

2013

## The influence of selected perceptual and demographic characteristics on the attitude toward mental health of students among faculty a public universities in the Southeastern United States

Shannon Kuehne Walsdorf

*Louisiana State University and Agricultural and Mechanical College*

Follow this and additional works at: [https://digitalcommons.lsu.edu/gradschool\\_dissertations](https://digitalcommons.lsu.edu/gradschool_dissertations)



Part of the [Human Resources Management Commons](#)

---

### Recommended Citation

Walsdorf, Shannon Kuehne, "The influence of selected perceptual and demographic characteristics on the attitude toward mental health of students among faculty a public universities in the Southeastern United States" (2013). *LSU Doctoral Dissertations*. 1361.

[https://digitalcommons.lsu.edu/gradschool\\_dissertations/1361](https://digitalcommons.lsu.edu/gradschool_dissertations/1361)

This Dissertation is brought to you for free and open access by the Graduate School at LSU Digital Commons. It has been accepted for inclusion in LSU Doctoral Dissertations by an authorized graduate school editor of LSU Digital Commons. For more information, please contact [gradetd@lsu.edu](mailto:gradetd@lsu.edu).

THE INFLUENCE OF SELECTED PERCEPTUAL AND DEMOGRAPHIC  
CHARACTERISTICS ON THE ATTITUDE TOWARD MENTAL HEALTH OF STUDENTS  
AMONG FACULTY AT PUBLIC UNIVERSITIES IN THE  
SOUTHEASTERN UNITED STATES

A Dissertation

Submitted to the Graduate Faculty of the  
Louisiana State University and  
Agricultural and Mechanical College  
in partial fulfillment of the  
requirements for the degree of  
Doctor of Philosophy

in

The School of Human Resource Education  
And Workforce Development

by

Shannon Kuehne Walsdorf  
B. S. Louisiana State University, 2008  
M.S.W. Louisiana State University, 2010  
May 2013

© Copyright 2013  
Shannon Walsdorf  
All Rights Reserved

## **DEDICATION**

This dissertation is dedicated to my son, Jax. Half of this dissertation was typed with you in my belly and the other half was typed with you in my left arm while I attempted to type using only my right. When I felt like giving up your kicks were my cheers of encouragement and when I was trying to finish your smiles were my motivation. Completing my Ph.D. was challenging and there were many times I doubted myself. I hope my completion of this degree shows you (and any future siblings you may have) that with hard work and determination, anything is possible. This accomplishment is a dream come true, but you are my best dream come true.

## **ACKNOWLEDGEMENTS**

This degree would not have been possible without so many amazing people that have blessed my life. First I would like to thank my committee members. Dr. Burnett, choosing you as my major professor was the best decision I made in this program. I don't know how you did it but I felt like your top priority throughout this process even though I know your plate was overflowing. I could not have done this without your confidence, support, and guidance. Dr. Machtmes, thank you for your support and encouragement. Your confidence in me and my work meant so much to me. Dr. Johnson, thank you for your wonderful feedback and for showing a genuine interest in my topic and this study. You gave me confidence that what I was working towards was worth the effort. Dr. Allen, thank you for your time and active participation in our discussions.

Brittany, I am so thankful that I have been able to share this experience with you. You have been a great friend and I am so happy we get to graduate together for a third time. Mom and Dad, thank you for raising me with the slightly unrealistic belief that I could do anything. Your belief in me has allowed me to dream big and never settle. My life today is more amazing than I ever could have imagined it could be because of you. Ian, I would actually like to thank you for consistently reminding me that completing this degree was something I wanted to do and not something I had to do. You have always wanted whatever makes me happy and supported every decision I have made. I could not have designed a better partner for myself and I love you and our little family so much.

## TABLE OF CONTENTS

ACKNOWLEDGEMENTS .....	iv
LIST OF TABLES .....	vi
LIST OF FIGURES .....	xii
ABSTRACT .....	xiii
CHAPTER	
1     INTRODCUTION .....	1
2     REVIEW OF RELATED LITERATURE .....	11
3     METHODS .....	41
4     FINDINGS/RESULTS .....	49
5     SUMMARY, CONCLUSIONS, IMPLICATIONS, & RECOMMENDATIONS .....	157
REFERENCES .....	187
APPENDIX A: INSTRUMENT .....	193
APPENDIX B: LOUISIANA STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) FOR PROTECTION OF HUMAN SUBJECTS .....	200
VITA .....	201

## LIST OF TABLES

1. Age of Currently Employed Faculty of Faculty of Four Year Public Universities .....	50
2. Race/Ethnicity of Currently Employed Faculty of Faculty of Four Year Public Universities .....	51
3. Years of Experience of Currently Employed Faculty of Faculty of Four Year Public Universities .....	52
4. Employment Status of Currently Employed Faculty of Faculty of Four Year Public Universities .....	52
5. Rank of Currently Employed Faculty of Faculty of Four Year Public Universities .....	53
6. Actual Job Duties of Currently Employed Faculty of Faculty of Four Year Public Universities .....	54
7. Typical Class Size of Currently Employed Faculty of Faculty of Four Year Public Universities .....	54
8. College/Department of Currently Employed Faculty of Faculty of Four Year Public Universities .....	55
9. Mental Health Experience of Currently Employed Faculty of Faculty of Four Year Public Universities .....	55
10. Self-Rating of Knowledge of Campus Mental Health Available to Students by Currently Employed Faculty of Four Year Public Universities .....	57
11. Attitude towards Mental Health of Currently Employed Faculty of Faculty of Four Year Public Universities .....	58
12. Factor Analysis of Responses to “Attitude towards Mental Health” Scale of Currently Employed Faculty of Faculty of Four Year Public Universities .....	60
13. Willingness to Help Students with Mental Health Issues of Currently Employed Faculty of Faculty of Four Year Public Universities .....	62
14. Factor Analysis of Responses to “Willingness to Help Students with Mental Health Issues” Scale of Currently Employed Faculty of Faculty of Four Year Public Universities .....	64
15. Ability to Identify Students with Mental Health Issue of Currently Employed Faculty of Four Year Public Universities .....	66

16. Factor Analysis of Responses to “Ability to Identify Students with Mental Health Issues” Scale of Currently Employed Faculty of Four Year Public Universities .....	68
17. Responses to Vignette One: Long-Term Depression by Currently Employed Faculty of Four Year Public Universities .....	70
18. Faculty Responses to Vignette Two: Unable to Eat or Sleep by Currently Employed Faculty of Four Year Public Universities .....	71
19. Faculty Responses to Vignette Three: Death of a Parent by Currently Employed Faculty of Four Year Public Universities .....	71
20. Faculty Responses to Vignette Four: Threatening Suicide by Currently Employed Faculty of Four Year Public Universities .....	72
21. Faculty Responses to Vignette Five: Unconcerned About Grades by Currently Employed Faculty of Four Year Public Universities .....	72
22. Accuracy of Responses to Items Measuring Faculty Ability to Help Students with Mental Health Issues of Currently Employed Faculty of Four Year Public Universities .....	73
23. “Ability to Help Students with Mental Health Issues” Scores of Currently Employed Faculty of Four Year Public Universities .....	75
24. Comparison of “Attitude toward Mental Health” Scale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty Members of Four Year Public Universities .....	76
25. Comparison of “Attitude toward Mental Health” Scale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	78
26. Comparison of “Attitude toward Mental Health” Scale Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity .....	79
27. Comparison of “Attitude toward Mental Health” Scale Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Department .....	80
28. Comparison of “Attitude toward Mental Health” Scale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty Members of Four Year Public Universities .....	81



29. Comparison of “Willingness to Help Students with Mental Health Issues – Involvement” Subscale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty Members of Four Year Public Universities .....	82
30. Comparison of “Willingness to Help Students with Mental Health Issues – Involvement” Subscale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	85
31. Comparison of “Willingness to Help Students with Mental Health Issues - Involvement” Subscale Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity .....	86
32. Comparison of “Willingness to Help Students with Mental Health Issues – Involvement” Subscale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	87
33. Comparison of “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	88
34. Comparison of “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	91
35. Comparison of “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	92
36. Comparison of “Ability to Identify Students with Mental Health Issues- Related Issues” Subscale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	94
37. Comparison of “Ability to Identify Students with Mental Health Issues- Related Issues” Subscale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	96
38. Comparison of “Ability to Identify Students with Mental Health Issues – Related Issues” Subscale Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity .....	97

39. Comparison of “Ability to Identify Students with Mental Health Issues – Related Issues” Subscale Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Department .....	98
40. Comparison of “Ability to Identify Students with Mental Health Issues- Related Issues” Subscale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	99
41. Comparison of “Ability to Identify Students with Mental Health Issues- Emotions” Subscale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	100
42. Comparison of “Ability to Identify Students with Mental Health Issues- Emotions” Subscale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	102
43. Comparison of “Ability to Identify Students with Mental Health Issues – Emotions” Subscale Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity .....	103
44. Comparison of “Ability to Identify Students with Mental Health Issues- Emotions” Subscale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	104
45. Comparison of “Ability to Help Students with Mental Health Issues” Scale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	105
46. Comparison of “Ability to Help Students with Mental Health Issues” Scale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	108
47. Comparison of “Ability to Help Students with Mental Health Issues” Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity .....	109
48. Comparison of “Ability to Help Students with Mental Health Issues” Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Department .....	109

49. Comparison of “Ability to Help Students with Mental Health Issues” Scale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities .....	110
50. Relationship Between “Attitude toward Mental Health” and Other Selected Perceptual Measures of Currently Employed Faculty of Four Year Public Universities .....	112
51. Relationship Between “Willingness to Help Students with Mental Health Issues – Involvement” Subscale and Other Selected Perceptual Measures of Currently Employed Faculty of Four Year Public Universities .....	114
52. Relationship Between “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale and Other Selected Perceptual Measures of Currently Employed Faculty of Four Year Public Universities .....	115
53. Relationship Between Selected Demographic Characteristics and “Attitude toward Mental Health” Scale Scores Among Currently Employed Faculty Members of Four Year Public Universities .....	122
54. Multiple Regression Analysis of “Attitude toward Mental Health” Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities .....	125
55. Relationship Between Selected Demographic Characteristics and “Willingness to Help Students with Mental Health Issues - Involvement” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities .....	128
56. Multiple Regression Analysis of “Willingness to Help Students with Mental Health Issues - Involvement” Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities .....	130
57. Relationship Between Selected Demographic Characteristics and “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities .....	134
58. Multiple Regression Analysis of “Willingness to Help Students with Mental Health Issues – Faculty Role” Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities .....	136
59. Relationship Between Selected Demographic Characteristics and “Ability to Identify Students with Mental Health Issues – Related Issues” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities .....	140

60. Multiple Regression Analysis of “Ability to Identify Students with Mental Health Issues – Related Issues” Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities .....	143
61. Relationship Between Selected Demographic Characteristics and “Ability to Identify Students with Mental Health Issues – Emotions” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities .....	146
62. Multiple Regression Analysis of “Ability to Identify Students with Mental Health Issues – Emotions” Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities .....	148
63. Relationship Between Selected Demographic Characteristics and “Ability to Help Students with Mental Health Issues” Scale Scores Among Currently Employed Faculty Members of Four Year Public Universities .....	151
64. Multiple Regression Analysis of “Ability to Help Students with Mental Health Issues” Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities .....	153

## **LIST OF FIGURES**

1. Conceptual framework .....	11
-------------------------------	----

## **ABSTRACT**

The primary purpose of this study was to determine the influence of selected personal and professional demographic characteristics on the attitudes toward and perceptions of selected mental health issues among currently employed faculty of four year public universities. Faculty members at two universities in Southeastern Louisiana were invited to participate in an online survey designed by the researcher to assess attitude toward mental health, willingness to help students with mental health issues, ability to identify students with mental health issues, ability to help students with mental health issues, along with a variety of personal and professional demographic characteristics. A total of 281 faculty members participated in the study and 261 provided usable responses.

Overall, faculty members in this study demonstrated positive attitudes towards mental health and a willingness to help students with mental health issues. Also, this study found that previous mental health training was significantly, positively correlated with attitude toward mental health, willingness to help students with mental health issues, ability to identify students with mental health issues, and ability to help students with mental health issues. Furthermore the majority of participants indicated that they did not believe that their university was doing enough to address student mental health concerns or to ensure faculty members were aware of mental health services available to students.

Based on these findings the researcher concluded that faculty members are willing to participate in addressing student mental health concerns and those that are trained are best able to help. The researcher recommends that universities invest in developing training programs for faculty members covering various mental health topics. Although at least a portion of this training should be part of an annual requirement for all faculty members, universities should also

give faculty access to additional, online mental health training which they can choose to utilize. Furthermore, the researcher recommends that universities develop a hotline for faculty members so that they are able to reach university mental health professionals at all hours in the event of student mental health emergencies.

## **CHAPTER 1 INTRODUCTION**

### **Rationale**

Mental health is a major issue in society today and impacts almost every aspect of daily life. Mental health was defined by the World Health Organization (WHO) (2001) as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community,” (para. 2). Mental illnesses, on the other hand, are defined by the National Alliance on Mental Illness (NAMI) (2012) as “medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning” (para. 1). This breakdown in coping can take the form of any one of many mental health diagnoses listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM). Of these diagnoses, major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD), and borderline personality disorder are referred to as “serious mental illnesses” (NAMI, 2012, para. 2). Approximately 6% of Americans today are living with a serious mental illness and even more are living with less severe mental illnesses (NAMI, 2012).

Not only do these mental illnesses impact the lives of those living with these conditions, they also impact society in general. According to the National Institute of Mental Health (NIMH) (2003), the Substance Abuse and Mental Health Services Administration (SAMHSA) estimates that \$100 billion was spent on mental healthcare in 2002 and \$1.6 trillion was spent on all medical services in the same year. This means that mental health represented 6.2% of the total healthcare cost in the United States in 2002 (NIMH, 2003). NAMI (2012) warned, however, that the real cost to consider may be the cost of untreated mental illness. They estimate the annual



cost of untreated mental illness to be more than \$100 billion due to things like “unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives” (NAMI, 2012, para. 9).

One population that is vulnerable to the development of mental health issues is college students. NAMI (2006) explained that the age range most college students fall into, 18-24, is also the same age range as the typical onset of serious mental illness. The college years, in fact, “can be a crucial time to diagnose and treat young people in the early stages of mental illness” (NAMI, 2006, para. 2). Recent, high-profile events such as the suicide of Elizabeth Shin at MIT and the killings and suicide of Seung-Hui Cho at Virginia Tech have shed new light on the importance of mental health in this population (Mier, Boone, & Shropshire, 2009).

The importance of mental health services for this population has long been established. According to Kraft (2011) the first mental health service was established at Princeton in 1910 to address the apparent problem of academically capable students dropping out of school prematurely. Today most higher education institutions have some form of mental health treatment available to students (Suicide Prevention Resource Center [SPRC], 2004). The National Survey of Counseling Center Directors regularly collects data from many of these mental health centers. According to the 2005 National Survey of Counseling Center Directors, approximately 9% of students utilize counseling services (Gallagher, 2005). That is not to say that only 9% of students are in need of mental health services; Mier, Boone, and Shropshire (2009) explain, “college counseling centers see only a small percentage of students who could benefit from their services” (p. 18). Furthermore, even though campus mental health centers only see a small portion of students who are in need of their services, most still struggle to keep up with the number of students who are accessing services (Chung et al., 2011).

Arguably the most serious consequence of mental illness is suicide which is the third leading cause of death among 15-24 year olds, behind accidents and homicide (American Association of Suicidology [AAS], 2012b). As WHO (2002) pointed out, however, it is highly possible that the suicide rate is underestimated because of deaths resulting from suicide being reported or documented incorrectly, often as accidents. The directors participating in the 2005 National Survey of Counseling Center Directors reported 154 student suicides in the past year (Gallagher, 2005). Additionally, it is estimated that for every completed suicide in this age group there may be as many as 100-200 attempts (AAS, 2012a). The Center for Disease Control and Prevention (CDC) (2009) sheds further light on the depth of the problem, explaining that “each year, approximately 149,000 youth between the ages of 10 and 24 receive medical care for self-inflicted injuries at Emergency Departments across the U.S.” (para. 2).

According to the 2005 National Survey of Counseling Center Directors 90.3% of directors believe that there has been a recent increase in the number of students with severe psychological problems (Gallagher, 2005). Cook (2007) explained that the prevalence of mental illnesses on college campuses may be due to the fact that “most college students are in the highest risk age group (18 to 25) for the manifestation of symptoms of some of the more common mental health disorders, such as depression, schizophrenia, anxiety, and substance abuse problems” (p. 41). Furthermore, Kraft (2009) asserted that advances in and the widespread use of psychotropic medications may have led to a recent increase in the number of students with mental illnesses that are able to enter college and, therefore, an increase in the number of college students with mental illnesses. Directors reported a rate of about 42.8% of clients with severe psychological problems, 8.5% who cannot remain in school due to these problems and 34.5% who can remain in school with appropriate treatment (Gallagher, 2005).

With the strong presence of mental illnesses on college campuses both risk and protective factors must be considered. Áegisdóttir, O’Heron, Hartong, Haynes, and Linville (2011) reported that “at least three factors have been identified as hindering college student mental health treatment-seeking: negative attitudes towards seeking help, treatment fears, and worries about the associated stigma” (p. 329). Áegisdóttir et al. (2011) recommend discussing these fears of stigma with clients at the start of treatment but, obviously, this would only help those who have already begun treatment.

NAMI (2012) reports that “early identification and treatment is of vital importance; By ensuring access to the treatment and recovery supports that are proven effective, recovery is accelerated and the further harm related to the course of illness is minimized” (para. 12). Therefore, one possible protective factor could be simply the awareness of campus mental health services. According to NAMI (2004), about half of students reported that they never received any information on mental health from their universities. Furthermore, less than 50% of counseling center directors believe that their schools provide adequate information about suicide and student support programs (Gallagher, 2005).

This information begs the question, who else in the campus community can assist in identifying and referring students in need of mental health services? Klein, Ciotoli, and Chung (2011) and Chung et al. (2011) looked at the role of campus primary care physicians in this endeavor. Another possibility, however, is faculty. Although it is true that most campus faculty are not trained mental health professionals, Cukrowicz et al. (2011) report that “many gatekeepers to mental health services on college campuses are not likely to have training in the identification of depression and other risk factors for suicide” (p. 580). The American Association of Suicidology (AAS) (2012a) reports that “the vast majority of individuals who are

suicidal often display cues and warning signs” (p. 3). The Cleveland Clinic (1995) listed the following warning signs of emotional stress on their website: apathy, difficulty making decisions, difficulty “keeping track” of things, feeling on edge, change in eating habits, change in sleep pattern, increased emotionality, and increased use of drugs or alcohol. They go on to also point out certain behavioral changes that may be easily recognized by college faculty in certain circumstances such as marked decline in school performance, increased anxiety, inability to cope with the demands of life, irrational fears, persistent physical ailments/complaints, self-mutilation or destructive behavior, and withdrawn mood (Cleveland Clinic, 1995). This means that there are things that faculty can be trained to look for when attempting to identify mentally ill or suicidal students. Furthermore some students struggling with mental health may actually reach out for help from faculty on their own (Virginia Tech Cook Counseling Center, n.d.).

Mier et al. (2009) urged “it is imperative to have outreach programs that utilize their entire campus community as essential resources for helping students who might be vulnerable to emotional and/or psychological difficulties who otherwise may not initiate coming into the counseling center on their own” (p. 19). Faculty, as a part of the campus community, could be an untapped resource in campus initiatives to combat the damaging effects of mental illness on college campuses. Although faculty are not trained clinicians and should not be the end of the line for students struggling with mental health issues, they can be another helpful link in the chain of campus resources, directing students to needed help.

### **Purpose Statement**

The primary purpose of this study was to determine the influence of selected personal and professional demographic characteristics on the attitudes toward and perceptions of selected mental health issues among currently employed faculty of four year public universities.

## Objectives

1. To describe currently employed faculty of four year public universities on the following personal and professional demographic characteristics:
  - a. Age
  - b. Gender
  - c. Race/Ethnicity
  - d. University
  - e. Years of experience as a faculty member
  - f. Employment status
  - g. Faculty rank
  - h. Actual job duties
  - i. Typical class size
  - j. College/Department
  - k. Mental health experience
  - l. Knowledge of university mental health services available to students
  - m. Beliefs about university's role in mental health services
2. To describe currently employed faculty of four year public universities on their attitude toward mental health as measured by a researcher-designed scale.
3. To describe currently employed faculty of four year public universities on their willingness to help students with mental health issues as measured by a researcher-designed scale.
4. To describe currently employed faculty of four year universities on their ability to identify students with mental health issues as measured by a researcher-designed scale.

5. To describe currently employed faculty of four year universities on their ability to help students with mental health issues as measured by a researcher-designed scale.
6. To determine if a relationship exists between selected personal and professional demographic characteristics of currently employed faculty of four year public universities and the following perceptual measures:
  - a. Attitude toward mental health
  - b. Willingness to help students with mental health issues
  - c. Ability to identify students with mental health issues, and
  - d. Ability to help students with mental health issues.
7. To determine if a relationship exists between attitude toward mental health among currently employed faculty of four year public universities and the following perceptual measures:
  - a. Willingness to help students with mental health issues
  - b. Ability to identify students with mental health issues, and
  - c. Ability to help students with mental health issues.
8. To determine if a relationship exists between willingness to help students with mental health issues among currently employed faculty of four year public universities and the following perceptual measures:
  - a. Ability to identify students with mental health issues, and
  - b. Ability to help students with mental health issues.
9. To determine if a relationship exists between ability to identify students with mental health issues among currently employed faculty of four year public universities and ability to help students with mental health issues.

