on their first visit, they were told CAPS wasn’t equipped to handle their concerns.

“So, I went to one of the walk-in things as you do. And they paired me with this guy...he essentially told me my problems were not dealable with at CAPS. And so was like, ‘I can put you in contact with our referral coordinator.’ And that was that. I did follow-up with the referral people.”

According to V’s impression, the provider determined that CAPS couldn’t help them, implying that their problems were beyond the scope of what CAPS could provide. V’s experience aligns with broader campus uncertainty about who CAPS will and will not take on for therapy. CAPS seems to be clued into this conversation, considering a recent effort they made to address “myths” about their services. On the CAPS website, a short video called “CAPS Mythbusters” asserts that “any concern is a good concern to bring to CAPS,” and that only “thirty percent of students are referred to the community to meet their mental health needs” (CAPS Myths, 2017). The website is unclear about what determines whether a student will be referred.

D, T, and V’s stories demonstrate a perception that CAPS is quick to refer students upon their first interaction with a CAPS counselor, regardless of whether this is the option the student considers best for them. According to these interviewees, CAPS providers decide for, rather than with the student whether their mental health concerns can be addressed at CAPS. If in this fifteen minute walk-in session, the provider decides that CAPS cannot take on a particular student, that student is given a referral.

1. *The “Quick Fix” and Subsequent Referral*

G, a graduating senior, had a personal experience with the referral process at CAPS when he was a sophomore. Though he went through a short period of therapy at CAPS, he was referred to an outside therapist for the long term. He felt that the CAPS model could be much more supportive:

“It was fine, I think is about the strongest word I can use. It’s fine. I – my sophomore year I went in and did their series of counseling sessions. It sort of worked for [the] short-term. Like issues and sort of talking through things, but it seemed very based on the – on like a model of ‘we’re gonna fix you and then you can get out’…it didn’t necessarily yield the most support…it was just very much like ‘We don’t have what you need, but we can help you get what you need.’”

The mode of operation G described as “we’re gonna fix you and then you can get out,” was also confirmed by a sophomore interviewee, B. Though she herself received therapy she described as consistent and “pretty good,” she believes her experience is out of the ordinary:

“[My experience at CAPS] was pretty good, like the consistent therapist that I have…in my experience, my therapist was actually really helpful and actually let me stay with her a little longer than usual… I’ve had lots of friends that have not had that experience.”

B believes that her therapist allowed her to stay on at CAPS for longer than is the norm. Thus, B’s experience was dependent on the provider bending the rules. She says that therapy was “actually” helpful, and that her therapist “actually” let her stay longer, emphasizing how her experience was unexpected compared to those of her friends. Significantly, even though her personal experience at CAPS was good, B’s account reveals how much the students perceive themselves to be at the mercy of the individual provider rather than institutionally protected.

On the surface, the “we’re gonna fix you and then you can get out” model may seem different from the immediate referral model described in the above section, but they have similar implications for how students experience therapy. Most commonly, interviewees felt that CAPS gives students referrals (either during the first appointment, or after brief therapy) regardless of their emotional or financial situation, and regardless of what the students themselves desire. This made them feel abandoned or unsupported, and led them to feel that CAPS could not or would not allocate their own resources for students’ care.

Although my interviewees did not explicitly say they felt disempowered or coerced, I suggest that their negative experiences of ‘referral’ taken as a whole reveal a structural authoritarianism combined with a kind of built-in powerlessness in the CAPS operation, regardless of the minutiae of their encounters at CAPS.

1. *An Exception to Prove the Rule*

B described a unique experience her friends had at CAPS, which ultimately contrasts with the most common of CAPS being quick to dole out referrals (either immediately or after short therapy), but paradoxically supports my argument regarding the perception of CAPS as an authoritarian structure. Though B personally felt that she had a good experience with her therapist internally at CAPS, she described how several of her friends were denied referrals:

“[CAPS was] really horrible, a lot of [my friends] didn’t get referrals to go outside, even though everyone had a big book of referrals to give to people...and the way – it really stressed a lot of people out, especially who had anxiety over calling people, which I did and my therapist helped me, and if she didn’t I’m pretty sure I wouldn’t have gotten help.”