10. To determine if a model exists explaining a significant portion of the variance in attitudes toward and perceptions of selected mental health issues among currently employed faculty of four year public universities from the following personal and professional demographic characteristics:
- a. Age
  - b. Gender
  - c. Race/Ethnicity
  - d. University
  - e. Years of experience as a faculty member
  - f. Employment status
  - g. Faculty rank
  - h. Actual job duties
  - i. Typical class size
  - j. College/Department
  - k. Mental health experience
  - l. Knowledge of university mental health services available to students
  - m. Beliefs about university's role in mental health services

### **Significance of the Study**

Recent high-profile suicides of university students like that of Elizabeth Shin at M.I.T. and the shooting spree and suicide of Seung Hui Cho at Virginia Tech have thrust the importance of campus mental health intervention in the spotlight (Mier et al., 2009). Experts recommended utilizing the entire campus community in this effort (Mier et al., 2009). Faculty, as part of the campus community, may be seen as “gatekeepers” to campus mental health services, yet many

gatekeepers in the campus community, including faculty, are unlikely to have necessary training on identification of warning signs of mental health issues (Cukrowicz et al., 2011).

Without providing training to faculty on what to look for and what to do when helping students with mental health concerns, mistakes are possible if not likely. These mistakes put students and sometimes the entire campus community at risk. The intention of this study is not to offer solutions but to uncover possible barriers to faculty being effective gatekeepers to mental health services in college communities. Their attitudes towards or personal beliefs about mental illness may prevent them from offering help when necessary, their belief about their role as a faculty member of the university may prevent them from getting involved in mental health concerns in general, and finally their lack of knowledge on what to look for and what to do in these situations may lead them to make mistakes that could further jeopardize student safety or well-being. This study seeks to find if these issues truly are barriers to faculty being effective gatekeepers to campus mental health services.

### **Definition of Terms**

- Mental Health – “A state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (World Health Organization, 2010, para. 1)
- Mental Illnesses - “Medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning” (National Alliance on Mental Illness, 2012, para. 1)



- Postvention - “The prevention measures implemented after a crisis or traumatic event to reduce the risk for suicide to those who have witnessed or been affected by the tragedy” (SPRC, n.d., p. 7)
- Stigma - “A socially constructed mark of disapproval, shame or disgrace that causes significant disadvantage through curtailment of opportunities” (Martin, 2010, p. 261)

## CHAPTER 2: REVIEW OF RELATED LITERATURE

Figure 1 presents a conceptual framework that guides this research study.

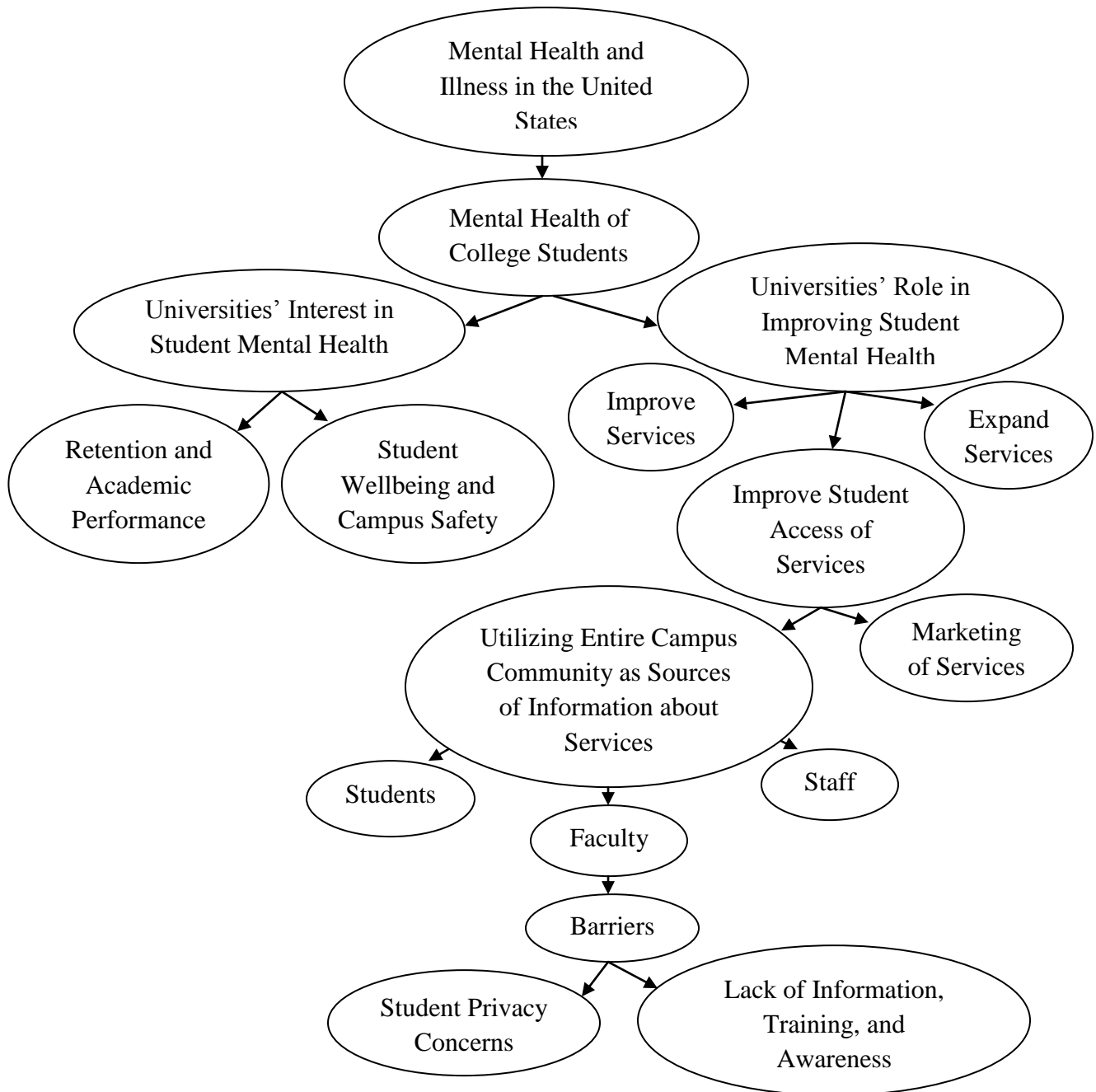


Figure 1. Conceptual framework.

## **Mental Health and Illness in the United States**

Mental illness is a major problem in the world today (Centers for Disease Control and Prevention [CDC], 2011a, 2011b; NAMI, 2004, 2006, 2012; WHO, 2010). Although the terms “mental health” and “mental illness” are frequently used in conjunction, they are also often mistakenly used synonymously. It is important to have an awareness of the differences between these two terms. NAMI (2012) defined mental illnesses as “medical conditions that disrupt a person’s thinking, feeling, mood, ability to relate to others and daily functioning” (para. 1).

Another definition offered by the CDC (2011b) reads as follows:

The term mental illness refers collectively to all diagnosable mental disorders. Effects of the illness include sustained abnormal alterations in thinking, mood, or behavior associated with distress and impaired functioning. The effects of mental illness include disruptions of daily function; incapacitating personal, social, and occupational impairment; and premature death. (para. 3)

Mental health, on the other hand, was defined by WHO (2010) as “a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community” (para. 2).

Taking the view of mental health as being self-defined, Keyes et al. (2012) explained, “Mental health is conceived of as subjective well-being: individuals’ evaluations of how good they feel about and how well they see themselves functioning in life” (p. 126). It is important to note that a vital distinction between mental health and mental illness that is commonly missed is that mental health is not simply the absence of mental illness (Keyes et al., 2012; WHO, 2010). In fact, studies have found that there are far more people without mental illnesses than there are people that are mentally healthy (Keyes et al., 2012). Generally people are more familiar with the term mental illness rather than mental health because more time and resources are generally devoted

to the diagnosis and treatment of mental illnesses rather than the promotion of mental health (CDC, 2011a).

WHO (2010) stated “multiple social, psychological, and biological factors determine the level of mental health of a person at any point in time” (para. 3). WHO (2010) reported that more than 450 million people are currently struggling with diagnosable mental illnesses and many more have mental problems. In the United States, approximately one in four adults have a mental illness (CDC, 2011b). The burden of these prevalence rates is not concentrated on any distinct population. NAMI (2012) explained, “Mental illnesses can affect persons of any age, race, religion, or income” (para. 3).

The burden of severity, however, is placed upon a small group. NAMI (2012) reported that 1 in 17 or 6% of Americans live with a serious mental illness. As with many medical conditions such as autism and cerebral palsy, mental disorders fall along a continuum of severity (NAMI, 2012). According to NAMI (2012), “Serious mental illnesses include major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder”(para. 2). The most common mental disorders, however, are anxiety and depression (Sanderson & Andrews, 2006).

Perhaps the most severe consequence of mental illness is suicide and violence (CDC, 2011b). CDC (2011b) reported that “rates for both intentional (e.g., homicide, suicide) and unintentional (e.g., motor vehicle) injuries are two to six times higher among people with a mental illness than in the population overall” (para. 7). Overall, suicide is the 10th leading cause of death in the United States (American Association of Suicidology [AAS], 2012a, 2012b). In fact, suicide outranks homicide which is the 15<sup>th</sup> leading cause of death among all age groups in the United States (AAS, 2012b). In 2009, the last year for which suicide data is currently

published, there were 36,909 suicides in the United States (AAS, 2012a, 2012b). This equates to one suicide approximately every 14 minutes in that year (AAS, 2012a, 2012b).

It is important to note that this suicide rate only represents the number of suicides that were officially ruled as suicides. WHO (2002) explained, “Data on mortality from suicide usually underestimate the true prevalence of suicide in a population” (p. 189). Sometimes suicide deaths can be mistakenly ruled as something other than suicide (WHO, 2002). This can be because it was deliberately made to look like an accident by the person completing suicide, and sometimes it can be falsely documented as a suicide so as to protect the person or person’s family from the stigma associated with suicide (WHO, 2002). Finally, some laws actually cause suicides to be registered as other types of death (WHO, 2002). For example, if someone were to overdose and die days later their cause of death may be listed as heart failure or brain damage instead of suicide even though this heart or brain damage was caused by a suicidal act.

Psychological autopsies reveal that more than 90% of people who complete suicide had diagnosable mental illnesses (AAS, 2012a). This does not mean that 90% of people who complete suicide were diagnosed, it just means they could have met criteria for diagnosis had they sought out diagnosis or treatment. Experts estimate that there are as many as 25 attempts for every completed suicide for the general population of the United States (AAS, 2012a, 2012b). If this is true, that means that there could have been approximately 922,725 suicide attempts in the United States in 2009, although this figure could represent multiple attempts by the same people.

Another way to consider the consequences of mental illness in the United States is to look at the economic burden of mental illnesses, which the CDC (2011b) estimated to be \$300 billion in 2002. In 2002, \$1.6 trillion was spent on medical expenditures in the United States (NIMH, 2003). Of this, \$100 billion, 6.2%, was spent on mental health care (NIMH, 2003). In

2006, the U.S. population reached 300 million (Cable News Network [CNN], 2006). In this same year, NIMH (2006) reported that the average expenditure per person on mental healthcare was \$1,591.

In addition to the cost of mental healthcare in the United States, much of the economic burden of mental illnesses is related to the workplace (Dewa, McDaid, & Ettner, 2007; Greenberg et al., 2003; Sanderson & Andrews, 2006). Dewa et al. (2007) stated, “There is growing awareness that mental and emotional health problems are associated with staggering social and economic costs that place a heavy burden on the workplace” (p. 347). In fact, one of the major consequences of mental illness with a great deal of economic impact is unemployment (Dewa et al., 2007). Dewa et al. (2007) stated:

Although a large proportion of the burden of unemployment falls on individuals with mental illness and their families, the costs to government are also substantial, owing both to losses in income tax revenues and to increased use of the public ‘safety net’ which leads to higher expenditures on unemployment benefits, disability insurance, welfare programs, and in more industrialized countries, health care. (pp. 347-348)

In other words, although many people in the United States may not think they are personally impacted by mental illness because they themselves do not have mental health issues or they do not know anyone struggling with mental health issues, they are still impacted by the economic consequences of mental illness through their taxes and healthcare costs. NAMI (2012) explained that “without treatment the consequences of mental illness for the individual and society are staggering: unnecessary disability, unemployment, substance abuse, homelessness, inappropriate incarceration, suicide and wasted lives” (para. 9). Dewa et al. (2007) pointed out that disability benefits often work as a disincentive for people with mental illness to return to work while Sanderson and Andrews (2006) argued that people with untreated mental illness remaining in the workplace despite their conditions also represent a major negative economic

impact caused by mental illness. Greenberg et al. (2003) studied the economic burden of depression in the workplace across 10 years, 1990 to 2000, and found that while the cost remained relatively stable, money spent on treatment increased substantially, possibly highlighting a trend toward the lessening of the negative impact of mental illness in the workplace in the future. Evidence suggests that many of these mental health issues begin in young adulthood, often during a person's college years (Cook, 2007; Martin, 2010; NAMI, 2006, 2012).

### **Mental Health of College Students**

The transition from high school to college can be a very stressful event in the lives of young people (Reynolds et al., 2011; SPRC, 2004). SPRC (2004) stated, "Major life transitions – such as leaving home and going to college – may exacerbate existing psychological difficulties or trigger new ones. Moreover, leaving family and peer supports to enter an unfamiliar environment with higher academic standards can deepen depression or heighten anxiety," (p. 8). Even older students and graduate students returning to school seem to experience great amounts of stress related to their transition back into school (SPRC, 2004). Cook (2007) reported that sometimes this stress can become overwhelming and cause students to choose negative coping mechanisms such as alcohol and substance abuse when they are unable to find an effective positive coping mechanism. Another possible negative outcome of this stress is mental illness such as depression (Reynolds et al., 2011).

Chung et al. (2011) warned, "Depression and other mental disorders present common and significant health and educational risk factors for university students" (p. 628). According to NAMI (2004) 50% of students rate their mental health as below average to poor. In fact the American College Health Association (ACHA) (2012) found that within a 12-month time span,

12% of students reported being diagnosed with or treated for anxiety, 11.1% reported being diagnosed with or treated for depression, 5.6 % reported being diagnosed with or treated for panic attacks, 1.5% reported being diagnosed with or treated for bipolar disorder, and 0.2% reported being diagnosed with or treated for schizophrenia. Furthermore, 7.3% of students reported being treated for a combination of depression and anxiety within the last 12 months (ACHA, 2012). Cook (2007) stated, “Common mental health problems in college-aged students include depression, anxiety, eating disorders, alcohol and other substance abuse problems, suicide, self-mutilation, and various other self-destructive and reckless behaviors” (p. 41).

One possible explanation for the prevalence of mental health issues on college campuses has to do with the typical age of college students and the typical age at which many mental illnesses present themselves (Cook, 2007; Leavitt, Spellings & Gonzales, 2007; Martin, 2010; NAMI, 2006, 2012). Cook (2007) pointed out that “most college students are in the highest risk age group (18 to 25) for the manifestation of symptoms of some of the more common mental health disorders, such as depression, schizophrenia, anxiety, and substance abuse problems,” (p. 41). NAMI (2006) similarly warned “the college years (typically 18 to 24 years of age) also coincide with the age of onset for serious mental illnesses and can be a crucial time to diagnose and treat young people in the early stages of mental illness” (para. 2).

A recent trend that many researchers are taking a look at is the apparent increase in the number of students with mental illnesses in school (Cook, 2007; Gallagher, 2005; Kraft, 2009; Leavitt et al., 2007; Osberg, 2004). Additionally, there is also evidence pointing towards increased severity of the mental health problems of college students (Cook, 2007; Gallagher, 2005; Kraft, 2009; Osberg, 2004). One study that took a look at these trends is Benton,



Robertson, Tseng, Newton, and Benton's (2003) study entitled "Changes in Counseling Center Client Problems Across 13 Years." Benton et al. (2003) found the following:

Overall our results indicated that students who were seen in counseling services in more recent time periods frequently have more complex problems that include both normal college student problems, such as difficulties in relationships and developmental issues, as well as the more severe problems, such as anxiety, depression, suicidal ideation, sexual assault, and personality disorders. Some of the increases were dramatic: The number of students seen each year with depression doubled over the time period, while the number of suicidal students tripled and the number seen after sexual assault quadrupled. (pp. 69-70)

Researchers proposed that advances in medication and treatment of mental illnesses may explain this apparent worsening of college student mental health (Kraft, 2009; Leavitt et al., 2007). Leavitt et al. (2007) contended that these advances have led to a higher concentration of students with mental illnesses on college campuses than ever before. Kraft (2009) reported, "The use of antipsychotic and mood stabilizing medications has allowed many students to remain in or return to school to complete their education. In earlier times, many such students would have dropped out" (p. 273). Evidence of this trend has also been reported by directors. According to Gallagher (2005), 95% of directors reported an increase of students coming in for services already on psychiatric medication and Benton et al. (2003) found an increase in the number of counseling center clients on medication over 13 years, from 10% to 25%.

### **Universities' Interest in Student Mental Health**

**Retention and academic performance.** Although mental health problems are prevalent on many college campuses, most of these issues can be managed successfully with appropriate treatment (CDC, 2011b; NAMI, 2006, 2012). According to Gallagher (2005), directors reported that 34.5% of their clients have severe psychological problems that can be treated successfully with treatment available to students while 8.5% have impairment that is so severe that they cannot remain in school using only treatment ordinarily available to students. Cook (2007)

warned, “Left unrecognized and untreated, mental health problems may lead to students dropping out or failing out of college” (p. 44).

Timothy M. Osberg, Ph.D. (2004) authored an article entitled “A Business Case for Increasing College Mental Health Services: Increasing counseling services can increase student retention rates – and ultimately a college’s bottom line.” This article made a case for universities to look at investing in student mental health as an investment in their university (Osberg, 2004); in other words, that putting more money towards treating student mental health could ultimately financially benefit the university because of retention of students and their tuition dollars. Although this represents a relatively new way of thinking about the motivation for universities providing mental health services, this concept of investing in mental health to improve an organization’s bottom-line has been well studied in the workplace, specifically when discussing why so many companies offer employee assistance programs (EAPs) to their employees today.

Many studies have looked at the consequences of depression in employees (Harvard Medical School, 2010; Hilton, Schuffham, Vecchio, & Whiteford, 2010). Mental health problems and psychological distress have been found to be highly prevalent in the workforce (Harvard Medical School, 2010; Hilton et al., 2010). These mental health problems have been shown to be linked with reduced employee productivity (Dewa et al., 2007; Dewa, Thompson, & Jacobs, 2011; Haaz, Maynard, Petrica, & Williams, 2003; Hilton, Sheridan, Cleary, & Whiteford, 2009). Specifically, studies have generally focused on two aspects of employee productivity that are frequently impacted by mental health status: absenteeism, which is the number of days missed by employees, and presenteeism, which is essentially physically being at work but not being as productive and focused as employees without mental health issues (Dewa et al., 2007; Hilton et al., 2009).

One possible reason for the prevalence of mental health issues offered by researchers is changes in the nature of work environments over time (Dewa et al., 2007; Sanderson & Andrews, 2006). Dewa et al. (2007) explained, “Changes in the nature of work have created workplaces demanding a level of skills and training that may also create barriers to individuals with more severe mental health problems, poor work histories, and limited qualifications” (p. 348). Just as many workplaces become more demanding over time, so do universities which is why more mental distress is seen in older students (Silverman, Meyer, Sloane, Raffel, & Pratt, 1997). This is why looking at what has been effective in the workplace may be beneficial to addressing mental health issues at universities.

Dewa et al. (2011) stated, “One of the ways that employers have helped to decrease the impact of mental disorders is by providing employees access to health care services through health care benefits and services, such as EAPs” (p. 744). EAPs emerged in the 1940’s, originally to help employees struggling with alcoholism (Haaz et al., 2003). Haaz et al. (2003) offered the following definition of an EAP, as defined by the 1988 Association of Labor and Management Administration Board of Directors:

An EAP is a work-site based program designed to assist in the identification and resolution of productivity problems associated with employees impaired by health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal concerns which may adversely affect employee job performance. (p. 5)

Employee assistance programs today encompass an endless array of issues related to workplace performance (Haaz et al., 2003).

Studies looking at the effectiveness of EAPs have found that with treatment, employees struggling with mental health issues were able to be more productive than those with mental health issues that were not in treatment, although they were still less productive than those employees without mental health struggles all together (Hilton et al., 2010). Hilton et al. (2010)

wrote, “Given the current global and economic crisis with downturn in overall productivity and output, an investment in the mental health of employees may play a role in increasing company productivity” (p. 159). In other words, Hilton et al. (2010) and Harvard Medical School (2010) urged businesses to look at mental health services for employees as an investment in the company instead of simply a service to employees.

Just as EAPs are realistically an investment in the company, campus mental health services for students can be seen as an investment in the university. Osberg (2004) explained, “Because mental health problems are predictive of student retention, the expansion of counseling services has the potential to significantly impact a school’s bottom line. Improved retention will ultimately translate into additional and more stable tuition dollars” (pp. 35-36). According to Gallagher (2005), in fact, when clients were given evaluation forms, 54.6% report that mental health services allowed them to stay in school and 60% claim that their academic performance was improved because of services. Osberg (2004) reported that not only is mental health related to retention, but students receiving counseling services are much more likely to remain in school. Osberg (2004) urged universities to consider the following when weighing the costs and benefits of adding or expanding mental health services for students:

Administrators need to be reminded that adding counseling staff can positively impact a school’s bottom line. Every counseling position added at \$40,000 per year pays for itself if a counselor can help retain just two to three students who otherwise may have left. (p. 35)

**Student wellbeing and campus safety.** Recent highly publicized incidences of violence carried out by college students have drawn a lot of attention to the importance of mental health of college students and demand for improved services and policies from universities to prevent these tragedies (Knox & Roberts, 2005; Kraft, 2009; Mier, Boone, & Shropshire, 2009).

Examples include the suicide of MIT student Elizabeth Shin who set herself on fire in her dorm

room, the campus killing spree and suicide of Virginia Tech student Seung Hui-Cho, and the movie theater shooting carried out by James Holmes, a former student of the University of Colorado. These events along with others have forced universities to prioritize and evaluate their crisis response and prevention policies (Benton et al., 2003). Knox and Roberts (2005) explained, “Recent incidents of school violence have made it clear that being prepared for crises and their aftermath is today’s reality” (p. 93).

Suicide is the third leading cause of death for 15-24 year olds, behind accidents and homicides (AAS, 2012a, 2012b). In 2009, the last year for which there is published data on suicide rates, there were 4,371 suicides for this age group, approximately one suicide every two hours (AAS, 2012b). Furthermore, studies have shown that non-fatal suicidal behavior (e.g., suicide attempts that do not result in death) is most prevalent among young people (WHO, 2002). This is why it is estimated that there are as many as 100-200 attempts for every completed suicide for this age group (AAS, 2012a, 2012b). If this is true, then considering that there were 4,371 suicides among 15-24 year olds in 2009, there could have been as many as 874,200 attempts among this age group in that same year, although this number could reflect multiple attempts by the same young people (AAS, 2012b). According to the CDC (2009) approximately 149,000 youth between 10 and 24 are seen in emergency rooms each year for self-inflicted injuries; many more youth could either go to the emergency claiming an accident occurred or could not be seeking medical care at all for their self-inflicted injuries.

It is important to note that the data and statistics described above reflect all 15-24 year-olds in the United States, not only college students although many college students do fall into that age category. Silverman et al. (1997) set out to find out what the true suicide rate of college students specifically was in their study entitled The Big Ten Student Suicide Study. This study

took place from 1980-1990 at 12 Midwestern universities (Silverman et al., 1997). Ultimately, researchers found that the suicide rate of students on these campuses was half the national average for a matched sample by age, gender and race (Silverman et al., 1997). Additionally, other studies have found that the homicide rate is also much lower among college students (SPRC, 2004). Therefore, although the rate of suicide is lower for college students than the general population, it is actually the second leading cause of death among college students, out-ranking homicide (American Foundation for Suicide Prevention [AFSP], n.d.a).

One explanation for the reduced suicide rate of college students compared to the general population is because of the mental health services available to students on campus (Kraft, 2009; Silverman et al., 1997). With the increased prevalence and severity of mental health problems of college students, however, many university mental health centers struggle to keep up (Cook, 2007). SPRC (2004) warned, “There is clear evidence of increased incidence of depression among college students” (p. 6). According to the CDC (2011a) the risk of suicide is 50% higher in depressed individuals, meaning that with this increasing rate of depression there is also cause for concern about the rate of suicide among college students. Furthermore, suicide is not only completed by students struggling with depression (Cukrowicz et al., 2011); according to AAS (2012a) psychological autopsies show that approximately 90% of people who complete suicide have one or more mental disorders, meaning that 10% do not.

WHO (2002) urged universities to consider the following, “Since much published material and clinical experience show that a number of mental disorders are significantly associated with suicide, the early identification and appropriate treatment of these disorders is an important strategy for preventing suicide” (p. 199). The link between untreated mental illness and suicide has been well-established (AFSP, n.d.b). Universities may want to take a look at

their mental health services not only to address student suicide, but also campus violence and the effect these events have on other students. SPRC (2004) warned, “Suicide is the tip of an iceberg of mental health issues” (p. 6).

In the workplace, many studies have looked at how the mental health of employees struggling with mental illness affects their coworkers (Dewa et al., 2007). One such study found the following: “Workers do not work in isolation; they have the potential to affect their work environments. As they struggle with the symptoms of their disorders, coworkers and supervisors will also be affected” (Dewa et al., 2007, p. 351). Similarly, students struggling with their mental health may impact the campus environment (Chung et al., 2011). Chung et al. (2011) explain, “the impact of depression, suicide attempts, and completed suicides not only have serious consequences for these affected students, but also friends, family, faculty, and the campus community” (p. 628).

The term “postvention” was defined by SPRC (n.d.) as “the prevention measures implemented after a crisis or traumatic event to reduce the risk for suicide to those who have witnessed or been affected by the tragedy” (p. 7). Postvention services range widely, depending on the specific situation (SPRC, n.d.). AFSP (n.d.b) has even published a document entitled “Recommendations for Reporting on Suicide,” due to the negative impact on others that a suicide may cause. They reported that “more than 50 research studies worldwide have found that certain types of news coverage can increase the likelihood of suicide in vulnerable individuals” (AFSP, n.d.b, p. 1). They listed a number of dos and don’ts for media to use as guidelines following a suicide (AFSP, n.d.b).

The people closest to someone who completes suicide are referred to as “survivors” (AAS, 2012a, 2012b). AAS (2012a) stated, “The designation of ‘survivor of suicide’ refers to the

family members and friends who are impacted [by] the death of their loved one by suicide,” (p. 4). Researchers estimate that there are approximately six survivors for every completed suicide, meaning that there could be about 4.73 million “survivors” in the United States today (AAS, 2012a, 2012b). Considering the rate of suicide among college students, it is logically likely that many students on college campuses today are “survivors.”

The problem of college student suicide and violence is well-established (Kraft, 2009; Mier et al., 2009); How exactly to address this problem, however, remains a challenge for many universities. Leavitt et al. (2007) explained, “We can not maintain a free and open society and eliminate the possibility that violence in schools, offices, or malls will happen again” (p. 5). Leavitt et al. (2007) contended that the focus should be on minimizing the chance of these events occurring again.

### **Universities’ Role in Improving Student Mental Health**

The first college health program was established at Amherst College in 1861 (Kraft, 2009, 2011). These early medical services encouraged students to engage in physical exercise in order to avoid emotional problems (Kraft, 2011). Almost 50 years later, in 1910, the first mental health service was established at Princeton University (Kraft, 2011). This service was established by a psychiatrist, Stewart Paton, MD, to address the problem of academically capable students dropping out of Princeton because of emotional issues (Kraft, 2011). Many other universities followed in their footsteps, but campus mental health services really took off following two events, World War II and “baby boomers” entering college (Kraft, 2009, 2011). These events increased both the sheer number of students on campuses and the number of students in need of mental health services (Kraft 2009, 2011). Although early services were run by psychiatrists because the fields of psychology, social work, and counseling had not yet “taken off,” once these



fields did “take off,” these mental health professionals began providing services simply to keep up with the demand for services (Kraft 2009, 2011). In 1954, ACHA established a “Mental Hygiene” committee that later came to be known as the Mental Health Committee (Kraft, 2009). In 2006, ACHA created a Mental Health Best Practices Task Force in order to identify “strategies that would help Mental Health section members to function more effectively in the delivery of mental health services” (ACHA, 2010, p. 584).

Today, most universities provide some sort of mental health services to students although the structure, practices, and policies of these services vary considerably (ACHA, 2010). Most campus mental health centers provide individual counseling to students but there is a wide range of other services that universities may choose to provide (ACHA, 2010). Initially these services were paid for out of the general university budget (Kraft, 2009, 2011). Today, however, campus mental health centers usually operate on separate health fees that may either be mandatory or associated with service utilization (Gallagher, 2005; Kraft, 2009, 2011; SPRC, 2004). This funding procedure can sometimes result in problems for campus mental health centers; SPRC (2004) explained, “students without insurance rely almost exclusively on the student health center resources. Campus mental health centers face an increasing burden to see and monitor large numbers of students for longer periods of time” (p. 15).

This problem with funding not only affects the mental health centers but also the students. SPRC (2004) stated:

While basic student health services are usually available without restriction, campus mental health benefits tend to be limited to a specific number of annual visits. Students in crisis may receive extending counseling services, but long-term psychiatric care of students within a student mental health clinic setting is the exception rather than the rule. (p. 14)

Obviously students with insurance have more options than students without insurance, but often students do not want to utilize their insurance benefits for fear that their parents will find out about their mental health status or even simply to avoid high co-payments and deductibles (SPRC, 2004).

The importance of student mental health services can be summed up in one sentence: “Mental illnesses are treatable” (NAMI, 2012, para. 3). NAMI (2012) found that 70-90% of individuals who received treatment had improved quality of life. The importance of mental health services for students who are in need of these services is clear as are the benefits to the university for providing these services. What universities can do to improve current services, however, is yet to be determined with any kind of certainty.

### **Future Directions of Campus Mental Health Services**

**Improve services.** Starting in the 1950’s, diversity on college campuses has been increasing steadily with the increasing number of international students at U.S. colleges and universities (Byrd & McKinney, 2012; Davidson, Yakushka, & Sanford-Martens, 2004; SPRC, 2004). This fact can sometimes make it difficult for mental health centers to meet the needs of all students because of cultural differences (SPRC, 2004). Davidson et al. (2004) urged, “It is imperative for university and college counseling center staff to better understand and attend to the needs of all individuals who seek counseling, particularly students who belong to traditionally under-served or under-represented populations” (p. 260). Although all students are susceptible to stress during the transition from high school to college, international students also have to deal with the stress of cultural adjustment (Mori, 2000). Davidson et al. (2004) advised that campus counseling centers should evaluate their current services to ensure cultural acceptance and appropriateness for all cultures represented at the university.

International students are not the only group on college campuses that should be considered when attempting to make services more appropriate and accepting. Studies show that Native American, Alaskan Native, and Hispanic youth have the highest rates of suicide fatalities; therefore, campus mental health centers may want to be aware of this fact and the factors that lead to this high rate of suicide (CDC, 2009). Also, SPRC (2004) advised campus mental health centers to be aware of and available to gay, lesbian, bisexual, and transgender (GLBT) students. They stated, “Promoting a positive environment that includes gay, lesbian, bisexual, and transgender students, staff, and faculty can go a long way towards supporting the mental health and well-being of GLBT students” (SPRC, 2004, p. 12). Finally, another group that campus mental health centers need to be aware of and cater to is veterans returning to school after deployment (Ackerman et al., 2009). These are just a few examples of special populations that campus mental health centers should focus on when evaluating their current practices and services in order to ensure that none of these groups, or any student for that matter, are at a disadvantage. Mier et al. (2009) warned, “If campus support services –including counseling services – are considered part of an environment tainted by prejudice, accessing help might be particularly hard” (p. 18).

Another way university mental health centers could improve services is by offering more preventative, educational services. NAMI (2004) reports, “Mental illness is a major concern for the college student population, yet nearly half of students report receiving no education on mental health issues before starting college” (para. 7). In order to mend this problem some universities have started offering freshmen courses designed to help them adjust to college life which include information about available mental health services (Cook, 2007). WHO (2001)

urges schools to become “more involved in a broader educational role fostering healthy social and emotional development of pupils” (para. 8).

**Expand services.** Despite the inevitable flaws of current services on college campuses, these services do help students (Gallagher, 2005). However, they cannot help students that are unable to access them. Campus mental health centers today are overburdened by demand for their services (Chung et al., 2011; Cook, 2007; Gallagher, 2005; Leavitt et al., 2007; Osberg, 2004). Benton et al. (2003) found in their study that over 13 years, the average number of sessions per clients decreased from 6.87 to 5.98. Also, the average ratio of counselors to students on college campuses today is 1 to 1,698 (Gallagher, 2005). NAMI (2012) highlights the importance of solving this problem of meeting the need of increased demand by saying, “Early identification and treatment is of vital importance; By ensuring access to the treatment and recovery supports that are proven effective, recovery is accelerated and further harm related to the course of the illness is minimized” (para. 12).

Osberg (2004) explained, “An obvious solution to the growth of mental health problems on college campuses is to increase counseling center staffing. Yet for some higher education institutions this may not seem fiscally feasible” (p. 34). Many universities, in fact, struggle with budgetary concerns and cannot justify putting more money towards mental health services for students (Kraft, 2009; Osberg, 2004). As stated earlier, however, investment in campus mental health centers has great potential for return on investment because of retention (Gallagher, 2005; Osberg, 2004).

The possibilities are really endless when looking at expanding services. Universities could implement fee-for-service practices which have helped some universities provide larger amounts of services (Kraft, 2009). Other possibilities include session limits and referral options

(Benton et al., 2003). Many university mental health centers, in fact, utilize community resources such as crisis lines to help meet the needs of students they are unable to help (SPRC, 2004).

Resources such as crisis lines are particularly helpful since most universities do not have 24/7 coverage for mental health services (SPRC, 2004). One thing is clear, as prevalence and severity of student mental health issues rise, so does demand for services (Benton et al., 2003). Whether universities are aware of this impending problem or not, all will have to face it in the near future.

**Improve student access of services.** According to Gallagher (2005), approximately 9% of students seek counseling each year from campus mental health centers. Cook (2007) reported, however, “Although many university counseling centers have reported a dramatic increase in the demand for services for troubled students, there is still a substantial number of students who could benefit from services but do not actively seek them” (p. 42). As stated earlier, NAMI (2004) reported that 50% of students rate their mental health as being below average yet nowhere near half of students access mental health services. Furthermore, Áegisdóttir, O’Heron, Hartong, Haynes, and Linville (2011) pointed out that there is even a discrepancy between the number of students with diagnosable mental illnesses and the amount of students seen in campus mental health services.

An obvious question here is why focus on how to get more students to access services if campus mental health centers are already overburdened? Osberg (2004) explained that many campus mental health centers have “curtailed their student outreach efforts for lack of staffing to handle potential increases in new cases that could result” (p. 34). In order for funding to increase and services to expand at campus mental health centers, however, there must be demand for these services. Perhaps the low utilization rates have been falsely making it appear that current services are adequate. How to get more students to access services when they need them is a

challenge for many universities. Some options for improving service utilization of students in need are discussed below.

**Marketing of services.** Many students are simply unaware of campus mental health services (Yorgason, Linville, & Zitzman, 2008). In their study, Yorgason et al. (2008) found that only 32% of students rated their awareness of campus mental health services as “adequate” or better. Also, they found that awareness of services increased the longer the student had been in college (Yorgason et al., 2008). This may explain why graduate students have higher utilization rates of mental health services than undergraduates (SPRC, 2004). Yorgason et al. (2008) urged, “Innovative approaches to increasing knowledge and use of campus mental health services is needed” (p. 178).

Generally the majority of funding for mental health services goes into treatment, leaving little behind for marketing and outreach efforts (WHO, 2001). Many universities have resorted to advertising their mental health services on the internet (Yorgason et al., 2008). Yorgason et al. (2008) warned, however, “Although students’ internet use has increased substantially in the past decade and although campus mental health centers and services are typically on university Web sites, having this information available on the Internet may not be sufficient for informing students” (p. 178). Many universities, in fact, are truly unaware of where students are receiving information about campus mental health services, meaning students could possibly be getting inaccurate information about services (Yorgason et al., 2008).

Martin (2010) recommended that universities utilize a wellness model of health promotion on their campuses. Not only would mental health promotion inform students about mental health services, it may also serve to decrease the stigma surrounding mental illness which is a major barrier to students accessing mental health services (Égisdóttir et al., 2011; CDC,

2009; Cook, 2007; Martin, 2010). Martin (2010) defined stigma as “a socially constructed mark of disapproval, shame or disgrace that causes significant disadvantage through curtailment of opportunities” (p. 261). Not only do students fear stigma, they also fear discrimination from the university itself because of this stigma surrounding mental health (Martin, 2010).

Martin (2010) advised, “Addressing the stigma of mental illness is a first and crucial step in getting students to overcome their fears and concerns of disclosing to university staff and gaining access to the support they require to succeed in their studies” (p. 271). Furthermore, campus mental health awareness efforts may also serve to improve the campus atmosphere in general. WHO (2010) stated, “A climate that respects and protects basic civil, political, socio-economic and cultural rights is fundamental to mental health promotion. Without the security and freedom to provide these rights, it is very difficult to maintain a high level of mental health” (para. 7). The need for improved awareness, promotion, and marketing is highlighted by Gallagher’s (2005) finding that less than 50% of directors believe their schools provide adequate public education regarding mental health issues.

### **Utilizing Entire Campus Community as Sources of Information about Services**

Mier et al. (2009) wrote, “It is imperative to have outreach programs that utilize the entire campus community as essential resources for helping students who might be vulnerable to emotional and/or psychological difficulties who otherwise may not initiate coming into the counseling center on their own” (p. 19). Included in this “campus community” are students, staff, and faculty, all of whom could potentially serve as sources of information about campus mental health services for students in need of those services (Cook, 2007; SPRC, 2004). Ensuring that students are aware of these services cannot be left up to the campus mental health center staff alone (SPRC, 2004). In their study, Knox, Litts, Talcott, Feig, and Caine (2003) found that a

suicide prevention program at a US Air Force base that utilized the entire community resulted in a 33% reduction in suicide. SPRC (2004) stated, “An important element of campus social marketing strategy is making students, faculty, staff members, and administrators aware of the problem and the resources to promote mental health and prevent suicide” (p. 23).

**Students.** As mentioned earlier, in their study Yorgason et al. (2008) found that approximately one-third of students reported being adequately aware of campus mental health services. Obviously this means many students in need of services may not know about services, but it also means that many students who have friends in need of mental health services also do not know about these services. This is important considering that Yorgason et al. (2008) found that students reported learning about services most often from friends and fellow students. NAMI (2004) explained that “students are most likely to turn to friends should they experience a serious emotional problem while at school” (para. 10). Increased marketing and campus awareness of services may not only be able to improve utilization by getting this information to students in need directly but also by getting this information to students that will later pass this information on to their friends in need of mental health services.

**Staff.** Staff on university campuses can hold a wide range of roles and come with a wide range of training. Academic counselors, for example, generally hold degrees in either counseling or a related field (United States Department of Labor, 2012); therefore they have some training in mental health while other staff members may have no training in mental health. Staff members also vary considerably in their amount of contact with students. Academic counselors, for example, may meet with many students all day while campus IT professionals that work with faculty may have very limited student interaction. The importance of staff’s awareness of mental health issues among students, however, is undeniable; SPRC (2004) explained, “Mental health



emergencies are often handled by campus security or college administrators in place of trained clinicians or healthcare providers” (p. 20).

Even healthcare providers face some challenges when confronted with student mental health issues; even though they may be trained in mental health diagnosis and treatment, many physicians do not deal with mental health concerns on a daily basis. ACHA (2010) looked at the role of campus primary care physicians in identifying students in need of mental health services and referring them on. They justify their study saying:

Many students with mental health concerns may feel more comfortable seeing a healthcare professional rather than a mental health professional. A number of mental health concerns may initially present with physical symptoms (e.g., panic disorder) that bring them to the student health center for evaluation and treatment demonstrating how student health services is an important resource for the counseling program. (ACHA, 2010, p. 583)

Klein, Ciotoli, and Chung (2011) found promising results in a similar study, and ACHA (2010) recommends universities consider merging counseling and health services in order to improve utilization and coordination of care.

**Faculty.** According to Gallagher (2005), 69% of directors believe that worsening student mental health is a growing concern for faculty. This may be related to the fact that many students first seek help from faculty when they are in need of help related to a mental health issue (SPRC, 2004; Virginia Tech Cook Counseling Center, n.d). Although a number of resources pointed out that students may approach faculty regarding mental health issues, this author was unable to find much information regarding how faculty handles this new role.

One article that did discuss faculty’s role in facilitating student mental health was an article written by Mier et al. (2009) about Cornell’s Community Consultation and Intervention (CCI) program which focused on helping both faculty and staff support the mental health of students who do not access mental health services. CCI provides consultation, student support,

crisis intervention, advocacy, and case management (Mier et al., 2009). This article highlights the importance of having faculty involved in mental health issues on college campuses. Furthermore, this study shows how faculty's role in facilitating student mental health can be fostered but does not discuss the barriers faced by faculty members that assist students with mental health issues and why they might be reluctant to take on this role. Some of these barriers are discussed below.

### **Barriers to Faculty as Information Sources for Campus Mental Health Services**

**Student privacy concerns.** On April 21, 2007 President George W. Bush ordered a report which was later published and entitled, "Report to the President: On Issues Raised by the Virginia Tech Tragedy," (Leavitt et al., 2007). This "tragedy" refers to the April 16, 2007 shooting spree of Seung-Hui Cho at Virginia Tech University which resulted in the deaths of 33 students and faculty members, including Cho himself (Virginia Tech Review Panel, 2007). Secretaries Michael Leavitt and Margaret Spellings and Attorney General Alberto Gonzales met with officials in the fields of politics, law enforcement, mental health, and education in Colorado, Florida, Minnesota, Tennessee, Texas, Utah, West Virginia, California, New Mexico, Indiana, Oklahoma, and Mississippi between April 26 and May 4, 2007 (Leavitt et al., 2007). They ultimately derived three key findings, one of which reads as follows:

Critical information sharing faces substantial obstacles: Education officials, healthcare providers, law enforcement personnel, and others are not fully informed about when they can share critical information on persons who are likely to be a danger to self or others, and the resulting confusion may chill legitimate information sharing. (Leavitt et al., 2007, p. 2)

A similar endeavor was undertaken in the state of Virginia, as ordered by the governor of Virginia at the time of the shootings (Virginia Tech Review Panel, 2007). A panel was assembled specifically to determine where the university and community went wrong with

Seung-Hui Cho (Virginia Tech Review Panel, 2007). Ultimately the panel made more than 70 recommendations to prevent similar events from happening in the future. Their second and third major findings were:

During Cho's junior year at Virginia Tech, numerous incidents occurred that were clear warnings of mental instability. Although various individuals and departments within the university knew about each of these incidents, the university did not intervene effectively. No one knew all the information and no one connected all the dots...University officials in the office of Judicial Affairs, Cook Counseling Center, campus police, the Dean of Students, and others explained their failure to communicate with one another or with Cho's parents by noting their belief that such communications are prohibited by the federal laws governing the privacy of health and education record. In reality, federal laws and their state counterparts afford ample leeway to share information in potentially dangerous situations. (Virginia Tech Review Panel, 2007, p. 2)

The United States Department of Education (2011) explained, "The Family Educational Rights Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education" (para. 1). Although not enacted until 1974, some might argue that FERPA's roots began setting in 1965 during the case of *Griswold versus Connecticut* (Public Broadcasting Service [PBS], 2007). Although many people today think of privacy as a right, it is important to note that privacy is not actually listed in the Bill of Rights (PBS, 2007). Through this case, however, Supreme Court Justice William O. Douglas ruled that in the "spirit" of other amendments such as protection from self-incrimination, a right to privacy was implied thus establishing the right to privacy that is so nationally accepted and expected today (PBS, 2007). It is important to note that this ruling remains controversial to this day and could be overturned at any time (PBS, 2007).