After this, B went on to add that, had she heard about these negative experiences before visiting CAPS herself, she would have been “really afraid” to go. I was surprised to hear about B’s experience, because almost all of my other participants seemed to imply that CAPS was quick to give referrals, even prioritizing this over discussing what the students had come in to talk about. Like in the previous accounts, the CAPS providers in B’s story act as gatekeepers, only this time controlling access to and withholding a different resource. This was not the only time an interviewee mentioned some allegedly universal resources being denied to their friends. A different participant described how she was given “many resources” when she came to CAPS, and that her experience as a “straight-passing cis woman” is different from her “queer not-cis friends, and...queer friends of color...don’t tend to get the same resources.”

1. *Campus Mental Health Institutions At Large: Seen As A Site of Structural Powerlessness*

V, a junior quoted above in the “Referral Reflex” section, describes both their lived and secondhand experiences with CAPS. These descriptions poignantly reveal a disturbing pattern in the way students expect they will be treated by campus mental health resources. Recall that V explained how the provider told them their “problems were not dealable with at CAPS.” Though V was personally satisfied with their interactions with the referral coordinator and the ease of the process, they felt anger with the idea and frequency that they believe students are sent away to outside resources, both at UNC and at other universities who provide mental health services, describing a friend’s experience:

“I had a friend who went to CAPS at [another university] who was just going in to sort it out to get on track with getting on medication and going to therapy and being their own person. And upon disclosing aspects of their personal history, the people there decided the best thing would be to hospitalize that person on the second day of classes, their first year of college, without really properly assessing whether or not that person was a risk to themselves at that point. Which they weren’t. So I was, based on that, terrified of going to CAPS. Because I was like, well, the framing of my experiences and the framing of the reasons why I was going to CAPS were very different than this person’s. But that’s how mental health resources work at college campuses. They send you away if they’re too scared to deal with your problems. I’m still mad about that.”

This harrowing story reveals what some students fear most about accessing mental health resources on campus: that they could be institutionalized without their consent. Even the less severe implications of V’s story reveal a perceived incompetency on the part of mental health providers at large.

1. *Summary*

Referrals to an outside therapist were sometimes part of the interviewee’s first (triage) appointment, and other times they followed a short period of therapy. Thus, the implicit message most interviewees provided about CAPS was that it was clear they were not an option for long term therapy, at least for most students, and if long term therapy inside CAPS was provided, it was not the norm. This somewhat aligns with CAPS’ own description of their services, as I included at the start of the section. However, the relatively common perception among my interviewees and their peers that CAPS refers students more often than not seems to directly contradict their 30% referral statistic (CAPS Myths, 2018). It is unclear whether this perception is simply incorrect, or whether it is possible that queer students are more likely to be referred (perhaps because they are more likely to be diagnosed with psychiatric disorders and other chronic mental illnesses).

Of the seven referral experiences given, three were described as wholly difficult, negative, or unsatisfactory. Two interviewees discussed both affirming and frustrating elements of the process, and two described how the process was entirely helpful to them. Of the negative and mixed experiences, interviewees described a variety of reasons why they found the referral process unhelpful, not what they wanted, or lacking. Some of these reasons included a lack of understanding for students financial ability to attend outside therapy, a feeling that CAPS was “abandoning” them or their friends, a feeling that the counselors in triage appointments were more concerned with referring students rather than attending to their immediate crisis (though both of these services are advertised as part of walk-in sessions), a perception that CAPS was withholding referral services from some students or not assisting them enough through the process, a feeling that the referral system was bureaucratic and difficult to navigate, and that the therapists students are referred to are “generic” or not specialized enough. Although not discussed in depth in this section, elements of good experiences included CAPS being a good go-between for connection with outside resources and therapists, a feeling that CAPS was “supporting” them, satisfaction with being given many options, impressions that the referral coordinator was kind, and impressions that the instructions for following up with potential outside therapists were clear and thorough.

Common in each of these experiences, though they describe differing levels of satisfaction with the referral process, is the articulation of a lack of agency on the part of the student coming in to receive counseling. In other words, interviewees described how, despite having varying, and even at times contradictory experiences with the CAPS staff, in almost every instance the student was not considered the expert about their own needs. Not every instance involves a direct, or “primary source” experience at CAPS, but each is significant for what it reveals about how the queer students I interviewed perceive university counseling resources, both at large, and specifically at UNC.