FERPA was originally presented to the US Senate by Senator James Buckley of New York and is commonly referred to as the "Buckley Amendment," (Graham, Hall, & Gilmer, 2008). FERPA was presented as an amendment to the General Education Provisions Act

(GEPA), not as a new bill, so it did not go through the channels a new law typically passes through and that may explain why so much confusion surrounds the specifics of FERPA (Graham, et al., 2008). FERPA was officially signed into law by Gerald Ford on August 21, 1974 and has been amended 11 times since then (Graham, et al., 2008).

Many university personnel are unaware of what FERPA specifically allows and restricts (Graham et al., 2008; Leavitt et al., 2007). Graham et al. (2008) reported:

Universities tended to be more restrictive than the law required in interpreting FERPA and its regulations, in part because of a prevailing and often articulated sense of a right to privacy on the part of the student and in part to avoid lawsuits (even though there is no right to private action under FERPA). (p. 308)

And not only are university personnel unclear on FERPA, but they are also unclear on what HIPAA and other state laws and regulations allow (Leavitt et al., 2007; Virginia Tech Review Panel, 2007). One of the recommendations for federal action made by the panel assembled by President George W. Bush is that “The U.S. Departments of Health and Human Services and Education should develop additional guidance that clarifies how information can be shared legally under HIPAA and FERPA and disseminate it widely to the mental health, education, and law enforcement communities” (Leavitt et al., 2007, p. 8).

**Lack of information, training, and awareness.** Most faculty members are not trained mental health professionals and therefore should not be seen as the end-of-the-line for student mental health concerns. Even faculty members that are trained in mental health cannot ethically engage in providing mental health services to students as this would be a dual relationship (Louisiana Licensed Professional Counselors Board of Examiners, n.d.; Louisiana Board of Social Work Examiners, 2011). This does not mean, however, that faculty cannot be a link on the chain that leads students to campus mental health services.

Both SPRC (n.d.) and Hamrick, Goldman, Sapp, and Kohler (2004) pointed out that teachers are in an advantageous position to identify and help students struggling with mental health issues because of their contact with students. Although both of these comments were directed at primary school teachers who have more interaction with their students than college faculty members, in general, the same could be said for college faculty members. Virginia Tech's Cook Counseling Center website, in fact, states that "many students initially seek assistance from faculty or staff members" (Virginia Tech Cook Counseling Center, n.d., para. 2). Although this seems to be a common statement on many university websites, this researcher was unable to find any articles regarding how faculty members function in this role.

What and how faculty should be taught in order to help students with mental health issues is a big question with a variety of answers. First, universities may want to ensure that faculty members are simply aware of mental health services available to students. Although there are certainly studies assessing whether or not students are aware of services, this researcher was unable to find any studies that looked at faculty members' awareness of these services. If faculty members are not aware of services or misinformed about services (e.g., that there is a cost associated when there is not) then this could lead to them further preventing students from accessing services.

Another area that could be addressed in faculty awareness and training is discussing the stigma surrounding mental health issues. Many students do not seek out needed mental health services due to the stigma of mental illness (Áegisdóttir et al., 2011; CDC, 2009; Cook, 2007; Martin, 2010). If students believe that their professors or instructors hold this stigma they may fear discussing mental health issues with them. Studies show that students not only fear stigma while in college, but that this stigma may affect their future careers, possibly because of how

recommendations from faculty and staff would be impacted by them being aware the student had mental health struggles (Martin, 2010). Dewa et al. (2007) found that a mental health literacy program successfully reduced the stigma surrounding mental illness in the workplace, thus making employees more comfortable accessing needed services. Participants in the study carried out by Leavitt et al. (2007) following the Virginia Tech tragedy, “expressed hope that the work being done at the federal and state levels continues to de-stigmatize mental-illness, thereby normalizing requests for help” (p. 5).

The identification of warning signs of student mental distress is another possible area of future training for faculty. Both Leavitt et al. (2007) and Cook (2007) stressed the importance of faculty members being aware of common warning signs for student mental health issues.

Virginia Tech Cook Counseling Center (n.d.), in fact, offers faculty and staff members guidelines for identifying students in distress on their website. In a study of public school teachers, Hamrick et al. (2004) found that teachers were relatively ineffective in identifying which students were at highest risk for suicide. This researcher could not find a similar study for university faculty.

Finally, crisis intervention techniques are frequently taught to non-mental health personnel such as law enforcement as training on how to talk to someone in crisis (Vecchi, 2009a, 2009b). Vecchi (2009a) defined a crisis as “a situation where a person perceives insurmountable obstacles to important life goals that cannot be handled effectively through customary methods of problem-solving” (p. 37). In other words, a crisis is essentially a breakdown in coping of the person going through the crisis (Vecchi, 2009a, 2009b). All crises are unique, and even the smallest events could potentially send someone into a crisis state (Knox

& Roberts, 2005). Faculty, if exposed to crisis intervention training, could potentially learn how to talk to students in crisis and be better able to encourage students to access services.

Faculty being informed, trained, and aware of student mental health issues is just a small part of the larger student mental health issue on college campuses. Clearly, other problems exist: Although mental health centers generally help students, both Seung Hui Cho and James Holmes did see mental health professionals on campus before their violent shooting sprees (Coffman, 2012; Virginia Tech Review Panel, 2007). Additionally, campus mental health centers are clearly overburdened (Benton et al., 2003; Chung et al., 2011; Cook, 2007; Gallagher, 2005; Leavitt et al., 2007; Osberg, 2004; SPRC, 2004). Some might ask why faculty should be involved in encouraging students to access these flawed services. The current state of college student mental health in the United States, however, demands just that. There will always be improvements to be made with services, but faculty members are essential resources for identifying and informing students in need of mental health services (Cook, 2007; Leavitt et al., 2007).

## CHAPTER 3 METHODS

The primary purpose of this study was to determine the influence of selected personal and demographic characteristics on the attitudes toward and perceptions of selected mental health issues among currently employed faculty of four year public universities.

### Population and Sample

The target population for this study was faculty members of four year public universities in the Southeastern United States. The accessible population of this study was faculty members at two four year public universities in Southern Louisiana. The minimum required sample size, determined using Cochran's formula (Snedecor & Cochran, 1980), was as follows:

$$n_o = t^2 s^2 / d^2$$

$$n_o = (1.96)^2 (.7)^2 / (.1)^2$$

$$n_o = (3.8416)(.49) / .01$$

$$n_o = 1.882 / .01$$

$$n_o = 189$$

In these calculations:

$d^2$  = acceptable margin of error (+/- 2% of 5-point likert-type scale)

$s^2$  = estimated variance (highest possible score [5.0] minus lowest possible score [1.00]

divided by 6 [number of standard deviations that normally capture the range]  $5-1 = 4/6 = .67$ , rounded to .7)

$t^2$  = acceptable risk (t at .05 = 1.96)

$n_o$  = unadjusted sample size

In order to establish a population frame, e-mail addresses for all faculty listed on each university's website were obtained using general departmental searches. Only e-mail addresses



accessible to anyone visiting these websites were used; no list was obtained directly from the university and no access codes were used. All faculty listed in the population frame were asked to participate in the study.

### **Instrumentation**

This study used a researcher-designed instrument (See Appendix A). The initial draft of the instrument was designed through a review of literature and using principles from the Tailored Design Method by Dillman, Smyth, and Christian (2009). Items included in the various scales of the instrument were selected and/or designed based on studies in the literature related to the concepts being studied in the research including Roth, Antony, Kerr, Downie, and Antony (2000) who investigated attitude toward mental illness and Hamrick, Goldman, Sapp, and Kohler (2004) who investigated the ability of high school educators to identify the warning signs of suicide in students. To establish the content validity of the instrument, the researcher selected a panel of experts consisting of individuals with extensive experience in the area of mental health. Of the six experts included in this panel, all are currently Licensed Clinical Social Workers (LCSW) in the state of Louisiana, three are Board Approved Clinical Supervisors (BACS), three hold Ph.D.'s, three are currently associate professors of social work at a major university, and all experts have between 10 and 24 years of experience as social workers. The instrument was reviewed by this panel of experts in the field of mental health and necessary revisions based on their feedback were made to the instrument. The revised form of the instrument consisted of 55 items and was divided into five categories. The first three sections included 30 statements designed to measure attitude toward mental health, willingness to help students with mental health issues, and self-perceived ability to identify students with mental health issues. Participants were given the following response options: strongly disagree, disagree, slightly

disagree, slightly agree, agree, and strongly agree. The fourth section consisted of five multiple-choice questions and was designed to measure ability to help students with mental health issues. These questions were vignettes which participants read and were asked to select one option which they believed would be the best action to take, given the specifics of the vignette. Finally the last section consisted of demographic questions that assessed a variety of personal and professional characteristics; there were 20 questions in this section. The reason each of these demographic questions was included in this study is explained in the following items:

1. Age. – This personal demographic characteristic was selected based on studies such as the research of Currin, Hayslip, Schneider, and Kooken (1998) who have examined the influence of age on attitude toward mental health. Currin et al. (1998) found differences in age were associated with differences in attitude toward mental health services in their study.
2. Gender. – This personal demographic characteristic was selected based on the research of Yorgason, Linville, & Zitzman (2008) who have found that female students are generally more aware of campus mental health services than male students. Perhaps this same trend would be found among faculty, with female faculty members being more aware of campus mental health services than male members of faculty. This awareness of services may impact willingness to help of faculty members.
3. Race/Ethnicity. – This personal demographic characteristic was selected based on the research of Gonzales, Alegría, Prihoda, Copeland, and Zeber (2011) who examined the influence of race and ethnicity on attitude towards mental health treatment. Gonzales et al. (2011) recommended examining racial and ethnic differences when studying attitudes toward mental health.

4. University. – This professional demographic characteristic was selected in order to determine if there are any differences in the way the faculty members of each university respond to this instrument. According to the Carnegie Foundation for the Advancement of Teaching one of the universities included in this study is classified as a research university with high research activity (RU/H) while the other is classified as a master's university (Master's L). Perhaps this difference in research focus versus teaching focus would impact how faculty members at each of these universities respond to this instrument.
5. Years of experience as a faculty member. – This professional demographic characteristic was selected based on the personal experience of the researcher that faculty with more experience may differ from newer faculty members in their familiarity with campus resources, student behavior, and mental health in general.
6. Faculty status. – This professional demographic characteristic was selected based on the personal experience of the researcher that part-time faculty may differ from full-time faculty in the way they view and handle potential mental health issues in their students. Furthermore there may also be a difference between tenured or tenure track faculty and non-tenure track faculty. Perhaps faculty seeking tenure are less willing to help because they fear negative repercussions for acting outside of their typical duties while faculty that have already achieved tenure or are not seeking tenure are more willing and comfortable reaching out to students.
7. Faculty rank. – This professional demographic characteristic was selected based on the personal experience of the researcher that difference in rank may be related to differences in how faculty view and handle student mental health issues. Sometimes instructors may

seem more approachable than higher-ranked professors and therefore may have different experiences and views related to student mental health.

8. Time spent teaching versus time spent doing research. – This professional demographic characteristic was included based on the personal experience of the researcher that faculty that spend more time with students (i.e., teaching) may have more may have more opportunities to be confronted with student mental health issues and may, therefore, differ in their awareness and willingness to help students with these issues because of their experience.
9. Class size. – This professional demographic characteristic was selected because of the personal experience of the researcher that faculty with smaller classes may have more time to observe and interact with students and therefore may have a different view of their role in student mental health than faculty members with large classes.
10. College/Department. – This professional demographic characteristic was selected based on the researcher's personal experience that faculty in different colleges/departments differ in their views of their role as an educator. Perhaps this view affects the way they handle student mental health issues.
11. Holding a degree in psychology, social work, or counseling. – This professional demographic was included based on the research of Srivastava and Tiwari (2012) who studied the differences in attitude toward suicide of mental health versus non-mental health professionals. Srivastava and Tiwari (2012) ultimately found significant differences in attitude toward suicide between these two groups. This difference could possibly also be seen in relation to all mental health issues.

12. Knowing someone who has been diagnosed with a mental illness or has attempted or completed suicide. – This personal demographic characteristic was selected based on the research of Roth, Antony, Kerr, Dowie, and Antony (2000) who investigated the impact of personal experience with mental illness on attitudes toward mental illness. Roth et al. (2000) found that prior personal experience with mental illness was associated with more positive attitudes towards mental illness.
13. Having a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide. – This personal demographic was selected based on the research of Roth et al. (2000) who investigated the impact of personal experience with mental illness on attitudes toward mental illness. Roth et al. (2000) found that prior personal experience with mental illness was associated with more positive attitudes towards mental illness. This personal demographic was included in addition to the previous question because the nature of the relationship may influence the relationship's impact on attitude toward mental illness.
14. Personal mental health diagnosis. – This personal demographic was selected based on the research of Roth et al. (2000) who investigated the impact of personal experience with mental illness on attitudes toward mental illness. Roth et al. (2000) found that prior personal experience with mental illness was associated with more positive attitudes towards mental illness.
15. Personal suicide contemplation or attempt. – This personal demographic was selected based on the research of Roth et al. (2000) who investigated the impact of personal experience with mental illness on attitudes toward mental illness. Roth et al. (2000) found that prior personal experience with mental illness was associated with more positive

attitudes towards mental illness. It is important to note that contemplating suicide is not necessarily an indication of mental illness.

16. Religion/spirituality/faith. – This personal demographic characteristic was selected based on the research of Kunst (1993) who found that religion influences attitudes toward mental health intervention.
17. Personal experience with training on mental health issues or suicide prevention. – This personal demographic was selected based on the research of Ritter, Teller, Munetz, and Bonfine (2010) who examined the influence of crisis intervention training on police officers' perceptions of people with mental illness.
18. Belief about whether or not their university should offer training on how to identify students struggling with mental health issues. – Although willingness to participate in such trainings was assessed in the willingness to help students struggling with mental health issues scale, this question asks participants whether or not they believe their university *should* provide such trainings. This is an exploratory question that aims to gauge if those that believe the university has a responsibility to offer such training have different views of student mental health issues than those who do not believe the university has this responsibility.
19. Knowledge of university mental health services. – This self-reported item was included based on the research of Yorgason, Linville, and Zitzman (2008) who found that only one-third of university students report being adequately informed about campus mental health services. Perhaps faculty members are also uninformed about these services and this may impact their level of involvement in student mental health issues.

20. Beliefs about university's responsibility to ensure faculty members are aware of mental health services available to students. – This is an exploratory question. Perhaps faculty members that believe it is the responsibility of the university to ensure faculty members are aware of mental health services also feel that faculty members should have some responsibility in the mental health of their students and, therefore, be more willing to reach out to students with mental health issues.

It was estimated that it would take participants approximately 20 minutes to complete this survey. Since anyone who has experienced trauma in their life related to mental health may experience distress when discussing mental health issues, a resource was given at the end of the study which participants could choose to utilize anonymously if needed.

### **Data Collection**

The researcher obtained permission from the Louisiana State University Institutional Review Board before any surveys were distributed (See Appendix B). The survey was distributed using Survey Monkey© online survey software. An e-mail was sent to all participants requesting that they complete the survey. This e-mail included the IRB-required informed consent information and stressed protection of confidentiality. Follow-ups occurred weekly for three weeks giving participants a total of four weeks to respond to the instrument. All participants who completed the survey were directed to a customized “thank-you” page, thanking them for their participation in the study. Once the survey was active for four weeks the survey closed and no more responses were accepted. The researcher then downloaded all responses from Survey Monkey© into an Excel spreadsheet and erased any and all identifying information before uploading to SPSS.

## **CHAPTER 4**

### **FINDINGS/RESULTS**

#### **Objective One Results**

Objective one was to describe currently employed faculty of four year public universities on the following personal and professional demographic characteristics:

- a. Age
- b. Gender
- c. Race/Ethnicity
- d. University
- e. Years of experience as a faculty member
- f. Employment status
- g. Faculty rank
- h. Actual job duties
- i. Typical class size
- j. College/Department
- k. Mental health experience
- l. Knowledge of university mental health services available to students
- m. Beliefs about university's role in mental health services

A total of 281 respondents began the survey and 261 provided usable responses. The results for each of these variables are reported in the following sections.

**Age.** The first variable examined was age. The largest group of respondents was in the 56-65 age group ( $\underline{n} = 75$ , 29.5%). Almost as many were in the categories 46-55 ( $\underline{n} = 70$ , 27.6%) and 36-45 ( $\underline{n} = 66$ , 26%) (See Table 1).



Table 1

## Age of Currently Employed Faculty of Four Year Public Universities

Age	Frequency	Percent
25 or under	1	.4
26-35	21	8.3
36-45	66	26.0
46-55	70	27.5
56-65	75	29.5
66 or older	21	8.3
Total	254 <sup>a</sup>	100.0

*Note.* <sup>a</sup> 7 study participants did not respond to this item.

**Gender.** The second variable examined was gender. Of the 251 participants that responded to this item, 109 reported their gender as male (43.4%) and 142 reported their gender as female (56.6%). Ten participants did not respond to this item.

**Race/Ethnicity.** The next variable examined was race/ethnicity. The largest portion of the 247 participants that responded to this item reported their race/ethnicity as being white, non-Hispanic or Latino ( $n = 189$ , 76.5%) (See Table 2).

**University.** The next variable examined was university. Of the 250 participants that responded to this item, 160 reported being faculty members of the university that is described in the Carnegie Classification as a large master's university (64 %) and 90 reported being faculty members of the university that is described in the Carnegie Classification as a medium research university (36 %). Eleven participants did not respond to this item.

Table 2

## Race/Ethnicity of Currently Employed Faculty of Four Year Public Universities

Race/Ethnicity	Frequency	Percent
White, not Hispanic or Latino	189	76.5
White, Hispanic or Latino	26	10.5
Asian	18	7.3
Black or African American	11	4.5
American Indian or Alaskan Native	3	1.2
Total	247 <sup>a</sup>	100.0

*Note.* <sup>a</sup> 14 study participants did not respond to this item.

**Years of experience as a faculty member.** Another variable examined was total years of experience as a faculty member, combining all colleges and universities at which participants may have worked. Study participants were asked to check the most appropriate from the 10-year increments provided. The largest portion of participants reported their faculty experience as 10-19 years ( $\underline{n} = 91$ , 36.1%) followed by 20-29 years ( $\underline{n} = 69$ , 27.4%) and 0-9 years ( $\underline{n} = 61$ , 24.2%), respectively (See Table 3).

**Employment status.** The next variable that was examined was employment status. In this study employment status addressed both their tenure status and their full or part-time status. The largest portion of participants that responded to this item reported being tenured ( $\underline{n} = 107$ , 42.3%) with the next largest proportion of participants reporting their status as being full-time, non-tenure track ( $\underline{n} = 81$ , 32%) (See Table 4).

Table 3

Years of Experience as a Faculty Member of Currently Employed Faculty of Four Year Public Universities

Years of Experience	Frequency	Percent
0-9	61	24.2
10-19	91	36.1
20-29	69	27.4
30-39	23	9.1
40-49	8	3.2
50+	0	0.0
Total	252 <sup>a</sup>	100

*Note.* <sup>a</sup> 9 study participants did not respond to this item.

Table 4

Employment Status of Currently Employed Faculty of Four Year Public Universities

Faculty Status	Frequency	Percent
Tenured	107	42.3
Full-Time, Non-Tenure Track	81	32.0
Full-Time, Tenure Track	52	19.9
Adjunct	10	4.0
Part-Time	3	1.2
Total	253 <sup>a</sup>	100.0

*Note.* <sup>a</sup> 8 study participants did not respond to this item.

**Faculty rank.** Another variable that was examined was faculty rank. The largest portion of participants reported their rank as instructor ( $\underline{n} = 90$ , 35.9%) and the smallest portion of participants reported their rank as Assistant Professor ( $\underline{n} = 43$ , 17.1%) (See Table 5).

Table 5

## Rank of Currently Employed Faculty of Four Year Public Universities

Rank	Frequency	Percent
Instructor	90	35.9
Assistant Professor	43	17.1
Associate Professor	54	21.5
Professor	64	25.5
Total	251 <sup>a</sup>	100.0

*Note.* <sup>a</sup> 10 study participants did not respond to this item.

**Actual job duties.** The next variable that was examined was actual job duties. In the current study, this refers to the amount of time spent teaching versus amount of time spent doing research. The largest portion of participants reported that they spend more time teaching ( $\underline{n} = 165$ , 65.5%). Only one participant reported that they did not teach at all (.4%) while 31 reported that they did not do research at all (12.3%) (See Table 6).

**Typical class size.** The variable typical class size was also examined in this study. Study participants were asked to choose a range of numbers that best described the typical class size of the courses they teach. The majority of participants described their typical class size as being from 25 to 49 students ( $\underline{n} = 140$ , 55.6 %) and the second largest portion of participants described their typical class size as being from 0 to 24 students ( $\underline{n} = 84$ , 33.3%) (See Table 7).

**College/Department.** Another variable examined was the college/department in which participants work. The largest portion of participants indicated working in humanities & social sciences ( $\underline{n} = 87$ , 34.5%) or science ( $\underline{n} = 77$ , 30.6%) and the smallest portion of participants were in engineering ( $\underline{n} = 10$ , 4.0%) or art ( $\underline{n} = 13$ , 5.2%) (See Table 8).

Table 6

## Actual Job Duties of Currently Employed Faculty of Four Year Public Universities

Job Duties	Frequency	Percent
Spend more time teaching	165	65.5
Do not do research at all	31	12.3
About equal	30	11.9
Spend more time doing research	25	9.9
Do not teach at all	1	.4
Total	252 <sup>a</sup>	100.0

*Note.* <sup>a</sup> 9 study participants did not respond to this item.

Table 7

## Typical Class Size of Currently Employed Faculty of Four Year Public Universities

Number of Students	Frequency	Percent
0-24	84	33.3
25-49	140	55.6
50-74	16	6.3
75-99	7	2.8
100 +	5	2.0
Total	252 <sup>a</sup>	100.0

*Note.* <sup>a</sup> 9 study participants did not respond to this item.