**An Unreliable Resource for Queer Students: “CAPS isn’t finely tuned for queer stuff”**

Six interviewees described specific experiences that they had at CAPS regarding their identity and the ability of CAPS to be specifically competent in queer students’ needs. Three out of these six interviewees described how it was clear that CAPS was making an effort to appeal to or accommodate queer and otherwise marginalized students, and that CAPS was attempting to brand itself as a “safe space.” Three specifically described signage in the physical space of CAPS. This signage included placards that indicated a therapist’s completion of Safezone[[2]](#footnote-2) training, a poster titled “What’s Your Sexual Orientation?” and pins in a box at the front desk that displayed different gender pronouns (Image from Sheperd, 2017).



Below I will include several quotes that illuminate a range of experiences relating to CAPS as a resource tailored for queer and marginalized students. These experiences reveal how the queer students I interviewed considered CAPS as a resource available to them or not available to them. The first section will encounter the perceived discrepancy between the physical environment of CAPS, and what they actually provide for queer students. The second will consider gendered, racialized, and classed experiences of CAPS that complicate the idea of a monolithic queer experience.

1. *Looks Can Be Deceiving*

I begin this section with a quote from a senior I’ll refer to as R. R is involved in multiple LGBTQIA, feminist, and other advocacy organizations on campus and has significant knowledge about mental health and other support resources that exist for queer and otherwise marginalized students on campus. R described how CAPS makes an effort to be visibly queer friendly, but that she’s unclear about the concrete resources they actually provide:

“It’s not really – CAPS isn’t, of course, probably finely tuned for what you need if we’re talking about queer stuff. They have little things that say, ‘Safezone trained’ or like, ‘What’s your sexual orientation?’ when you come through the door so, you know... They might have, maybe – I don’t even know if they have support groups, if I’m honest with you…I just don’t know if they have queer specific [groups].”

Despite R’s position as a leader and her multiple personal experiences visiting CAPS, she is uncertain of the resources they have available to queer students, or whether certain queer specific resources exist in the first place. Thus, according to R, there seems to be a discrepancy between how CAPS markets itself as a safe space, and whether queer students can easily access knowledge about safe spaces, such as support groups. As mentioned at the start of the section, no queer-specific group therapy meetings were listed on the CAPS website as per my own investigation in April 2018.

T, a sophomore, also noted how the physical environment of CAPS was visually queer affirming. Despite this, she described how CAPS is preceded by its reputation, especially among her queer friends. Even though she hasn’t heard much, she knows that CAPS has “mixed reviews.”

“I haven’t actually heard very much about CAPS. I heard that other people have heard about CAPS. It’s really mixed. Especially the queer circles that I’m in. People that I know that have friends or have been themselves have heard really mixed reviews. Like some people are very queer affirming and some are not or are just totally oblivious or whatever…when I was in there, there were a lot of things that seemed to be queer affirming, at least visually.”

T describes how, at least optically, CAPS appears to be branded as a space for queer students. This branding, however, conflicts with what she’s heard about the inconsistency of her queer friends’ experiences, because some providers are “totally oblivious” to queer students’ needs.

*Gendered, Racialized, and Classed Experiences of CAPS*

Grounded in Kimberlé Crenshaw’s theory of intersectionality and subsequent scholarship inspired by Crenshaw, I consider the elimination of racism, classism, and other forms of marginalization fundamental to queer experience. Because it is impossible to separate the multiple facets of an individual’s identity that cause them to experience marginalization, and because of the ways queerness is racialized and classed, it is irresponsible not to analyze experiences of racially-motivated, class-based, and other forms of discrimination and oppression in research about queer students. Thus, I argue, for example, that racism queer students of color describe at CAPS is fundamentally an experience that cannot be separated from queer identity.

This section will discuss gendered, racialized, and classed experiences of CAPS, and how they relate to CAPS’ perceived ability or inability to accommodate queer students. However, in creating a distinct section to explore these intersections, I do not suggest that they do not exist throughout every facet of students’ experiences. Here I simply wish to render them more visible and explicit.