**Mental health experience.** The next variable examined in the study was actually comprised of seven separate “yes” or “no” items that asked about participants’ mental health experience. The items to which the largest number of participants responded “Yes” related to knowing anyone who has been diagnosed with a mental illness or has attempted or completed suicide ( $n = 217$ , 86.5%) and to having a close friend or family member who has been diagnosed

with a mental illness or has attempted or completed suicide ( $\underline{n} = 165$ , 65.2%). The largest number of participants responded “No” to practicing a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling ( $\underline{n} = 237$ , 95.2%). The responses to all items included in this variable are presented in Table 9.

Table 8

College/Department of Currently Employed Faculty of Four Year Public Universities

College/Department	Frequency	Percent
Humanities & Social Sciences	87	34.5
Science	77	30.6
Education	37	14.7
Business	28	11.1
Art	13	5.2
Engineering	10	4.0
Total	252 <sup>a</sup>	100.0

*Note.* <sup>a</sup> 9 study participants did not respond to this item.

Table 9

Mental Health Experience of Currently Employed Faculty Members of Four Year Public Universities

Experience	Yes		No		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?	217	86.5	34	13.5	251 <sup>a</sup>	100

(Table 9 continued)

Experience	Yes		No		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Have you ever had any training on mental health issues or suicide prevention?	79	31.6	171	68.4	250 <sup>b</sup>	100
Have you ever received a mental health diagnosis?	49	19.5	202	80.5	251 <sup>a</sup>	100
Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?	28	11.2	223	88.8	251 <sup>a</sup>	100
Have you ever contemplated or attempted suicide?	27	10.8	223	89.2	250 <sup>b</sup>	100
Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?	12	4.8	237	95.2	249 <sup>c</sup>	100

*Note.* <sup>a</sup> 10 study participants did not respond to this item <sup>b</sup> 11 study participants did not respond to this item <sup>c</sup> 12 study participants did not respond to this item

**Knowledge of university mental health services available to students.** Another variable examined was knowledge of campus mental health services available. The largest group of participants rated themselves as “somewhat aware of services” ( $\underline{n} = 121$ , 48.4%) while 32% ( $\underline{n} = 80$ ) rated themselves as somewhat or very “unaware of services” (See Table 10).

**Beliefs about university’s role in mental health services.** The next variable examined consisted of two items aimed at gauging participants’ beliefs about their university’s role in mental health services. Participants were asked whether or not they believed their university should offer training on how to identify students with mental health issues. The majority of

participants indicated that they did think their university should offer training ( $n = 215$ , 86.7%) while 33 participants said they did not (13.3%). Thirteen participants did not respond to this item. Participants were also asked whether or not they believe their university should make more of an effort to ensure that faculty members are aware of mental health services. The majority of participants indicated they did think their university should make more of an effort ( $n = 218$ , 87.6%) while 31 did not (12.4%). Twelve participants did not respond to this item.

Table 10

Self-Rating of Knowledge of Campus Mental Health Services Available to Students by Currently Employed Faculty of Four Year Public Universities

Awareness Rating	Frequency	Percent
Very Aware of Services	49	19.6
Somewhat Aware of Services	121	48.4
Somewhat Unaware of Services	43	17.2
Very Unaware of Services	37	14.8
Total	250 <sup>a</sup>	100.0

*Note.* <sup>a</sup> 11 participants did not respond to this item.

## Objective Two Results

Objective two was to describe attitude toward mental health as measured by a researcher-designed scale. Participants rated their level of agreement on a total of 10 statements. “Strongly agree” was assigned a value of six while “strongly disagree” was assigned a value of one.

Participants indicated the highest level of agreement to the statement “I admire people who seek help for mental health issues when needed” ( $M = 5.26$ ,  $SD = .95$ ) and the highest level of disagreement to the statement “If I found out that one of my students was going to counseling, I would think less of them” ( $M = 1.23$ ,  $SD = .51$ ) (See Table 11). The following interpretive scale was developed by the researcher to aid in reporting faculty attitudes: 5.5-6 = Strongly Agree, 4.5-



5.49 = Agree, 3.5-4.49 = Slightly Agree, 2.51-3.49 = Slightly Disagree, 1.51-2.5 = Disagree, 1-1.5 = Strongly Disagree. Using this scale, three items received a rating of “Agree,” one item a rating of “Slightly Disagree,” three items a rating of “Disagree,” and three items a rating of “Strongly Disagree.”

Table 11

Altitude toward Mental Health of Currently Employed Faculty at Four Year Public Universities

Statement	Mean	Standard Deviation	Interpretation <sup>a</sup>
I admire people who seek help for mental health issues when needed	5.26	.95	A
I admire people who advocate for the rights of the mentally ill	5.21	.90	A
Mental health is equally or more important than physical health	5.11	.95	A
If I had a mental health diagnosis I would be ashamed for <u>anyone</u> to find out, even my closest family and friends	2.67	1.33	DS
People with mental health issues typically come from messed up families	1.95	.98	D
Mental illness is just an obstacle in life that can be overcome with will power	1.65	.89	D
Mental illnesses are more common in weak-minded people	1.57	.88	D
Mental health diagnoses are not "real" diagnoses	1.48	.74	SD
If I found out that one of my friends or family members was going to counseling, I would think less of them	1.34	.65	SD
If I found out that one of my students was going to counseling, I would think less of them	1.23	.51	SD

(Table 11 continued)

*Note.* The response scale used was 6 = strongly agree, 5 = agree, 4 = slightly agree, 3 = slightly disagree, 2 = disagree, and 1 = strongly disagree. The interpretive scale used was 5.5-6 = strongly agree, 4.5-5.49 = agree, 3.5-4.49 = slightly agree, 2.51-3.49 = slightly disagree, 1.51-2.5 = disagree, and 1-1.5 = strongly disagree.

<sup>a</sup> SA = strongly agree, A = agree, AS = slightly agree, DS = slightly disagree, D = disagree, SD = strongly disagree

To further examine the attitude toward mental health among faculty the researcher conducted a factor analysis to determine if underlying constructs existed in this scale, the researcher first examined the items for degree of deviation from normality using the Shapiro-Wilks test. In addition the measure of sampling adequacy was examined for both individual items and the overall scale. All data met the assumptions for use of factor analysis. The procedure used in conducting the factor analysis was principal components analysis with varimax rotation.

To determine the number of factors to be extracted from the scale responses, the researcher used a combination of the Latent Root criterion and the scree plot technique. Initially, the factor analysis was computed without restrictions on the number of factors extracted with the default minimum value of 1.00 on the latent root measure. Using these computations, the scree plot was examined to identify the optimum number of factors for extraction. This was accomplished by identifying the most pronounced bend in the scree plot curve. The optimum number of factors was determined to be two, plus or minus one. Each of these number of factors was then computed and examined for three criteria. First, the loadings for items in each of the factors extracted were examined to determine that they met the minimum acceptable loading criteria as specified by Hair, Black, Babin, Anderson, and Tatham (2006). For exploratory research Hair et al. (2006) suggested that this criterion may be as low as .30. Additionally, the analysis was examined for inefficient factors. Inefficient factors are those that include only one

or two items. If the purpose of the analysis is to identify underlying constructs in the data, constructs with only one item are of little benefit to the researcher. Finally, the researcher examined each of the analyses for the presence of significant cross-loadings in the data. If an item loads significantly on multiple factors in a factor analysis, it is possible that the item was perceived differently by different individuals or groups in the responding audience. Using a combination of these three criteria the researcher determined that there were no underlying constructs in this scale. The results of the factor analysis are presented in Table 12.

Table 12

Factor Analysis of Responses to “Attitude towards Mental Health” Scale of Currently Employed Faculty of Four Year Public Universities

Responses	Factor Loading
Mental illnesses are more common in weak-minded people <sup>a</sup>	.767
Mental health diagnoses are not "real" diagnoses <sup>a</sup>	.717
If I found out that one of my students was going to counseling, I would think less of them <sup>a</sup>	.706
If I found out that one of my friends or family members was going to counseling, I would think less of them <sup>a</sup>	.681
I admire people who advocate for the rights of the mentally ill	-.654
Mental illness is just an obstacle in life that can be overcome with will power <sup>a</sup>	.646
I admire people who seek help for mental health issues when needed	-.638
If I had a mental health diagnosis I would be ashamed for <u>anyone</u> to find out, even my closest family and friends <sup>a</sup>	.525
People with mental health issues typically come from messed up families <sup>a</sup>	.461
Mental health is equally or more important than physical health	-.401

*Note.* <sup>a</sup> Reverse coded item.

An overall scale score was computed for each participant. Since there were reverse coded items in the scale these items had to be recoded in order to give participants accurate scale scores. All negatively worded items were recoded so that a higher score indicated a more positive attitude towards mental health. An overall attitude toward mental health score was then computed as the mean of the responses to the 10 items in the scale. The mean of this overall score was 5.27 ( $SD = .53$ ), and the values ranged from a low of 3.40 to a high of 6.00.

### **Objective Three Results**

Objective three was to describe currently employed faculty of four year public universities on their willingness to help students with mental health issues as measured by a researcher designed scale. Participants were asked to rate their level of agreement or disagreement to a total of 10 statements. “Strongly agree” was assigned a value of six while “strongly disagree” was assigned a value of one. Participants indicated the highest level of agreement to the statement “If one of my friends or family members were struggling with a mental health issue I would hope someone would identify the problem and offer help” ( $M = 5.52$ ,  $SD = .98$ ) and the highest level of disagreement to the statement “I wouldn't get involved in student mental health concerns, no matter the circumstances” ( $M = 2.10$ ,  $SD = 1.02$ ) (See Table 13). The following interpretive scale was developed by the researcher to aid in reporting faculty willingness to help students with mental health issues: 5.5-6 = Strongly Agree, 4.5-5.49 = Agree, 3.5-4.49 = Slightly Agree, 2.51-3.49 = Slightly Disagree, 1.51-2.5 = Disagree, 1-1.5 = Strongly Disagree. Using this scale, one item received a rating of “Strongly Agree,” two items received a rating of “Agree,” four items received a rating of “Slightly Agree,” two items received a rating of “Slightly Disagree,” and one item received a rating of “Disagree.”

Table 13

## Willingness to Help Students With Mental Health Issues of Currently Employed Faculty of Four Year Public Universities

Statement	Mean	Standard Deviation	Interpretation <sup>a</sup>
If one of my friends or family members were struggling with a mental health issue I would hope someone would identify the problem and offer help	5.52	.98	SA
I am willing to learn more about warning signs for mental illness	5.09	.87	A
I am willing to learn more about campus mental health services for students	5.05	.84	A
I would intervene if I knew a student was struggling with a mental health issue	4.35	1.16	AS
I am willing to attend a training seminar on mental health	4.21	1.35	AS
Helping students who are struggling with mental health issues is part of my job	4.00	1.30	AS
If a student's mental health prevents them from being a competent participant in class then they should not be in college	3.55	1.42	AS
I would <u>only</u> reach out to a student and offer help if their behavior was affecting their performance or participation in class	2.93	1.21	DS
The campus mental health center is responsible for letting students know about services, not me	2.87	1.22	DS
I wouldn't get involved in student mental health concerns, no matter the circumstances	2.10	1.02	D

*Note.* The response scale used was 6 = strongly agree, 5 = agree, 4 = slightly agree, 3 = slightly disagree, 2 = disagree, and 1 = strongly disagree. The interpretive scale used was 5.5-6 = strongly agree, 4.5-5.49 = agree, 3.5-4.49 = slightly agree, 2.51-3.49 = slightly disagree, 1.51-2.5 = disagree, and 1-1.5 = strongly disagree.

<sup>a</sup> SA = strongly agree, A = agree, AS = slightly agree, DS = slightly disagree, D = disagree, SD = strongly disagree

To further examine willingness to help students with mental health issues among faculty the researcher conducted a factor analysis to determine if underlying constructs existed in this scale. The researcher first examined the items for degree of deviation from normality using the Shapiro-Wilks test. The measure of sampling adequacy was examined for both individual items and the overall scale. All data met the assumptions for use of factor analysis. The procedure used in conducting the factor analysis was principal components analysis with varimax rotation.

To determine the number of factors to be extracted from the scale responses, the researcher used a combination of the Latent Root criterion and the scree plot technique. Initially, the factor analysis was computed without restrictions on the number of factors extracted with the default minimum value of 1.00 on the latent root measure. With these computations, the scree plot was used to identify the optimum number of factors for extraction. This was accomplished by identifying the most pronounced bend in the scree plot curve. The optimum number of factors was determined to be two, plus or minus one. Each of these number of factors was then computed and examined for three criteria. First, the loadings for items in each of the factors extracted were examined to determine that they met the minimum acceptable loading criteria as specified by Hair, Black, Babin, Anderson, and Tatham (2006). For exploratory research Hair et al. (2006) suggested that this criterion may be as low as .30. Additionally, the analysis was examined for inefficient factors. Inefficient factors are those that include only one or two items. If the purpose of the analysis is to identify underlying constructs in the data, constructs with only one item (or in some cases two) are of little benefit to the researcher. Finally, the researcher examined each of the analyses for the presence of significant cross-loadings in the data. If an item loads significantly on multiple factors in a factor analysis, it is possible that the item was perceived differently by different individuals or groups in the responding audience. Using a

combination of these three criteria the researcher ultimately determined that the optimum number of factors to be extracted from this scale was two. The first subscale extracted was “Involvement” and contained six items. The second subscale extracted was “Faculty Role” and contained four items. The results of the factor analysis are presented in Table 14.

Table 14

Factor Analysis of Responses to “Willingness to Help Students With Mental Health Issues”  
Scale of Currently Employed Faculty of Four Year Public Universities

Subscale – Involvement	Factor 1	Factor 2
The campus mental health center is responsible for letting students know about services, not me <sup>a</sup>	.763	.078
I would intervene if I knew a student was struggling with a mental health issue	.701	.293
I wouldn't get involved in student mental health concerns, no matter the circumstances <sup>a</sup>	.699	.095
Helping students who are struggling with mental health issues is part of my job	.680	.264
I would <u>only</u> reach out to a student and offer help if their behavior was affecting their performance or participation in class <sup>a</sup>	.535	.227
If a student's mental health prevents them from being a competent participant in class then they should not be in college <sup>a</sup>	.372	.022
Subscale – Faculty Role	Factor 1	Factor 2
I am willing to learn more about warning signs for mental illness	.218	.856
I am willing to learn more about campus mental health services for students	.234	.845
I am willing to attend a training seminar on mental health	.343	.679
If one of my friends or family members were struggling with a mental health issue I would hope someone would identify the problem and offer help	-.014	.343

*Note.* <sup>a</sup> Reverse coded item

Overall sub-scale scores were computed for each participant. Since there were reverse coded items in the scale, these items had to be recoded to give participants accurate scores. All negatively worded items were recoded so that a higher score indicated more willingness to help students with mental health issues. An overall “Willingness to Help Students with Mental Health Issues - Involvement” subscale score was computed as the mean of six items in the subscale. The mean of these scores was 4.15 ( $SD = .79$ ), and the values ranged from 1.67 to 5.83. An overall “Willingness to Help Students with Mental Health Issues - Faculty Role” subscale score was computed as the mean of the four items that belong to that subscale. The mean of these scores was 4.97 ( $SD = .73$ ), and the values ranged from a low of 2.25 to a high of 6.00.

#### **Objective Four Results**

Objective four was to describe currently employed faculty of four year universities on their ability to identify students with mental health issues as measured by a researcher designed scale. Participants were asked to rate their level of agreement or disagreement to a total of 10 statements. “Strongly agree” was assigned a value of six while “strongly disagree” was assigned a value of one. Participants indicated the highest level of agreement to the statement “I admire people who advocate for the rights of the mentally ill” ( $M = 4.12$ ,  $SD = 1.15$ ) and the highest level of disagreement to the statement “The warning signs of mental health issues are clear-cut, someone struggling with a mental health issue can always be identified” ( $M = 1.58$ ,  $SD = .65$ ) (See Table 15). The following interpretive scale was developed by the researcher to aid in reporting faculty ability to identify students with mental health issues: 5.5-6 = Strongly Agree, 4.5-5.49 = Agree, 3.5-4.49 = Slightly Agree, 2.51-3.49 = Slightly Disagree, 1.51-2.5 = Disagree, 1-1.5 = Strongly Disagree. Using this scale, two items received a rating of “Slightly Agree,” two items received a rating of “Slightly Disagree,” and six items received a rating of “Disagree.”



Table 15

Ability to Identify Students with Mental Health Issues of Currently Employed Faculty of Four Year Public Universities

Statement	Mean	Standard Deviation	Interpretation <sup>a</sup>
I admire people who advocate for the rights of the mentally ill	4.12	1.15	AS
Many of the warning signs of mental health issues are normal emotions most people experience at one time or another	3.97	1.27	AS
Warning signs of mental health issues will be most obvious in those with more serious mental health issues	2.66	1.22	DS
Most people who are suicidal display warning signs	2.57	1.27	DS
People who tell others about wanting to harm or kill themselves are usually less serious than those who don't tell anyone	2.24	1.22	D
Recklessness is always a warning sign of mental illness	2.21	.92	D
If a student's mood turns from depression to happiness then there is no need for concern	1.89	.83	D
Extreme anger is always displayed by those with mental health issues	1.86	1.02	D
Mental health issues and substance abuse issues do not commonly impact the same people, generally people will only have one or the other	1.85	.86	D
The warning signs of mental health issues are clear-cut, someone struggling with a mental health issue can always be identified	1.58	.65	D

*Note.* The response scale used was 6 = strongly agree, 5 = agree, 4 = slightly agree, 3 = slightly disagree, 2 = disagree, and 1 = strongly disagree. The interpretive scale used was 5.5-6 = strongly agree, 4.5-5.49 = agree, 3.5-4.49 = slightly agree, 2.51-3.49 = slightly disagree, 1.51-2.5 = disagree, and 1-1.5 = strongly disagree.

<sup>a</sup> SA = strongly agree, A = agree, AS = slightly agree, DS = slightly disagree, D = disagree, SD = strongly disagree

To examine the ability to identify students with mental health issues, the researcher conducted a factor analysis to determine if underlying constructs existed in this scale. The researcher first examined the items for degree of deviation from normality using the Shapiro-Wilks test. In addition the measure of sampling adequacy was examined for both individual items and the overall scale. All data met the assumptions for use of factor analysis. The procedure used in conducting the factor analysis was principal components analysis with varimax rotation.

To determine the number of factors to be extracted from the scale responses, the researcher used a combination of the Latent Root criterion and the scree plot technique. Initially, the factor analysis was computed without restrictions on the number of factors extracted with the default minimum value of 1.00 on the latent root measure. Using these computations, the scree plot was examined to identify the optimum number of factors for extraction. This was accomplished by identifying the most pronounced bend in the scree plot curve. The optimum number of factors was determined to be two, plus or minus one. Each of these number of factors was then computed and examined for three criteria. First, the loadings for items in each of the factors extracted were examined to determine that they met the minimum acceptable loading criteria as specified by Hair, Black, Babin, Anderson, and Tatham (2006). For exploratory research Hair et al. (2006) suggested that this criterion may be as low as .30. Additionally, the analysis was examined for inefficient factors. Inefficient factors are those that include only one or two items. If the purpose of the analysis is to identify underlying constructs in the data, constructs with only one item (or in some cases two) are of little benefit to the researcher. Finally, the researcher examined each of the analyses for the presence of significant cross-loadings in the data. If an item loads significantly on multiple factors in a factor analysis, it is

possible that the item was perceived differently by different individuals or groups in the responding audience. Using a combination of these three criteria the researcher determined that the number of factors to be extracted from this scale was two. The first subscale was named “Related Issues” and contained six items. The second scale was named “Emotions” and contained four items. The results of the factor analysis are presented in Table 16.

Table 16

Factor Analysis of Responses to “Ability to Identify Students with Mental Health Issues” Scale of Currently Employed Faculty of Four Year Public Universities

Subscale – Related Issues	Factor 1	Factor 2
Warning signs of mental health issues will be most obvious in those with more serious mental health issues <sup>a</sup>	.700	-.178
Most people who are suicidal display warning signs	-.658	.357
If a student's mood turns from depression to happiness then there is no need for concern <sup>a</sup>	.644	.310
The warning signs of mental health issues are clear-cut, someone struggling with a mental health issue can always be identified <sup>a</sup>	.634	.177
People who tell others about wanting to harm or kill themselves are usually less serious than those who don't tell anyone <sup>a</sup>	.601	.069
Mental health issues and substance abuse issues do not commonly impact the same people, generally people will only have one or the other <sup>a</sup>	.535	.344
Subscale – Emotions	Factor 1	Factor 2
I admire people who advocate for the rights of the mentally ill	-.212	.701
Many of the warning signs of mental health issues are normal emotions most people experience at one time or another	.038	.525
Extreme anger is always displayed by those with mental health issues <sup>a</sup>	.495	.509
Recklessness is always a warning sign of mental illness <sup>a</sup>	.225	.406

*Note.* <sup>a</sup> Reverse coded item

Overall sub-scale scores were computed for each participant. Since there were reverse coded items in this scale these items had to be recoded in order to give participants accurate scores. All negatively worded items were recoded so that a higher score indicates more ability to identify students with mental health issues. An overall “Ability to Identify Students with Mental Health Issues - Related Issues” subscale score was computed as a mean of the six items determined to belong to that subscale. The mean of these scores was 4.56 (SD = .52), and the values ranged from a low of 3.00 to a high of 6.00. Also, an overall “Ability to Identify Students with Mental Health Issues – Emotions” subscale score was computed as a mean of the four items determined to belong to that subscale. The mean of these scores was 4.51 (SD = .66), and the values ranged from a low of 2.25 to a high of 6.00.

### **Objective Five Results**

Objective five was to describe currently employed faculty of four year universities on their ability to help students with mental health issues as measured by a researcher designed scale. This section of the instrument consisted of five multiple choice questions. Participants were asked to read a short vignette and choose the best action to take out of four choices given. These responses were not ranked and the best response was chosen by the researcher and validated by a panel of experts.