In the following quote, R, who identifies as a pansexual but “straight-passing” white, cisgender woman, points out that in her direct experience, she always receives the appropriate resources, and that the physical space of CAPS appears to be queer friendly. However, she says that she knows “for a fact” that her experience with receiving resources is different from her friends who aren’t cisgender and white.

“CAPS is fine, they give me many resources when I go in. I know for a fact they give other people different resources…I usually get the negative from my pals...my queer not-cis friends, and my queer friends of color who don’t tend to get the same resources...I get from a lot of friends who have been misgendered at CAPS, or whose sexual orientations have been invalidated.”

Here, R points out three specific interactions her peers have reported at CAPS: being misgendered, being denied resources, and being invalidated. While this thesis uses “queerness” as a lens and category for understanding students’ similar experiences, queer identity is not monolithic and R articulates why this is significant. Here, R specifically describes how her transgender friends face the potential violence of being misgendered when they choose to visit CAPS, as compared to cisgender queer students who do not have to face this emotional danger.

R was not the only interviewee to mention how queer students of color experience CAPS differently from white queer students. V, who identifies as Asian-American and genderqueer, described how they felt their time at CAPS could have been more meaningful if they’d been able to interact with someone who looked like them and could relate to their experiences:

“I think that when – a big red flag for me going to CAPS was the person who was there on duty or whatever was just some white guy. I wonder if my experience there would have any been different if the person that I talked to first wasn’t some…white man. I mean he could have been queer for all I know but he was still a white guy. And just – I don’t know, I felt like there as nothing about – I’m sure he’s encountered plenty of people before, but I felt like there was nothing about him personally that would have related to any experiences or problems that at the time I was having personally.”

Though CAPS offers itself as a “safe space” for all students, V was uncomfortable sharing their concerns with a white, male counselor and found it to be a red flag that he was the default person available to speak with them. They stressed the importance of representation as a part of their ability to access mental healthcare and felt that their experience would have been much more meaningful if they could have seen “more faces that look like [theirs]” among the CAPS staff.

R and V were just two of several interviewees who raised concerns about ways, in their eyes, the university has failed to serve queer students of color. Students understood racism as a part of the university as an institution, which inhibits the health of queer students of color. F shed light on the entire university as a site of white supremacy, that CAPS wasn’t unique in upholding a paradigm that oppresses queer students of color:

“The university having a…history of white supremacy and continuing to uphold white supremacy…transparency doesn’t exist because the university isn’t meant to be transparent as an institution. And it’s like, you need a whole complete overhaul of how everything here works if you want your students to be healthy.”

Thus, interviewees both considered CAPS as it was operating within larger structures of racial oppression and described experiences of direct discrimination (i.e. students of color being denied resources). V and R characterized their anecdotes as not unique, and V contextualized lack of representation as a commonly understood injustice: “I feel like that’s what everybody says about everything all the time.”

An interviewee I’ll refer to as L had a uniquely positive experience with CAPS being able to adapt their services to her experiences of marginalization, on a different note. L described how CAPS was successful in this way partly because of their partnership with one of the gender violence coordinators. The gender violence coordinators are a resource based out of the UNC Women’s Center for students who have experienced gender-based violence. L described how CAPS really “showed up” for her both because of her status as a survivor, and as a financial support. However, according to L, her experience is significant in that it is an anomaly.

“Yeah, after I was raped...I – the school just – it was helpful, because I’d already been connected to a gender violence coordinator, and so that relationship really – she served as a conduit for basically getting me all the necessary resources. But, I mean, CAPS really showed up, during that time….I desperately needed an anxiety medication, to help me with kind of the initial shock of it, and they – he didn’t even – my now psychiatrist didn’t even see me, he didn’t even ask to see me, he was just like, I’m just gonna prescribe this over the phone, it’s totally fine…I’ve had a really good experience, but I’m lucky...there’s a particular endowment for students with mental health issues, to basically help subsidize their therapy and medication, if they can’t afford it”.

While L said she was “lucky” to receive necessary mental health and financial support from the university, other students reported concerns that, in their eyes, CAPS isn’t doing enough to ensure the well-being of students who may not be able to afford care outside of the university. F listed many ways CAPS could improve, mentioning specifically how students who use CAPS might graduate, and suddenly no longer have access to these services.

“[CAPS could be improved by] not having a limit on how many appointments you can get because some people literally can’t afford therapy outside of CAPS. Like, having access to people who were using CAPS as a primary source of mental health and then who have graduated, and who don’t have therapy anymore and who maybe can’t afford it anymore. And realizing that the university and the degree that they were given isn’t enough to be able to literally afford their own mental healthcare. The university should take some responsibility for that.”

Overall, perceptions of CAPS were skewed negatively, with an inability to depend on CAPS a queer resource, and lack of agency over their mental healthcare experience at CAPS being reported as both lived and secondhand experiences. Interviewees reported, in their experience, significant problems with CAPS being able to support, in particular, queer students of color, trans students, and students who couldn’t pay for therapy. Still, interviews revealed opportunities for improving both the services CAPS provide and the process of accessing those services. Whether or not CAPS is willing to consider these accounts evidence of need for policy change, these experiences can inform CAPS key issues in its reputation among queer-identified students.

**Improving Queer Student Experiences and Access to CAPS: What Might Be Done?**

Because knowing the specific financial situation of CAPS and the amount of political will for major change would require extensive additional research, the following recommendations focus most specifically on potential policy change that would not require major shifts in the allocation of resources. Multiple interviewees perceived a tension between the physical environment and visual branding of CAPS as inclusive to queer students’ needs, and what they or their queer friends had actually experienced. Addressing at least some aspects of this tension would not require significant reallocation of resources or additional funding. Rather than continuing to brand itself as an entirely “safe space” for all marginalized students, CAPS might consider if they can really assert this claim. If not, CAPS might change their branding to reflect their office as a “safer space,” acknowledging that their endeavor to eliminate all oppressive experiences at CAPS is not finished, and that this process is and should be ever-evolving. This does not mean that changes should end here. In other words, if CAPS decides they must take more steps to increase their competency and capacity in meeting queer students’ needs, they could simultaneously acknowledge their limitations and be transparent about what are actually able to provide, giving students the opportunity to make informed decisions about pursuing therapy through CAPS.

Some interviewees discussed specific microaggressions they or their friends had experienced, and beginning with investigating or correcting these experiences by providing counselors with minimal education about proper language and cultural sensitivity seems rather actionable. Two examples of these experiences which came up in my interviews include trans students being misgendered by health providers, and students feeling that their sexual orientations were invalidated. Training, re-training, or continuing to check in with providers in how to properly ask for and use students preferred pronouns and educating them about a broader spectrum of experience in terms of sexual orientation identity would take minimal time, if CAPS decides this is a necessary step. A wealth of preexisting educational resources could facilitate the process. For CAPS to take steps to address and prevent blatantly discriminatory encounters would likely not require major systemic or financial change.

A similarly actionable recommendation for CAPS would address the experience (mentioned by “V”) of queer students, and queer students of color in particular. V described how, when they came in for a walk-in session, they were disappointed by how the “default” provider was a white man. Even if CAPS is unwilling to guarantee a provider who shares the same or a similar social location to every student who walks in for a triage appointment, at the very least CAPS might consider implementing a formal system by which students can request, among the providers available, persons of marginalized gender, sexual orientation, or racial experience. Additionally, if no provider is available that a particular student might feel comfortable seeing at the time of their walk-in appointment, knowing this information would allow that student the ability to make an informed decision about how to proceed. If such a system already exists, students are not aware of it, and I found no mention on the CAPS website of students being able to express a preference for a certain walk-in provider.

A large discrepancy exists between what my interviewees described about the referral process, and how CAPS purports to operate, based on their website. If it is true that CAPS only refers thirty percent of students, can take on students without session limits, and decides the best course of action with, rather than for the student, this was largely unclear to, or not the experience of, the students I interviewed and their peers. My interviewees words indicated that, whether referred, provided a short period of therapy, or not referred, they and their peers felt that students did not or would not be able to control what happened to them at CAPS. Based on my research, it is unclear how CAPS decides whether students will be referred or treated at CAPS. If CAPS considers ongoing mental health concerns such as psychiatric illness a reason to refer students to an outside provider, CAPS should be aware that queer students are more likely to experience ongoing mental health concerns and thus may be more likely to have referral suggested to them (either during a walk in session, or after a short period of therapy). Thus, the 30% statistic, as reported, on their website, may be incorrect for queer students, and CAPS should be transparent about this. In addition, in order for students to feel they are agents in the process of receiving mental healthcare, it may be useful for CAPS providers to be trained or re-trained in asking students what they want and making the process of receiving mental healthcare feel collaborative. This is particularly important, because as is shown by both the existing literature and by how students described their experiences, queer students are more likely to distrust, be dissatisfied with, or fear mental health providers.