The first vignette, “Long-Term Depression,” received 72.2% correct responses ( $\underline{n} = 182$ ) and 27.8% incorrect responses ( $\underline{n} = 70$ ). The possible responses and the percentage selecting each are presented in Table 17.

The second vignette, “Unable to Eat or Sleep,” received 62.2% correct responses ( $\underline{n} = 156$ ) and 37.9% incorrect responses ( $\underline{n} = 95$ ). The possible responses and the percentage selecting each are presented in Table 18.

Table 17

Responses to Vignette One <sup>a</sup>: Long-Term Depression by Currently Employed Faculty of Four Year Public Universities

Responses	Frequency	Percent
A) Contact the school mental health center and give them the student's name and ID number so that they can follow-up	17	6.7
B) Keep the student's confidentiality by not telling anyone about the situation so that the student knows they can trust you	38	15.1
C) Consult the mental health center without releasing the student's name for suggestions on what to do <sup>b</sup>	182	72.2
D) Call the student later at home to check on them	15	6.0
Total	252 <sup>c</sup>	100.0

*Note.* <sup>a</sup> A student comes to you and says they've been feeling extremely depressed for a long time. You talk to the student for a few minutes before they have to go to their next class and the student says they feel better and is no longer depressed. You suggest that the student talk to someone at the mental health center but the student says they don't want to get anyone else involved. Would you:

<sup>b</sup> Best answer as selected by researcher and validated by panel of experts

<sup>c</sup> 9 study participants did not respond to this item

The third vignette, "Death of a Parent," received 59% correct responses ( $\underline{n} = 148$ ) and 41.1% incorrect responses ( $\underline{n} = 103$ ). The possible responses and the percentage selecting each are presented in Table 19.

The fourth vignette, "Threatening Suicide," received 90.8% correct responses ( $\underline{n} = 226$ ) and 9.2% incorrect responses ( $\underline{n} = 23$ ). The possible responses and the percentage selecting each are presented in Table 20.

The fifth vignette, "Unconcerned about Grades," received 55.8% correct responses ( $\underline{n} = 135$ ) and 44.2% incorrect responses ( $\underline{n} = 107$ ). The possible responses and the percentage selecting each are presented in Table 21.

Table 18

Faculty Responses to Vignette Two <sup>a</sup>: Unable to Eat or Sleep by Currently Employed Faculty of Four Year Public Universities

Responses	Frequency	Percent
A) Attempt to empathize with the student's feelings <sup>b</sup>	156	62.2
B) Assure the student that although the break-up may seem major now, it's very minor when compared to adult problems	16	6.4
C) Encourage the student to focus on the good things in life instead of the bad	69	27.5
D) Do not talk to the student about this and let the student work through this issue on their own	10	4.0
Total	251 <sup>c</sup>	100.0

*Note.* <sup>a</sup> A student comes to you and says they've just been through a major break-up and they have been unable to eat or sleep. Would you:

<sup>b</sup> Best answer as selected by researcher and validated by panel of experts

<sup>c</sup> 10 study participants did not respond to this item

Table 19

Faculty Responses to Vignette Three <sup>a</sup>: Death of a Parent by Currently Employed Faculty of Four Year Public Universities

Responses	Frequency	Percent
A) Do nothing, the student did not exhibit any warning signs of distress	60	23.9
B) Call campus mental health services and see if they can see the student right away	17	6.8
C) Give the student information on campus mental health services <sup>b</sup>	148	59.0
D) Ask the student to meet with you weekly to discuss how they are handling the loss	26	10.4
Total	251 <sup>c</sup>	100.0

*Note.* <sup>a</sup> A student comes to your office after missing a number of classes and assignments. The student explains that they missed class due to the sudden death of a parent. The student asks what they can do to make-up the work missed and you work out a plan. Would you:

<sup>b</sup> Best answer as selected by researcher and validated by panel of experts

<sup>c</sup> 10 study participants did not respond to this item

Table 20

Faculty Responses to Vignette Four <sup>a</sup>: Threatening Suicide by Currently Employed Faculty of Four Year Public Universities

Responses	Frequency	Percent
A) Call the police <sup>b</sup>	226	90.8
B) Change the student's grade	0	0.0
C) Call the student's parents	14	5.6
D) Tell the student you don't change grades based on threats and ask them to leave	9	3.6
Total	249 <sup>c</sup>	100.0

*Note.* <sup>a</sup> A student comes to your office and says that, because of a low grade you gave them, they are planning to kill themselves. The student says they have a gun at home and plan to shoot themselves if you do not change their grade. You ask the student to walk with you to the mental health center and they refuse. If you are able, would you:

<sup>b</sup> Best answer as selected by researcher and validated by panel of experts

<sup>c</sup> 12 study participants did not respond to this item

Table 21

Faculty Responses to Vignette Five <sup>a</sup>: Unconcerned About Grades by Currently Employed Faculty of Four Year Public Universities

Responses	Frequency	Percent
A) Require the student to make an appointment with the campus mental health center	30	12.4
B) Require the student to meet with you weekly so that you can help them with class assignments	77	31.8
C) Assume that something must be going on in the student's life and start giving them better grades	0	0.0
D) Do nothing, the student simply doesn't care about grades <sup>b</sup>	135	55.8
Total	242 <sup>c</sup>	100.0

*Note.* <sup>a</sup> One of your students has gotten consistently poor grades in your course. You ask to talk to them after class and they seem genuinely unconcerned about their poor grades. Would you:

<sup>b</sup> Best answer as selected by researcher and validated by panel of experts

<sup>c</sup> 19 study participants did not respond to this item

All responses to these five items were recoded so that the correct responses were given a value of 1 and all other responses were given a value of 0. The vignette that received the largest number of correct responses was the vignette “A student comes to your office and says that, because of a low grade you gave them, they are planning to kill themselves. The student says they have a gun at home and plan to shoot themselves if you do not change their grade. You ask the student to walk with you to the mental health center and they refuse. If you are able, would you:” (N = 226, 90.8%). The vignette that received the largest number of incorrect responses was to the vignette “One of your students has gotten consistently poor grades in your course. You ask to talk to them after class and they seem genuinely unconcerned about their poor grades. Would you:” (N = 107, 44.2%). The total number of correct and incorrect responses to the items in this scale are presented in Table 22.

Table 22

Accuracy of Responses to Items Measuring Faculty Ability to Help Students with Mental Health Issues of Currently Employed Faculty Members of Four Year Public Universities

	Correct		Incorrect		Total	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Vignette Four <sup>a</sup> : Threatening Suicide	226	90.8	23	9.2	249	100.0
Vignette One <sup>b</sup> : Long-Term Depression	182	72.2	70	27.8	252	100.0
Vignette Two <sup>c</sup> : Unable to Eat or Sleep	156	62.2	95	37.8	251	100.0
Vignette Three <sup>d</sup> : Death of a Parent	148	59.0	103	59.0	251	100.0
Vignette Five <sup>e</sup> : Unconcerned About Grades	135	55.8	107	44.2	242	100.0



(Table 22 Continued)

*Note.* <sup>a</sup> A student comes to your office and says that, because of a low grade you gave them, they are planning to kill themselves. The student says they have a gun at home and plan to shoot themselves if you do not change their grade. You ask the student to walk with you to the mental health center and they refuse. If you are able, would you:

<sup>b</sup> A student comes to you and says they've been feeling extremely depressed for a long time. You talk to the student for a few minutes before they have to go to their next class and the student says they feel better and is no longer depressed. You suggest that the student talk to someone at the mental health center but the student says they don't want to get anyone else involved. Would you:

<sup>c</sup> A student comes to you and says they've just been through a major break-up and they have been unable to eat or sleep. Would you:

<sup>d</sup> A student comes to your office after missing a number of classes and assignments. The student explains that they missed class due to the sudden death of a parent. The student asks what they can do to make-up the work missed and you work out a plan. Would you:

<sup>e</sup> One of your students has gotten consistently poor grades in your course. You ask to talk to them after class and they seem genuinely unconcerned about their poor grades. Would you:

Additionally, an ability to help students with mental health issues score was computed from the responses provided by the participants to these five items. This score was computed by assigning a value of one for each item to which a correct response was provided (best response as specified by the researcher and validated by the panel of experts) and a value of zero for each to which an incorrect response was provided. Therefore, the possible range of scores was from zero to five with five indicating that the participant responded accurately to all of the items and a value of zero indicating that the participant responded inaccurately to all five items. The mean score of all participants was 3.35 (SD = .98). A summary of scores are presented in Table 23.

### **Objective Six Results**

Objective six was to determine if a relationship exists between selected personal and professional demographic characteristics of currently employed faculty of four year public universities and the following perceptual measures: attitude toward mental health, willingness to

help students with mental health issues, ability to identify students with mental health issues, and ability to help students with mental health issues.

Table 23

“Ability to Help Students with Mental Health Issues” Scores of Currently Employed Faculty of Four Year Public Universities

Score	Frequency	Percent
0	0	0.0
1	9	3.6
2	38	15.0
3	90	35.6
4	88	34.8
5	28	11.0
Total	253 <sup>a</sup>	100.0

*Note.* Mean Ability to Help Students with Mental Health Issues Score = 3.35, SD = .98

<sup>a</sup> 8 participants did not respond to one or more of the items

**Attitude toward mental health.** In order to determine if relationships existed between the attitude toward mental health of faculty members of four-year public universities and the demographics that were measured as dichotomous variables, the researcher chose to utilize the independent t-test procedure for the analysis. This procedure was chosen for ease of interpretation of the relevant findings. A total of 11 dichotomous variables were included in this analysis. Of these 11 variables, attitude scores were found to be significantly different by the categories of eight of the variables (See Table 24).

Six of the eight variables by which significant differences were found in attitude scores were part of the variable “Mental Health Experience.” These included: 1) having previous mental health training ( $t_{222.354} = 5.445, p < .001$ ), 2) having received a mental health diagnosis ( $t_{101.791} =$

3.852,  $p < .001$ ), 3) having a friend or family member who had a mental illness or had attempted or completed suicide ( $t_{145.467} = 3.747$ ,  $p < .001$ ), 4) knowing anyone who had a mental illness or who has attempted or completed suicide ( $t_{38.081} = 3.223$ ,  $p = .003$ ), 5) having a degree in psychology, social work, or counseling ( $t_{249} = 2.047$ ,  $p = .042$ ), and 6) practicing a religion which discourages the use of mental health services ( $t_{247} = 2.027$ ,  $p = .044$ ). For all of these variables the faculty in the category that was indicative of more mental health experience had higher attitude scores.

Table 24

Comparison of “Attitude toward Mental Health” Scale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty Members of Four Year Public Universities

Variable	<u>n</u>	M	SD	<u>t</u>	df	<u>p</u>
Had Training <sup>a</sup>	Yes	79	5.49	.37	5.445 <sup>n</sup>	222.354
	No	171	5.17	.57		
Diagnosis <sup>b</sup>	Yes	49	5.48	.39	3.852 <sup>n</sup>	101.791
	No	202	5.21	.56		
Friend/Family <sup>c</sup>	Yes	165	5.36	.48	3.747 <sup>n</sup>	145.467
	No	86	5.08	.59		
Offer Training <sup>d</sup>	Yes	215	5.31	.52	3.327	246
	No	33	4.98	.58		
Know Anyone <sup>e</sup>	Yes	217	5.32	.49	3.223 <sup>n</sup>	38.081
	No	34	4.92	.70		
Gender <sup>f</sup>	Male	108	5.15	.56	3.078	248
	Female	142	5.36	.51		

(Table 24 continued)

Variable	n	M	SD	t	df	p
Degree <sup>g</sup>	Yes	28	5.46	2.047	249	.042
	No	223	5.24			
Religion <sup>h</sup>	Yes	12	4.96	2.027	247	.044
	No	237	5.28			
Suicide <sup>i</sup>	Yes	27	5.39	1.275	248	.204
	No	223	5.25			
Effort <sup>j</sup>	Yes	218	5.28	1.017	247	.310
	No	31	5.17			
University <sup>k</sup>	A <sup>l</sup>	159	5.29	.637	247	.525
	B <sup>m</sup>	90	5.24			

*Note.* <sup>a</sup> Have you ever had any training on mental health issues or suicide prevention?

<sup>b</sup> Have you ever received a mental health diagnosis?

<sup>c</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>d</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>e</sup> Have you ever known anyone who has been diagnosed with a metal illness or has attempted or completed suicide?

<sup>f</sup> Please indicate your gender:

<sup>g</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>h</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>i</sup> Have you ever contemplated or attempted suicide?

<sup>j</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>k</sup> Which university are you a faulty member of:

<sup>l</sup> University "A" is described in the Carnegie Classification as a large, master's university

<sup>m</sup> University "B" is described in the Carnegie Classification as a medium research university

<sup>n</sup> t-test using separate variance estimate

Additionally, the mean attitude score for female faculty members ( $M = 5.36$ ) was found to be significantly higher ( $t_{248} = 3.078, p = .002$ ) than the mean attitude score for male faculty members ( $M = 5.15$ ). Also, faculty members who believe their university should offer training on how to identify students struggling with mental health issues ( $M = 5.31$ ) had significantly high attitude scores ( $t_{246} = 3.327, p = .001$ ) than those who did not ( $M = 4.98$ ).

In order to determine if relationships existed between the “Attitude toward Mental Health” scale score of faculty members of four-year public universities and the demographics that were measured as categorical variables with more than two categories, the researcher chose to utilize the one-way analysis of variance (ANOVA) procedure for the analysis. This procedure was chosen for ease of interpretation of the relevant findings. A total of four categorical variables were included in this analysis. Of these four variables, attitude scores were found to be significantly different by the categories of two of the variables (See Table 25). For this analysis, any category with less than 10 subjects was omitted from the comparisons.

Table 25

Comparison of “Attitude toward Mental Health” Scale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	df	F	<u>p</u>
Race/Ethnicity <sup>a</sup>	244	3, 240	7.998	<.001
Department <sup>b</sup>	252	5, 246	3.927	.002
Duties <sup>c</sup>	251	3, 247	1.398	.244
Faculty Status <sup>d</sup>	249	3, 245	.144	.934

*Note.* <sup>a</sup> Please indicate your race/ethnicity: A) American Indian or Alaskan Native (omitted due to low n) B) Asian C) Black or African American D) Native Hawaiian or Other Pacific Islander (omitted due to low n) E) White, Hispanic or Latino F) White, not Hispanic or Latino

<sup>b</sup> Which of the following best describes the college or department in which you work: A) Art B) Business C) Education D) Engineering E) Humanities & Social Sciences F) Science

(Table 25 continued)

<sup>c</sup> How would you describe the amount of time you spend teaching (including preparation and office hours) versus the amount of time you spend doing research? A) About equal B) Spend more time teaching C) Spend more time doing research D) Do not teach at all (omitted due to low n) E) Do not do research at all

<sup>d</sup> Please indicate the category that best describes your faculty status: A) Part-Time (omitted due to low n) B) Adjunct C) Full-Time, Non-Tenure Track D) Full-Time, Tenure Track E) Tenured  
“Attitude toward Mental Health” scores were found to be significantly different among

the categories of the variable race/ethnicity ( $F_{3, 240} = 7.998, p < .001$ ) and the variable department ( $F_{5, 246} = 3.927, p = .002$ ). Specifically, it was found that faculty members that identified as “Asian” had significantly lower “Attitude toward Mental Health” scale scores than the other three racial/ethnic groups (See Table 26). Also, faculty participants that reported that they worked in the department of art were found to have significantly higher “Attitude toward Mental Health” scores than those that reported working in engineering (See Table 27).

Table 26

Comparison of “Attitude toward Mental Health” Scale Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity

Source	df	MS	F	p
Between Groups	3	1.904	7.998	<.001
Within Groups	240	.238		
Total	240	.238		
Group	<u>n</u>	M	Tukey <sup>a</sup>	
Black or African American	11	5.37	B	
White, not Hispanic or Latino	189	5.35	B	
White, Hispanic or Latino	26	5.22	B	
Asian	18	4.77	A	

Note. <sup>a</sup> Groups that do not have a common letter are significantly different.

In order to determine if relationships existed between the attitude toward mental health among faculty members of four-year public universities and the demographics that were

measured as ordinal variables, the researcher chose to utilize the Kendall's Tau Correlation Coefficient procedure for the analysis. A total of five variables were included in this analysis. Of these five variables, "Attitude toward Mental Health" scores were found to be significantly related to one variable (See Table 28).

Table 27

Comparison of "Attitude toward Mental Health" Scale Scores of Currently Employed Faculty Members of Four Year Public Universities by Categories of Department

Source	df	MS	F	p
Between Groups	5	1.072	3.927	.002
Within Groups	246	.273		
Total	251			
Group	n	M	Tukey <sup>a</sup>	
Art	13	5.42	B	
Education	37	5.41	A, B	
Humanities & Social Sciences	87	5.39	A, B	
Science	77	5.14	A, B	
Business	28	5.08	A, B	
Engineering	10	4.97	A	

*Note.* <sup>a</sup> Groups that do not have a common letter are significantly different.

"Attitude toward Mental Health" scale scores among faculty members were found to be significantly positively correlated with awareness of campus mental health services available to students ( $r = .15$ ,  $p = .002$ ). In order to gauge faculty awareness of mental health services available to students, participants were asked to rate their awareness by choosing one of the following: very aware of services, somewhat aware of services, somewhat unaware of services, very unaware of services. This means that faculty who indicated that they were more aware of services tended to have more positive attitudes towards mental health than those who reported

being unaware of services. Using Davis' (1971) Descriptors this correlation is classified as a low association.

Table 28

Comparison of "Attitude toward Mental Health" Scale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty Members of Four Year Public Universities

Variable	r	<u>n</u>	<u>p</u>	Descriptor <sup>a</sup>
Services <sup>b</sup>	.15	250	.002	Low Association
Size <sup>c</sup>	-.09	251	.063	Negligible Association
Experience <sup>d</sup>	-.02	251	.674	Negligible Association
Age <sup>e</sup>	.01	253	.786	Negligible Association
Rank <sup>f</sup>	-.01	251	.871	Negligible Association

*Note.* <sup>a</sup> Davis' Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

<sup>b</sup> How much do you know about the mental health services available to students at your university? A) Very aware of services B) Somewhat aware of services C) Somewhat unaware of services D) Very unaware of services

<sup>c</sup> Which of the following best describes the typical class size of the courses you teach? A) 0-24 B) 25-49 C) 50-74 D) 75-99 E) 100 +

<sup>d</sup> Please indicate your total years of experience as a faculty member, combining all colleges and universities at which you may have worked: A) 0-19 B) 10-19 C) 20-29 D) 30-39 E) 40-49 F) 50 +

<sup>e</sup> Please indicate your age range: A) 25 or under B) 26-35 C) 36-45 D) 46-55 E) 55-65 F) 66 or older

<sup>f</sup> Please indicate which title best describes your rank as a faculty member: A) Instructor B) Assistant Professor C) Associate Professor D) Professor

**Willingness to help students with mental health issues – involvement subscale.** In order to determine if relationships existed between the "Willingness to Help Students with Mental Health Issues – Involvement" subscale score of faculty members of four-year public universities and the demographics that were measured as dichotomous variables, the researcher chose to utilize the independent t-test procedure for the analysis. This procedure was chosen for



ease of interpretation of the relevant findings. A total of 11 dichotomous variables were included in this analysis. Of these 11 variables, “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores were found to be significantly different by the categories of six of the variables (See Table 29).

Table 29

Comparison of “Willingness to Help Students with Mental Health Issues – Involvement” Subscale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty Members of Four Year Public Universities

Variable	<u>n</u>	M	SD	<u>t</u>	df	<u>p</u>
Had Training <sup>a</sup>	Yes	79	4.59	6.303	248	<.001
	No	171	3.96			
Offer Training <sup>b</sup>	Yes	215	4.24	4.908	246	<.001
	No	33	3.54			
Degree <sup>c</sup>	Yes	28	4.66	3.681	249	<.001
	No	223	4.09			
Know Anyone <sup>d</sup>	Yes	217	4.21	3.345	249	.001
	No	34	3.73			
Effort <sup>e</sup>	Yes	218	4.21	2.932	247	.004
	No	31	3.77			
Gender <sup>f</sup>	Male	109	4.01	2.570	249	.011
	Female	142	4.26			
Diagnosis <sup>g</sup>	Yes	49	4.34	1.878	249	.062
	No	202	4.11			

(Table 29 continued)

Friend/ Family <sup>h</sup>	Yes	165	4.22	.79	1.711	249	.088
	No	86	4.04	.79			
University <sup>i</sup>	A <sup>l</sup>	160	4.11	.80	1.597	248	.112
	B <sup>m</sup>	90	4.27	.72			
Suicide <sup>j</sup>	Yes	27	4.36	.79	1.449	248	.149
	No	223	4.13	.79			
Religion <sup>k</sup>	Yes	12	3.85	.90	1.352	247	.177
	No	237	4.16	.79			

*Note.* <sup>a</sup> Have you ever had any training on mental health issues or suicide prevention?

<sup>b</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>c</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>d</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>e</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>f</sup> Please indicate your gender:

<sup>g</sup> Have you ever received a mental health diagnosis?

<sup>h</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>i</sup> Which university are you a faculty member of:

<sup>j</sup> Have you ever contemplated or attempted suicide?

<sup>k</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>l</sup> University "A" is described in the Carnegie Classification as a large, master's university

<sup>m</sup> University "B" is described in the Carnegie Classification as a medium research university

Three of the six variables by which significant differences were found in "Willingness to Help Students with Mental Health Issues – Involvement" subscale scores were part of the variable "Mental Health Experience." These included: 1) having previous mental health training ( $t_{248} = 6.303, p < .001$ ), 2) having a degree in psychology, social work, or counseling ( $t_{249} =$

3.681,  $p < .001$ ), and 3) knowing anyone who had a mental illness or who has attempted or completed suicide ( $t_{249} = 3.345$ ,  $p = .001$ ). For all of these variables the faculty in the category that was indicative of more mental health experience had higher “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores. Two of the other six variables by which significant differences were found in “Willingness to Help students with Mental Health Issues – Involvement” subscale scores were part of the variable “Beliefs about University’s Role in Mental Health Services.” These included beliefs about whether or not their university should offer training on how to identify students struggling with mental health issues ( $t_{246} = 4.908$ ,  $p < .001$ ) and beliefs about whether or not their university should make more of an effort to ensure that faculty members are aware of mental health services available to students ( $t_{247} = 2.932$ ,  $p = .004$ ). For both of these variables the faculty in the category that was indicative of believing the university should have a larger role in mental health services was associated with higher “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores. The final variable by which significant differences were found in “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores was gender ( $t_{249} = 2.570$ ,  $p = .011$ ). Specifically the mean score for female faculty members ( $M = 4.26$ ) was found to be significantly higher than the mean score of male faculty members ( $M = 4.01$ ) for this subscale.