Another issue illuminated by the interviews was that students simply did not know much about what, if anything, CAPS provides for queer students. For example, one student, R, described how she didn’t know if there were any “queer support groups,” despite being relatively well-informed about what CAPS provided in general. After some research, I was unable to find confirmation of any queer specific group therapy meetings on the CAPS website. Thus, making clear on their website, in the CAPS office, and perhaps publicizing through the LGBTQ Center or queer-identity based student organizations on campus the kind of resources CAPS has available for queer identified students might be a significant step in the right direction.

The common theme in these recommendations is that CAPS might facilitate better experiences for queer students by communicating more clearly and pointedly to queer students to address potential myths about their services and to publicize resources specifically for queer students’ concerns. A secondary theme is that CAPS could consider investigating both the reports of discrimination my interviewees gave and how their policies play out in individual experiences for queer students. Though in order to recommend more changes, I would have to understand how CAPS itself operates rather than relying on reports of how CAPS operates, engaging in better communication about what is provided and addressing potential instances of discrimination are two potential routes for improving the relationship between CAPS and queer students.

*CAPS as Operating Within the Larger University*

It must be recognized that the ability for CAPS to make meaningful change in the way of accommodating queer students is situated within the broader context of the university as a political and financial institution. Though both political will for social change and available financial resources are dependent on what the university values and an ever-evolving political landscape, students expressed various specific actions either CAPS or the university could take to improve the mental health experiences of queer students. These actions included, but were not limited to providing free or subsidized CAPS support to former students after graduation, formalizing mental health support through more flexible attendance policies, and encouraging professors to include their gender pronouns or other symbolic gestures in class syllabi.

Students stressed the importance of accountability and acknowledgement. They desired sweeping institutional change as an ultimate goal - one interviewee said “the structure of this institution is not good for mental health” – but my interviewees were also concerned heavily with the administration being able to acknowledge how they have failed marginalized students and perpetuated systems of oppression. A particular example that stands out in the current historical moment is the administration’s unwillingness to acknowledge its history of white supremacy and remove Silent Sam, the confederate statue on upper campus. Two interviewees specifically mentioned that the removal of the statue would be a sign of the university’s commitment to mental health. In order for the university to address mental health concerns of queer students, they argued, the administration must admit to its previous wrongdoings and be accountable to marginalized communities.

**Conclusions**

This study was limited by its time frame, its scope, scheduling, and my choice to interview close friends rather than solicit personal information from acquaintances or students I didn’t know beforehand. Nine interviewees cannot represent the full range of queer –identified students’ experiences at UNC. Queer students of color were underrepresented in my sample, and white students were overrepresented. I was not able to interview any students of intersex or asexual identity, nor did I interview any persons of binary trans experience (trans women or trans men). Because queer experience is not monolithic, using queerness as a category of analysis has the potential to become reductive or paint experiences with too broad of a brush.

Significantly improving queer students’ relationships with campus mental health resources, however, cannot be achieved without further research. I end on this note partly because, although I entered this project with a much broader focus, students’ experiences with CAPS stood out to me as particularly consequential and overwhelmingly negative. My interviewees provided valuable insights that can inform potential policy change at CAPS now. However, nine interviews are simply insufficient to reveal the nuances of how queer students at large experience mental health challenges on UNC’s campus and how they interact with mental health resources.

Further research in this area should center queer students with multiple intersecting marginalized identities, because according to both prior literature and as this study shows, queer students of color and queer students with financial constraints experience not simply different, but more limiting difficulties accessing mental health resources and exercising agency in determining how their mental healthcare looks. Additionally, although many of the students I interviewed identify as mentally ill, focusing specifically on queer students who also identify as mentally ill might illuminate unique challenges with mental health resources for these students.