In order to determine if relationships existed between the “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores of faculty members of four-year public universities and the demographics that were measured as categorical variables with more than two categories, the researcher chose to utilize the one-way analysis of variance (ANOVA) procedure for the analysis. This procedure was chosen for ease of interpretation of the relevant findings. A total of four categorical variables were included in this analysis. Of these four

variables, “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores were found to be significantly different by the categories of one variable (See Table 30).

For this analysis, any category with less than 10 subjects was omitted from the comparisons.

Table 30

Comparison of “Willingness to Help Students with Mental Health Issues – Involvement” Subscale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	df	F	<u>p</u>
Race/Ethnicity <sup>a</sup>	244	3, 240	2.710	.046
Department <sup>b</sup>	252	5, 246	.868	.503
Faculty Status <sup>c</sup>	250	3, 246	.418	.740
Duties <sup>d</sup>	251	3, 247	.044	.988

*Note.* <sup>a</sup> Please indicate your race/ethnicity: A) American Indian or Alaskan Native (omitted due to low n) B) Asian C) Black or African American D) Native Hawaiian or Other Pacific Islander (omitted due to low n) E) White, Hispanic or Latino F) White, not Hispanic or Latino

<sup>b</sup> Which of the following best describes the college or department in which you work: A) Art B) Business C) Education D) Engineering E) Humanities & Social Sciences F) Science

<sup>c</sup> Please indicate the category that best describes your faculty status: A) Part-Time (omitted due to low n) B) Adjunct C) Full-Time, Non-Tenure Track D) Full-Time, Tenure Track E) Tenured

<sup>d</sup> How would you describe the amount of time you spend teaching (including preparation and office hours) versus the amount of time you spend doing research? A) About equal B) Spend more time teaching C) Spend more time doing research D) Do not teach at all (omitted due to low n) E) Do not do research at all

“Willingness to Help Students with Mental Health Issues – Involvement” subscale scores were found to be significantly different among the categories of the variable race/ethnicity ( $F_{3, 240} = 2.710$ ,  $p = .046$ ). Specifically, it was found that faculty members that identified as “Asian” had significantly lower “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores than those that identified as “Black or African American” (See Table 31).

Table 31

Comparison of “Willingness to Help Students with Mental Health Issues – Involvement”  
Subscale Scores of Currently Employed Faculty Members of Four Year Public Universities by  
Categories of Race/Ethnicity

Source	df	MS	F	p
Between Groups	3	1.659	2.710	.046
Within Groups	240	.612		
Total	243			
Group	n	M	Tukey <sup>a</sup>	
Black or African American	11	4.51	B	
White, Hispanic or Latino	26	4.26	A, B	
White, not Hispanic or Latino	189	4.18	A, B	
Asian	18	3.73	A	

*Note.* <sup>a</sup> Groups that do not have a common letter are significantly different.

In order to determine if relationships existed between the “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores among faculty members of four-year public universities and the demographics that were measured as ordinal variables, the researcher utilized the Kendall’s Tau Correlation Coefficient procedure for the analysis. A total of five variables were included in this analysis. Of these five variables, “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores were found to be significantly related to one variable (See Table 32).

“Willingness to Help Students with Mental Health Issues – Involvement” subscale scores among faculty members were found to be significantly positively correlated with awareness of campus mental health services available to students ( $r = .27$ ,  $p < .001$ ). Using Davis’ (1971) Descriptors this correlation was described as a “low association.” This means that faculty who indicated that

they were more aware of services tended to have higher “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores.

Table 32

Comparison of “Willingness to Help Students with Mental Health Issues – Involvement” Subscale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	r	n	p	Descriptor <sup>a</sup>
Services <sup>b</sup>	.27	250	<.001	Low Association
Age <sup>c</sup>	.06	254	.254	Negligible Association
Experience <sup>d</sup>	.03	252	.611	Negligible Association
Size <sup>e</sup>	-.02	252	.716	Negligible Association
Rank <sup>f</sup>	-.01	251	.851	Negligible Association

*Note.* <sup>a</sup> Davis’ Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

<sup>b</sup> How much do you know about the mental health services available to students at your university? A) Very aware of services B) Somewhat aware of services C) Somewhat unaware of services D) Very unaware of services

<sup>c</sup> Please indicate your age range: A) 25 or under B) 26-35 C) 36-45 D) 46-55 E) 55-65 F) 66 or older

<sup>d</sup> Please indicate your total years of experience as a faculty member, combining all colleges and universities at which you may have worked: A) 0-19 B) 10-19 C) 20-29 D) 30-39 E) 40-49 F) 50 +

<sup>e</sup> Which of the following best describes the typical class size of the courses you teach? A) 0-24 B) 25-49 C) 50-74 D) 75-99 E) 100 +

<sup>f</sup> Please indicate which title best describes your rank as a faculty member: A) Instructor B) Assistant Professor C) Associate Professor D) Professor

### **Willingness to help students with mental health issues – faculty role subscale.** In

order to determine if relationships existed between the “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores among currently employed faculty members of public four year universities and the personal and professional demographics that were measured as dichotomous variables, the researcher chose to utilize the independent t-test

procedure for the analysis. This procedure was chosen for ease of interpretation of the relevant findings. A total of 11 dichotomous variables were included in this analysis. Of these 11 variables, “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores were found to be significantly different by the categories of five of the variables (See Table 33).

Table 33

Comparison of “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable		<u>n</u>	<u>M</u>	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Offer Training <sup>a</sup>	Yes	215	5.10	.64	6.259 <sup>n</sup>	38.523	<.001
	No	33	4.19	.80			
Had Training <sup>b</sup>	Yes	79	5.22	.65	3.821	248	<.001
	No	171	4.85	.74			
Effort <sup>c</sup>	Yes	218	5.06	.65	3.804 <sup>n</sup>	34.215	.001
	No	31	4.40	.94			
Know Anyone <sup>d</sup>	Yes	217	5.01	.73	2.508	249	.013
	No	34	4.67	.67			
Degree <sup>e</sup>	Yes	28	5.23	.69	2.189	249	.030
	No	223	4.93	.73			
Suicide <sup>f</sup>	Yes	27	5.20	.69	1.769	248	.078
	No	223	4.94	.73			

(Table 33 continued)

Variable	n	M	SD	t	df	p
Gender <sup>g</sup>	Male	109	4.89	1.570	249	.118
	Female	142	5.03			
Diagnosis <sup>h</sup>	Yes	49	5.09	1.344	249	.180
	No	202	4.94			
Friend/ Family <sup>i</sup>	Yes	165	5.01	1.310	249	.191
	No	86	4.89			
Religion <sup>j</sup>	Yes	12	4.76	.970	247	.333
	No	237	4.97			
University <sup>k</sup>	A <sup>l</sup>	160	4.98	.339	248	.735
	B <sup>m</sup>	90	4.95			

<sup>a</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>b</sup> Have you ever had any training on mental health issues or suicide prevention?

<sup>c</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>d</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>e</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>f</sup> Have you ever contemplated or attempted suicide?

<sup>g</sup> Please indicate your gender:

<sup>h</sup> Have you ever received a mental health diagnosis?

<sup>i</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>j</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>k</sup> Which university are you a faculty member of:

<sup>l</sup> University "A" is described in the Carnegie Classification as a large, master's university

<sup>m</sup> University "B" is described in the Carnegie Classification as a medium research university

<sup>n</sup> t-test using separate variance estimate



Three of the five variables by which significant differences were found in “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores were part of the variable “Mental Health Experience.” These included: 1) having previous mental health training ( $t_{248} = 3.821, p < .001$ ), 2) knowing anyone who has had a mental illness or who has attempted or completed suicide ( $t_{249} = 2.508, p = .013$ ), and 3) having a degree in psychology, social work, or counseling ( $t_{249} = 2.189, p = .030$ ). For all of these variables, the faculty in the category that was indicative of more mental health experience had higher “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores. The other two variables by which significant differences were found in “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores were part of the variable “Beliefs about University’s Role in Mental Health Services.” These included beliefs about whether or not their university should offer training on how to identify students struggling with mental health issues ( $t_{38,523} = 6.259, p < .001$ ) and beliefs about whether or not their university should make more of an effort to ensure that faculty members are aware of mental health services available to students ( $t_{34,215} = 3.804, p = .001$ ). For both of these, the faculty in the category that was indicative of believing the university should have a larger role in mental health services was associated with higher “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores.

In order to determine if relationships existed between the “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores among currently employed faculty members of public four year universities and the demographics that were measured as categorical variables with more than two categories, the researcher chose to utilize the one-way analysis of variance (ANOVA) procedure for the analysis. A total of four categorical variables were included in this analysis. Of these four variables, “Willingness to Help Students with

Mental Health Issues – Faculty Role” subscale scores were not found to be significantly different by the categories of any of the variables (See Table 34).

Table 34

Comparison of “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	df	F	<u>P</u>
Department <sup>a</sup>	252	5, 246	1.347	.245
Race/Ethnicity <sup>b</sup>	244	3, 240	.840	.473
Faculty Status <sup>c</sup>	250	3, 246	.450	.718
Duties <sup>d</sup>	251	3, 247	.188	.905

<sup>a</sup> Please indicate your race/ethnicity: A) American Indian or Alaskan Native (omitted due to low n) B) Asian C) Black or African American D) Native Hawaiian or Other Pacific Islander (omitted due to low n) E) White, Hispanic or Latino F) White, not Hispanic or Latino

<sup>b</sup> Which of the following best describes the college or department in which you work: A) Art B) Business C) Education D) Engineering E) Humanities & Social Sciences F) Science

<sup>c</sup> Please indicate the category that best describes your faculty status: A) Part-Time (omitted due to low n) B) Adjunct C) Full-Time, Non-Tenure Track D) Full-Time, Tenure Track E) Tenured

<sup>d</sup> How would you describe the amount of time you spend teaching (including preparation and office hours) versus the amount of time you spend doing research? A) About equal B) Spend more time teaching C) Spend more time doing research D) Do not teach at all (omitted due to low n) E) Do not do research at all

In order to determine if relationships existed between “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores among currently employed faculty members of four-year public universities and the demographics measured as ordinal variables, the researcher utilized the Kendall’s Tau Correlation Coefficient procedure for the analysis. A total of five variables were included in this analysis. Of these five variables, “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores were found to be significantly related to one variable (See Table 35).

Table 35

Comparison of “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	r	<u>n</u>	<u>p</u>	Descriptor <sup>a</sup>
Services <sup>b</sup>	.20	250	<.001	Low Association
Age <sup>c</sup>	.05	254	.358	Negligible Association
Rank <sup>d</sup>	-.03	251	.602	Negligible Association
Experience <sup>e</sup>	.03	252	.618	Negligible Association
Size <sup>f</sup>	-.02	252	.777	Negligible Association

<sup>a</sup> Davis’ Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

<sup>b</sup> How much do you know about the mental health services available to students at your university? A) Very aware of services B) Somewhat aware of services C) Somewhat unaware of services D) Very unaware of services

<sup>c</sup> Please indicate your age range: A) 25 or under B) 26-35 C) 36-45 D) 46-55 E) 55-65 F) 66 or older

<sup>d</sup> Please indicate which title best describes your rank as a faculty member: A) Instructor B) Assistant Professor C) Associate Professor D) Professor

<sup>e</sup> Please indicate your total years of experience as a faculty member, combining all colleges and universities at which you may have worked: A) 0-19 B) 10-19 C) 20-29 D) 30-39 E) 40-49 F) 50 +

<sup>f</sup> Which of the following best describes the typical class size of the courses you teach? A) 0-24 B) 25-49 C) 50-74 D) 75-99 E) 100 +

“Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores were found to be significantly positively correlated with awareness of campus mental health services available to students ( $r = .20$ ,  $p < .001$ ). Using Davis’ (1971) Descriptors this correlation was described as a “low association.” This means that faculty who indicated that they were more aware of services tended to have more willingness to help students with mental health issues, according to the faculty role subscale.

**Ability to identify students with mental health issues – related issues subscale.** In order to determine if relationships existed between “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores among currently employed faculty members of public four year universities and the personal and professional demographics that were measured as dichotomous variables, the researcher chose to utilize the independent t-test procedure for the analysis. This procedure was chosen for ease of interpretation of the relevant findings. A total of 11 dichotomous variables were included in this analysis. Of these 11 variables, “Ability to Identify Students with Mental Health Issues - Related Issues” subscale scores were found to be significantly different by the categories of seven of the variables (See Table 36).

Six of the seven variables by which significant differences were found “Ability to Identify Students with Mental Illness – Related Issues” subscale scores were part of the variable “Mental Health Experience.” These included: 1) having previous mental health training ( $t_{248} = 5.046, p < .001$ ), 2) knowing anyone who has had a mental illness or who has attempted or completed suicide ( $t_{249} = 4.763, p < .001$ ), 3) having a degree in psychology, social work, or counseling ( $t_{249} = 3.966, p < .001$ ), 4) having received a mental health diagnosis personally ( $t_{90.791} = 2.679, p = .009$ ), 5) having a close friend or family member who has had a mental illness or who has attempted or completed suicide ( $t_{249} = 2.337, p = .020$ ), and 6) having personally contemplated or attempted suicide ( $t_{248} = 1.993, p = .047$ ). For all of these variables, the faculty in the category that was indicative of more mental health experience had higher ability to identify students with mental health issues related issues subscale scores. Additionally the mean “Ability to Identify Students with Mental Health Issues - Related Issues” subscale score of female faculty members ( $M = 4.64$ ) was found to be significantly higher than the mean score of male faculty members ( $M = 4.46$ ).

Table 36

Comparison of “Ability to Identify Students with Mental Health Issues- Related Issues” Subscale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	M	SD	<u>t</u>	df	<u>p</u>
Had Training <sup>a</sup>	Yes	79	4.79	5.046	248	<.001
	No	171	4.46			
Know Anyone <sup>b</sup>	Yes	217	4.62	4.763	249	<.001
	No	34	4.20			
Degree <sup>c</sup>	Yes	28	4.90	3.966	249	<.001
	No	223	4.52			
Gender <sup>d</sup>	Male	109	4.46	2.959	249	.003
	Female	142	4.64			
Diagnosis <sup>e</sup>	Yes	49	4.70	2.679 <sup>n</sup>	90.791	.009
	No	202	4.52			
Friend/Family <sup>f</sup>	Yes	165	4.61	2.337	249	.020
	No	86	4.46			
Suicide <sup>g</sup>	Yes	27	4.73	1.993	248	.047
	No	223	4.53			
Offer Training <sup>h</sup>	Yes	215	4.57	1.123	246	.262
	No	33	4.47			
Effort <sup>i</sup>	Yes	218	4.57	.833	247	.406
	No	31	4.49			

(Table 36 continued)

Variable		n	M	SD	<u>t</u>	df	<u>p</u>
University <sup>j</sup>	A <sup>l</sup>	160	4.56	.48	.106	248	.916
	B <sup>m</sup>	90	4.56	.53			
Religion <sup>k</sup>	Yes	12	4.56	.55	.033	247	.973
	No	237	4.56	.50			

<sup>a</sup> Have you ever had any training on mental health issues or suicide prevention?

<sup>b</sup> Have you ever known anyone who has been diagnosed with a metal illness or has attempted or completed suicide?

<sup>c</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>d</sup> Please indicate your gender:

<sup>e</sup> Have you ever received a mental health diagnosis?

<sup>f</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>g</sup> Have you ever contemplated or attempted suicide?

<sup>h</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>i</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>j</sup> Which university are you a faulty member of:

<sup>k</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>l</sup> University “A” is described in the Carnegie Classification as a large, master’s university

<sup>m</sup> University “B” is described in the Carnegie Classification as a medium research university

<sup>n</sup> t-test using separate variance estimate

In order to determine if relationships existed between the “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores among currently employed faculty members of public four year universities and the demographics that were measured as categorical variables with more than two categories, the researcher chose to utilize the one-way analysis of variance (ANOVA) procedure for the analysis. A total of four categorical variables were included in this analysis. Of these four variables, “Ability to Identify Students with Mental Health Issues - Related Issues” subscale scores were found to be significantly different by the categories of two of the variables (See Table 37).

Table 37

Comparison of “Ability to Identify Students with Mental Health Issues- Related Issues” Subscale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	df	F	<u>p</u>
Race/Ethnicity <sup>a</sup>	244	3, 240	11.607	<.001
Department <sup>b</sup>	252	5, 246	5.086	<.001
Duties <sup>c</sup>	251	3, 247	.987	.399
Faculty Status <sup>d</sup>	250	3, 246	.282	.838

<sup>a</sup> Please indicate your race/ethnicity: A) American Indian or Alaskan Native (omitted due to low n) B) Asian C) Black or African American D) Native Hawaiian or Other Pacific Islander (omitted due to low n) E) White, Hispanic or Latino F) White, not Hispanic or Latino

<sup>b</sup> Which of the following best describes the college or department in which you work: A) Art B) Business C) Education D) Engineering E) Humanities & Social Sciences F) Science

<sup>c</sup> How would you describe the amount of time you spend teaching (including preparation and office hours) versus the amount of time you spend doing research? A) About equal B) Spend more time teaching C) Spend more time doing research D) Do not teach at all (omitted due to low n) E) Do not do research at all

<sup>d</sup> Please indicate the category that best describes your faculty status: A) Part-Time (omitted due to low n) B) Adjunct C) Full-Time, Non-Tenure Track D) Full-Time, Tenure Track E) Tenured

“Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores were found to be significantly different among the categories of the variable race/ethnicity ( $F_{3, 240} = 11.607$ ,  $p < .001$ ) and the variable department ( $F_{5, 246} = 5.086$ ,  $p < .001$ ). Specifically, it was found that faculty members that identified as “Asian” had significantly lower “Ability to Identify Students with Mental Health Issues –Related Issues” subscale scores than the other three racial/ethnic groups (See Table 38). Also, faculty participants that reported that they worked in the department of art were found to have significantly higher “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores than those that reported working in engineering (See Table 39).

Table 38

Comparison of “Ability to Identify Students with Mental Health Issues – Related Issues” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity

Source	df	MS	F	p
Between Groups	3	2.461	11.607	<.001
Within Groups	240	.212		
Total	243			
Group	n	M	Tukey <sup>a</sup>	
White, not Hispanic or Latino	189	4.64	B	
White, Hispanic or Latino	26	4.57	B	
Black or African American	11	4.44	B	
Asian	18	3.98	A	

<sup>a</sup> Groups that do not have a common letter are significantly different.

In order to determine if relationships existed between “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores among currently employed faculty members of four-year public universities and the demographics measured as ordinal variables, the researcher utilized the Kendall’s Tau Correlation Coefficient procedure for the analysis. A total of five variables were included in this analysis. Of these five variables, “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores were found to be significantly related to one variable (See Table 40).

“Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores were found to be significantly positively correlated with awareness of campus mental health services available to students ( $r = .14$ ,  $p = .007$ ). Using Davis’ (1971) Descriptors this correlation was described as a “low association.” This means that faculty who indicated that they were more



aware of services tended to have higher “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores.

Table 39

Comparison of “Ability to Identify Students with Mental Health Issues – Related Issues” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities by Categories of Department

Source	df	MS	F	p
Between Groups	5	1.164	5.086	<.001
Within Groups	246	.229		
Total	251			
Group	n	M	Tukey <sup>a</sup>	
Art	13	4.85	C	
Education	37	4.70	B, C	
Humanities & Social Sciences	87	4.64	B, C	
Business	28	4.55	B, C	
Science	77	4.41	A, B	
Engineering	10	4.13	A	

<sup>a</sup> Groups that do not have a common letter are significantly different.

**Ability to identify students with mental health issues – emotions subscale.** In order to determine if relationships existed between “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores among currently employed faculty members of public four year universities and the personal and professional demographics that were measured as dichotomous variables, the researcher chose to utilize the independent t-test procedure for the analysis. This procedure was chosen for ease of interpretation of the relevant findings. A total of 11 dichotomous variables were included in this analysis. Of these 11 variables, “Ability to

Identify Students with Mental Health Issues – Emotions” subscale scores were found to be significantly different by the categories of five of the variables (See Table 41)

Table 40

Comparison of “Ability to Identify Students with Mental Health Issues- Related Issues” Subscale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	r	<u>n</u>	<u>p</u>	Descriptor <sup>a</sup>
Services <sup>b</sup>	.14	250	.007	Low Association
Size <sup>c</sup>	-.04	252	.391	Negligible Association
Experience <sup>d</sup>	-.03	252	.516	Negligible Association
Rank <sup>e</sup>	.03	251	.534	Negligible Association
Age <sup>f</sup>	.01	254	.852	Negligible Association

*Note.* <sup>a</sup> Davis’ Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

<sup>b</sup> How much do you know about the mental health services available to students at your university? A) Very aware of services B) Somewhat aware of services C) Somewhat unaware of services D) Very unaware of services

<sup>c</sup> Which of the following best describes the typical class size of the courses you teach? A) 0-24 B) 25-49 C) 50-74 D) 75-99 E) 100 +

<sup>d</sup> Please indicate your total years of experience as a faculty member, combining all colleges and universities at which you may have worked: A) 0-19 B) 10-19 C) 20-29 D) 30-39 E) 40-49 F) 50 +

<sup>e</sup> Please indicate which title best describes your rank as a faculty member: A) Instructor B) Assistant Professor C) Associate Professor D) Professor

<sup>f</sup> Please indicate your age range: A) 25 or under B) 26-35 C) 36-45 D) 46-55 E) 55-65 F) 66 or older

All of the five variables by which significant differences were found in “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were part of the variable “Mental Health Experience.” These included: 1) having previous mental health training ( $t_{248} = 3.527$ ,  $p = .001$ ), 2) having received a mental health diagnosis personally ( $t_{249} = 3.175$ ,  $p = .002$ ), 3) having a degree in psychology, social work, or counseling ( $t_{249} = 2.679$ ,  $p = .008$ ), 4)

knowing anyone who has had a mental illness or who has attempted or completed suicide ( $t_{249} = 2.304$ ,  $p = .022$ ), and 5) practicing a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling ( $t_{247} = 2.181$ ,  $p = .030$ ). For all of these variables, the faculty in the category that was indicative of more mental health experience had higher “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores.