Further research might also investigate some of the differences between what students perceive about CAPS and what CAPS perceives about their own operation, in order to determine whether it is more important for CAPS to improve their written policies, or to improve their reputation, relationship, and communication with queer students. A specific example of this is the relationship between queer students and the referral process. Though gaining a detailed understanding of how, when, and why CAPS decides to refer students was beyond the scope of this project, I suspect based on my interviews and the existing literature that students with ongoing mental health concerns are more likely to be referred (either at first, or after a short period of therapy), and this is significant because of the prevalence of ongoing mental illness in the queer community. I speculate that queer students with ongoing mental illness who come to CAPS in order to talk about a short-term problem or specific issue may face frustration or alienation if they are immediately referred. In order to provide queer students (who are more likely to have these long term mental health issues), with full autonomy over their mental healthcare, then, CAPS may need to focus on articulating options to students with ongoing illness apart from simply referral, recognizing that students with chronic illnesses may also come in for acute or short-term issues. Articulating these options to students would perhaps better align with students own definitions of mental health as being more than just the absence of illness.

The queer-identified students I interviewed provided insight about navigating complex, bureaucratic, and often oppressive experiences with Counseling and Psychological Services (CAPS). Their experiences were marked by feelings of reduced agency and their descriptions of how CAPS treated them were at odds with their personal definitions of what it means to pursue “mental health.” Ultimately, students understood their perceived failures of CAPS as part of a larger system of oppression, but their insights provided tangible recommendations for bettering queer mental health on campus. Ultimately, then, this thesis understands CAPS as responsible for responding to the oppression faced by queer students, both inside and outside their doors.

**Appendix: Interview Questions**

**Consent: Before we start, I just want to remind you that your participation in the interview is voluntary, and we can stop the interview at any time. You may also request to skip any question you do not feel comfortable answering.**

What is your age?

What year are you in school?

**Consent: Would you be comfortable with me asking some questions about your gender?**

What gender pronouns would you like me to use when referring to you?

How would you describe your gender? What comes to mind when I say the phrase “gender identity”?

**Consent: Would you be comfortable with me asking some questions about your sexual or romantic orientation?**

How would you describe your sexual or romantic orientation?

What does the label you described mean to you? What does that look like in practice?

**Consent: Would you be comfortable with me asking some questions about your ideas about mental health? I will not ask you to tell me your mental illness status.**

What associations come up when I say “mental health”?

What would being mentally healthy be? What would a mentally healthy person look like?

What associations do you have with the phrase “self care”?

What sorts of self care activities do you participate in regularly or semi-regularly?

What, if any, tools are necessary for you to perform self care?

What kinds of support, outside of yourself, do you rely on to help you take care of your mental health?

Do you have experience with queer identity-based student resource organizations on campus? Which organization(s)?

Do you have experience with counseling resources on campus such as CAPS, or counseling off campus? How would you describe your experience?

What could the university do better to support the mental health of queer students?

Is there anything you want to add?

**References**

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring Multiple Minority Stress: the LGBT People of Color Microaggressions Scale. Cultural Diversity and Ethnic Minority Psychology, 17(2), 163.

Bouris, Alida, Bethany G. Everett, Ryan D. Heath, Caitlin E. Elsaesser, and Torsten B. Neilands. "Effects of Victimization and Violence on Suicidal Ideation and Behaviors Among Sexual Minority and Heterosexual Adolescents." LGBT Health 3, no. 2 (2016): 153-161.

CAPS Myths (n.d.). UNC Counseling and Psychological Services Website. Retrieved March 31, 2018 from <https://caps.unc.edu/caps-myths>.

CAPS FAQ and Myths (n.d.) UNC Counseling and Psychological Services Website. Retrieved March 31, 2018 from https://caps.unc.edu/about-us/frequently-asked-questions-and-myths-about-caps.

Center for Collegiate Mental Health. (2018, January). 2017 Annual Report (Publication No. STA 18-166).

Cooper, H., Moore, L., Gruskin, S., & Krieger, N. (2004). Characterizing Perceived Police Violence: Implications for Public Health. American Journal of Public Health, 94(7), 1109-1118.

Coulter, R. W., & Rankin, S. R. (2017). College Sexual Assault and Campus Climate for Sexual-and Gender-minority Undergraduate Students. Journal of Interpersonal Violence, 0886260517696870..

Current Therapy Groups. UNC Counseling and Psychological Services Website. Retrieved March 31, 2018 from https://caps.unc.edu/services/group-therapy/current-therapy-groups.

Crenshaw, K. (2005). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color (1994).

Dunbar, M. S., Sontag-Padilla, L., Ramchand, R., Seelam, R., & Stein, B. D. (2017). Mental Health Service Utilization Among Lesbian, Gay, Bisexual, and Questioning or Queer College Students. Journal of Adolescent Health, 61(3), 294-301.

Ferguson, R. A. (2004). Aberrations in Black: Toward a Queer of Color Critique. U of Minnesota Press. Quoted in Elam, M. (2011). The Souls of Mixed folk: Race, Politics, and Aesthetics in the New Millennium. Stanford University Press. Page 37.

Hanisch, C. (1969). The Personal is Political. Radical Feminism: A Documentary Reader, 113-16.

Haraway, D. (1988). Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. Feminist Studies, 14(3), 575-599.

Herrman, H., Saxena, S., Moodie, R., & World Health Organization. (2005). Promoting mental health: concepts, emerging evidence, practice: a report of the World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation and the University of Melbourne.

Homepage (n.d.). UNC Counseling and Psychological Services Website. Retrieved March 31, 2018 from <https://caps.unc.edu/>.

Kadison, R., & DiGeronimo, T. F. (2004). College of the Overwhelmed: The Campus Mental Health Crisis and What to Do About It. Jossey-Bass.

Kann, L. (2011). Sexual Identity, Sex of Sexual Contacts, and Health-risk Behaviors Among Students in Grades 9-12: Youth Risk Behavior Surveillance, Selected Sites, United States, 2001-2009 (Vol. 60, No. 7). DIANE Publishing.

Kelleher, C. (2009). Minority Stress and Health: Implications for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) young people. Counselling Psychology Quarterly, 22(4), 373-379.

Mental Health. (n.d.). In Wikipedia. Retrieved March 31, 2017, from https://en.wikipedia.org/wiki/Mental\_health.

O'Brien, K. H. M., Putney, J. M., Hebert, N. W., Falk, A. M., & Aguinaldo, L. D. (2016). Sexual and Gender Minority Youth Suicide: Understanding Subgroup Differences to Inform Interventions. LGBT Health, 3(4), 248-251.

Powell, S. (2015). Dispelling Myths on Mental Illness. National Alliance on Mental Illness. Retrieved March 31, 2017 from <https://www.nami.org/blogs/nami-blog/july-2015/dispelling-myths-on-mental-illness>.

Quillin, M. (2018, May 2). She Turned To Action Against UNC's Silent Sam After Years of Talk Got Nowhere, Protester Says. Retrieved from http://www.newsobserver.com/news/local/article210303084.html.

Saewyc, E., & Veale, J. (2016). Being Safe, Being Me: Results of the Canadian Trans Youth Health Survey in Saskatchewan & Manitoba. Stigma and Resilience Among Vulnerable Youth Centre, School of Nursing, University of British Columbia.

Sheperd, S. 'She Her Hers': Pronoun Pins Handed Out at University of Kansas. NBC News. Image retrieved March 20, 2017 from: <https://www.nbcnews.com/feature/nbc-out/she-her-hers-pronoun-pins-handed-out-university-kansas-n700971>

Sood, A. B., & Martel, A. L. (2015). Failures in campus mental health systems: Lessons from Virginia Tech.

Stepanikova, I., & Oates, G. R. (2017). Perceived Discrimination and Privilege in Health Care: The Role of Socioeconomic Status and Race. American journal of preventive medicine, 52(1), S86-S94.

US Department of Health and Human Services. (2001). “Chapter 2: Culture Counts: The Influence of Culture and Society on Mental Health.” Mental health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

Vaccaro, A., & Mena, J. A. (2011). It's Not Burnout, it's More: Queer College Activists of Color and Mental Health. Journal of Gay & Lesbian Mental Health, 15(4), 339-367.

1. IRB number 17-2626. [↑](#footnote-ref-1)
2. Safezone is a three hour training module for UNC Students and Faculty, and staff that provides educational material about being an ally to LGBTQIA community members. Staff and faculty who have completed the training often post a certificate of completion on the door of their office. [↑](#footnote-ref-2)