Table 41

Comparison of “Ability to Identify Students with Mental Health Issues- Emotions” Subscale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	<u>M</u>	<u>SD</u>	<u>t</u>	<u>df</u>	<u>p</u>
Had Training <sup>a</sup>	Yes	79	4.72	3.527	248	.001
	No	171	4.41			
Diagnosis <sup>b</sup>	Yes	49	4.77	3.175	249	.002
	No	202	4.44			
Degree <sup>c</sup>	Yes	28	4.82	2.679	249	.008
	No	223	4.47			
Know Anyone <sup>d</sup>	Yes	217	4.55	2.304	249	.022
	No	34	4.27			
Religion <sup>e</sup>	Yes	12	4.10	2.181	247	.030
	No	237	4.53			
Friend/ Family <sup>f</sup>	Yes	165	4.56	1.532	249	.127
	No	86	4.42			
Suicide <sup>g</sup>	Yes	27	4.63	.962	248	.337
	No	223	4.50			

(Table 41 continued)

Variable		n	M	SD	<u>t</u>	df	<u>p</u>
Offer Training <sup>h</sup>	Yes	215	4.52	.68	.856	246	.393
	No	33	4.42	.61			
Gender <sup>i</sup>	Male	108	4.48	.67	.686	248	.493
	No	142	4.54	.66			
University <sup>j</sup>	A <sup>l</sup>	159	4.54	.67	.675	247	.500
	B <sup>m</sup>	90	4.48	.65			
Effort <sup>k</sup>	Yes	218	4.51	.67	.132	247	.895
	No	31	4.52	.62			

<sup>a</sup> Have you ever had any training on mental health issues or suicide prevention?

<sup>b</sup> Have you ever received a mental health diagnosis?

<sup>c</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>d</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>e</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>f</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>g</sup> Have you ever contemplated or attempted suicide?

<sup>h</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>i</sup> Please indicate your gender:

<sup>j</sup> Which university are you a faculty member of:

<sup>k</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>l</sup> University "A" is described in the Carnegie Classification as a large, master's university

<sup>m</sup> University "B" is described in the Carnegie Classification as a medium research university

In order to determine if relationships existed between the "Ability to Identify Students with Mental Health Issues – Emotions" subscale scores among currently employed faculty members of public four year universities and the demographics that were measured as categorical variables with more than two categories, the researcher utilized the one-way analysis

of variance (ANOVA) procedure for the analysis. A total of four categorical variables were included in this analysis. Of these four variables, “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were found to be significantly different by the categories of one of the variables (See Table 42).

Table 42

Comparison of “Ability to Identify Students with Mental Health Issues- Emotions” Subscale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	df	F	<u>p</u>
Race/Ethnicity <sup>a</sup>	244	3, 240	4.662	.003
Faculty Status <sup>b</sup>	249	3, 245	2.624	.051
Department <sup>c</sup>	252	5, 246	1.030	.401
Duties <sup>d</sup>	251	3, 247	.392	.759

<sup>a</sup> Please indicate your race/ethnicity: A) American Indian or Alaskan Native (omitted due to low n) B) Asian C) Black or African American D) Native Hawaiian or Other Pacific Islander (omitted due to low n) E) White, Hispanic or Latino F) White, not Hispanic or Latino

<sup>b</sup> Please indicate the category that best describes your faculty status: A) Part-Time (omitted due to low n) B) Adjunct C) Full-Time, Non-Tenure Track D) Full-Time, Tenure Track E) Tenured

<sup>c</sup> Which of the following best describes the college or department in which you work: A) Art B) Business C) Education D) Engineering E) Humanities & Social Sciences F) Science

<sup>d</sup> How would you describe the amount of time you spend teaching (including preparation and office hours) versus the amount of time you spend doing research? A) About equal B) Spend more time teaching C) Spend more time doing research D) Do not teach at all (omitted due to low n) E) Do not do research at all

“Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were found to be significantly different among the categories of the variable race/ethnicity ( $F_{3, 240} = 4.662$ ,  $p = .003$ ). Specifically, it was found that faculty members that identified as “Asian” had significantly lower “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores than faculty members that identified as “White, not Hispanic or Latino” (See Table 43).

Table 43

Comparison of “Ability to Identify Students with Mental Health Issues – Emotions” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity

Source	df	MS	F	p
Between Groups	3	1.935	4.662	.003
Within Groups	240	.415		
Total	243			
Group	n	M	Tukey <sup>a</sup>	
White, not Hispanic or Latino	189	4.60	B	
White, Hispanic or Latino	26	4.41	A, B	
Black or African American	11	4.30	A, B	
Asian	18	4.06	A	

<sup>a</sup> Groups that do not have a common letter are significantly different.

In order to determine if relationships existed between “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores among currently employed faculty members of four-year public universities and the demographics measured as ordinal variables, the researcher utilized Kendall’s Tau Correlation Coefficient procedure for the analysis. A total of five variables were included in this analysis. Of these five variables, “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were found to be significantly related to two variables (See Table 44).

“Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were found to be significantly positively correlated with rank as a faculty member ( $r = .13$ ,  $p = .010$ ) and awareness of campus mental health services available to students ( $r = .10$ ,  $p = .041$ ). Both of these correlations were described as “low” associations using Davis’ (1971) Descriptors. This means that faculty with higher ranks and those who indicated that they were more aware of

services tended to have higher “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores.

Table 44

Comparison of “Ability to Identify Students with Mental Health Issues- Emotions” Subscale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	r	<u>n</u>	<u>p</u>	Descriptor <sup>a</sup>
Rank <sup>b</sup>	.13	251	.010	Low Association
Services <sup>c</sup>	.10	250	.041	Low Association
Age <sup>d</sup>	.07	253	.133	Negligible Association
Experience <sup>e</sup>	.02	251	.733	Negligible Association
Size <sup>f</sup>	-.01	251	.817	Negligible Association

<sup>a</sup> Davis’ Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

<sup>b</sup> Please indicate which title best describes your rank as a faculty member: A) Instructor B) Assistant Professor C) Associate Professor D) Professor

<sup>c</sup> How much do you know about the mental health services available to students at your university? A) Very aware of services B) Somewhat aware of services C) Somewhat unaware of services D) Very unaware of services

<sup>d</sup> Please indicate your age range: A) 25 or under B) 26-35 C) 36-45 D) 46-55 E) 55-65 F) 66 or older

<sup>e</sup> Please indicate your total years of experience as a faculty member, combining all colleges and universities at which you may have worked: A) 0-19 B) 10-19 C) 20-29 D) 30-39 E) 40-49 F) 50

+

<sup>f</sup> Which of the following best describes the typical class size of the courses you teach? A) 0-24 B) 25-49 C) 50-74 D) 75-99 E) 100 +

**Ability to help students with mental health issues.** In order to determine if relationships existed between “Ability to Help Students with Mental Health Issues” scale scores among currently employed faculty members of public four year universities and the personal and professional demographics that were measured as dichotomous variables, the researcher chose to utilize the independent t-test procedure for the analysis. This procedure was chosen for ease of

interpretation of the relevant findings. A total of 11 dichotomous variables were included in this analysis. Of these 11 variables, “Ability to Help Students with Mental Health Issues” scores were found to be significantly different by the categories of five of the variables (See Table 45).

Table 45

Comparison of “Ability to Help Students with Mental Health Issues” Scale Scores by Selected Dichotomous Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	M	SD	<u>t</u>	df	<u>p</u>
Gender <sup>a</sup>	Male	108	3.11	3.507	248	.001
	Female	142	3.54			
Know Anyone <sup>b</sup>	Yes	217	3.42	3.027	249	.003
	No	34	2.88			
Had Training <sup>c</sup>	Yes	79	3.57	2.504	248	.013
	No	171	3.24			
Diagnosis <sup>d</sup>	Yes	49	3.61	2.194	249	.029
	No	202	3.27			
Degree <sup>e</sup>	Yes	28	3.71	2.127	249	.034
	No	223	3.30			
Religion <sup>f</sup>	Yes	12	2.83	1.829	247	.069
	No	237	3.36			
Suicide <sup>g</sup>	Yes	27	3.52	1.023	248	.307
	No	223	3.31			



(Table 45 continued)

Variable		n	M	SD	t	df	p
Friend/ Family <sup>h</sup>	Yes	165	3.38	.98	.876	249	.382
	No	86	3.27	.98			
Offer Training <sup>i</sup>	Yes	215	3.36	.97	.464	246	.643
	No	33	3.27	1.07			
University <sup>j</sup>	A <sup>l</sup>	159	3.37	.95	.381	247	.703
	B <sup>m</sup>	90	3.32	1.00			
Effort <sup>k</sup>	Yes	218	3.34	.97	.253	247	.801
	No	31	3.39	1.09			

Note. <sup>a</sup> Please indicate your gender:

<sup>b</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>c</sup> Have you ever had any training on mental health issues or suicide prevention?

<sup>d</sup> Have you ever received a mental health diagnosis?

<sup>e</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>f</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>g</sup> Have you ever contemplated or attempted suicide?

<sup>h</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>i</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?:

<sup>j</sup> Which university are you a faculty member of:

<sup>k</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>l</sup> University “A” is described in the Carnegie Classification as a large, master’s university

<sup>m</sup> University “B” is described in the Carnegie Classification as a medium research university

The first variable by which significant differences were found in “Ability to Help Students with Mental Health Issues” scores was gender ( $t_{248} = 3.507$ ,  $p = .001$ ). Specifically female faculty members ( $M = 3.54$ ) had a higher mean score on the “Ability to Help Students

with Mental Health Issues” scale than male faculty members ( $M = 3.11$ ). The other four variables by which significant differences were found in “Ability to Help students with Mental Health Issues” were part of the variable “Mental Health Experience.” These included: 1) knowing anyone who has had a mental illness or who has attempted or completed suicide ( $t_{249} = 3.027, p = .003$ ), 2) having previous mental health training ( $t_{248} = 2.504, p = .013$ ), 3) having received a mental health diagnosis personally ( $t_{249} = 2.194, p = .029$ ), and 4) having a degree in psychology, social work, or counseling ( $t_{249} = 2.127, p = .034$ ). For all of these variables, the faculty in the category that was indicative of more mental health experience had higher ability to help students with mental health issues scores.

In order to determine if relationships existed between the “Ability to Help Students with Mental Health Issues” scores among currently employed faculty members of public four year universities and the demographics that were measured as categorical variables with more than two categories, the researcher chose to utilize the one-way analysis of variance (ANOVA) procedure for the analysis. A total of four categorical variables were included in this analysis. Of these four variables, “Ability to Help Students with Mental Health Issues” scores were found to be significantly different by the categories of two of the variables (See Table 46).

“Ability to Help Students with Mental Health Issues” scores were found to be significantly different among the categories of the variables race/ethnicity ( $F_{3, 240} = 8.583, p < .001$ ) and department ( $F_{5, 246} = 2.937, p = .014$ ). Specifically, it was found that faculty members that identified as “Asian” had significantly lower “Ability to Help Students with Mental Health Issues” scores than the other three race/ethnicity categories (See Table 47). Also faculty members in the engineering department had significantly lower “Ability to Help Students

with Mental Health Issues” scores than faculty members in education, humanities & social sciences, and business (Table 48).

Table 46

Comparison of “Ability to Help Students with Mental Health Issues” Scale Scores by Selected Categorical Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	<u>n</u>	df	F	<u>p</u>
Race/Ethnicity <sup>a</sup>	244	3, 240	8.583	<.001
Department <sup>b</sup>	252	5, 246	2.937	.014
Faculty Status <sup>c</sup>	249	3, 245	1.341	.262
Duties <sup>d</sup>	251	3, 247	1.169	.322

*Note.* <sup>a</sup> Please indicate your race/ethnicity: A) American Indian or Alaskan Native (omitted due to low n) B) Asian C) Black or African American D) Native Hawaiian or Other Pacific Islander (omitted due to low n) E) White, Hispanic or Latino F) White, not Hispanic or Latino

<sup>b</sup> Which of the following best describes the college or department in which you work: A) Art B) Business C) Education D) Engineering E) Humanities & Social Sciences F) Science

<sup>c</sup> Please indicate the category that best describes your faculty status: A) Part-Time (omitted due to low n) B) Adjunct C) Full-Time, Non-Tenure Track D) Full-Time, Tenure Track E) Tenured

<sup>d</sup> How would you describe the amount of time you spend teaching (including preparation and office hours) versus the amount of time you spend doing research? A) About equal B) Spend more time teaching C) Spend more time doing research D) Do not teach at all (omitted due to low n) E) Do not do research at all

In order to determine if relationships existed between “Ability to Help Students with Mental Health Issues” among currently employed faculty members of four-year public universities and the demographics measured as ordinal variables, the researcher chose to utilize the Kendall’s Tau Correlation Coefficient procedure for the analysis. A total of five variables were included in this analysis. Of these five variables, “Ability to Help Students with Mental Health Issues” scores were found to be significantly related to one variable (See Table 49).

Table 47

Comparison of “Ability to Help Students with Mental Health Issues” Among Currently Employed Faculty Members of Four Year Public Universities by Categories of Race/Ethnicity

Source	df	MS	F	p
Between Groups	3	7.696	8.583	<.001
Within Groups	240	.897		
Total	243			
Group	n	M	Tukey <sup>a</sup>	
White, not Hispanic or Latino	189	3.46	B	
Black or African American	11	3.45	B	
White, Hispanic or Latino	26	3.35	B	
Asian	18	2.28	A	

Note. <sup>a</sup> Groups that do not have a common letter are significantly different.

Table 48

Comparison of “Ability to Help Students with Mental Health Issues” Among Currently Employed Faculty Members of Four Year Public Universities by Categories of Department

Source	df	MS	F	p
Between Groups	5	2.711	2.937	.014
Within Groups	246	.923		
Total	251			
Group	n	M	Tukey <sup>a</sup>	
Education	37	3.54	B	
Humanities & Social Sciences	87	3.52	B	
Business	28	3.32	B	

(Table 48 continued)

Group	<u>n</u>	M	Tukey <sup>a</sup>
Art	13	3.31	A, B
Science	77	3.17	A, B
Engineering	10	2.50	A

*Note.* <sup>a</sup> Groups that do not have a common letter are significantly different.

Table 49

Comparison of “Ability to Help Students with Mental Health Issues” Scale Scores by Selected Ordinal Personal and Professional Demographic Characteristics Among Currently Employed Faculty of Four Year Public Universities

Variable	r	<u>n</u>	<u>p</u>	Descriptor <sup>a</sup>
Services <sup>b</sup>	.11	250	.048	Low Association
Size <sup>c</sup>	.05	251	.339	Negligible Association
Age <sup>d</sup>	.02	253	.735	Negligible Association
Rank <sup>e</sup>	>.01	251	.949	Negligible Association
Experience <sup>f</sup>	>-.01	251	.950	Negligible Association

*Note.* <sup>a</sup> Davis’ Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

<sup>b</sup> How much do you know about the mental health services available to students at your university? A) Very aware of services B) Somewhat aware of services C) Somewhat unaware of services D) Very unaware of services

<sup>c</sup> Which of the following best describes the typical class size of the courses you teach? A) 0-24 B) 25-49 C) 50-74 D) 75-99 E) 100 +

<sup>d</sup> Please indicate your age range: A) 25 or under B) 26-35 C) 36-45 D) 46-55 E) 55-65 F) 66 or older

<sup>e</sup> Please indicate which title best describes your rank as a faculty member: A) Instructor B) Assistant Professor C) Associate Professor D) Professor

<sup>f</sup> Please indicate your total years of experience as a faculty member, combining all colleges and universities at which you may have worked: A) 0-19 B) 10-19 C) 20-29 D) 30-39 E) 40-49 F) 50 +

“Ability to Help Students with Mental Health Issues” scores were found to be significantly positively correlated with awareness of campus mental health services available to students ( $r = .11$ ,  $p = .048$ ). Using Davis’ (1971) Descriptors this correlation was described as a “low association.” This means that faculty who indicated that they were more aware of services tended to have higher “Ability to Help Students with Mental Health Issues” scale scores.

### **Objective Seven Results**

Objective seven was to determine if a relationship exists between attitude toward mental health among currently employed faculty of four year public universities and the following perceptual measures: 1) willingness to help students with mental health issues, 2) ability to identify students with mental health issues, and 3) ability to help students with mental health issues. This analysis was accomplished using Pearson’s Product Moment Correlation Coefficients calculated between the scales. For two of the scales, “Willingness to Help Students with Mental Health Issues” and “Ability to Identify Students with Mental Health Issues,” factor analyses determined that two sub-scales were present within each of the scales. Therefore the sub-scale scores for these two scales were used in this analysis.

Overall, there were significant correlations among the “Attitude toward Mental Health” scale scores and all other scales/sub-scales (See Table 50). All of these were positive correlations meaning that faculty with higher “Attitude toward Mental Health” scores tended to have higher “Willingness to Help Students with Mental Health Issues” scores, “Ability to Identify Students with Mental Health Issues” scores, and “Ability to Help Students with Mental Health Issues” scores. The highest correlation was found to be between “Attitude toward Mental Health” and “Ability to Identify Students with Mental Health Issues – Related Issues” subscale ( $r = .49$ ,  $p < .001$ ). Using Davis’ (1971) Descriptors the correlations between “Attitude toward Mental

Health” and “Ability to Identify Students with Mental Health Issues – Related Issues” ( $r = .49$ ,  $p < .001$ ), “Willingness to Help Students with Mental Health Issues - Involvement” ( $r = .48$ ,  $p < .001$ ), and “Willingness to Help Students with Mental Health Issues – Faculty Role” ( $r = .46$ ,  $p < .001$ ) were described as “moderate” associations while the correlations between “Attitude toward Mental Health” and “Ability to Identify Students with Mental Health Issues – Emotions” ( $r = .28$ ,  $p < .001$ ) and “Ability to Help Students with Mental Health Issues” ( $r = .28$ ,  $p < .001$ ) were described as “low” associations.

Table 50

Relationship Between “Attitude toward Mental Health” and Other Selected Perceptual Measures of Currently Employed Faculty of Four Year Public Universities

Scale/Subscale	<i>r</i>	<i>n</i>	<i>p</i>	Descriptor <sup>a</sup>
Ability to Identify Students with Mental Health Issues – Related Issues	.49	260	<.001	Moderate Association
Willingness to Help Students With Mental Health Issues – Involvement	.48	260	<.001	Moderate Association
Willingness to Help Students With Mental Health Issues – Faculty Role	.46	260	<.001	Moderate Association
Ability to Identify Students with Mental Health Issues – Emotions	.28	259	<.001	Low Association
Ability to Help Students with Mental Health Issues	.28	253	<.001	Low Association

*Note.* <sup>a</sup> Davis’ Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

## Objective Eight Results

Objective eight was to determine if a relationship exists between willingness to help students with mental health issues among currently employed faculty of four year public universities and the following perceptual measures: 1) ability to identify students with mental

health issues, and 2) ability to help students with mental health issues. This analysis was accomplished using Pearson's Product Moment Correlation Coefficients calculated between the scales. Since this scale was determined to have two subscales present within it, the results of this objective will be separated by the two subscales.

**Involvement subscale.** Overall, there were significant correlations among the “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores and all other scale/subscale scores (See Table 51). All of these were positive correlations meaning that faculty with higher scores on the “Involvement” subscale of the “Willingness to Help Students with Mental Health Issues” scale tended to have higher scores on the “Related Issues” subscale of the “Ability to Identify Students with Mental Health Issues” scale, the “Emotions” subscale of the “Ability to Identify Students with Mental Health Issues” scale, and “Ability to Help Students with Mental Health Issues” scale. The highest correlation was found to be between the “Involvement” subscale of the “Willingness to Help Students with Mental Health Issues” scale and the “Related Issues” subscale of the “Ability to Identify Students with Mental Health Issues” scale ( $r = .46, p < .001$ ). Using the Davis' (1971) Descriptors, the correlation between “Willingness to Help Students with Mental Health Issues – Involvement” and “Ability to Identify Students with Mental Health Issues – Related Issues” ( $r = .46, p < .001$ ) was described as a “moderate association” while the correlations between “Willingness to Help Students with Mental Health Issues – Involvement” and “Ability to Help Students with Mental Health Issues” ( $r = .22, p < .001$ ) and “Ability to Identify Students with Mental Health Issues – Emotions” ( $r = .22, p < .001$ ) were described as “low” associations.



Table 51

Relationship Between “Willingness to Help Students with Mental Health Issues – Involvement” Subscale and Other Selected Perceptual Measures of Currently Employed Faculty of Four Year Public Universities

Scale/Subscale	r	<u>n</u>	<u>p</u>	Descriptor <sup>a</sup>
Ability to Identify Students with Mental Health Issues – Related Issues	.46	261	<.001	Moderate Association
Ability to Help Students with Mental Health Issues	.22	253	<.001	Low Association
Ability to Identify Students with Mental Health Issues – Emotions	.22	259	<.001	Low Association

*Note.* <sup>a</sup> Davis’ Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

**Faculty role subscale.** Overall, there were significant correlations among the “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores and both of the subscales of the “Ability to Identify Students with Mental Health Issues” scale (See Table 52). These were both positive correlations meaning that faculty with higher scores on the “Faculty Role” subscale of the “Willingness to Help Students with Mental Health Issues” scale tended to have higher scores on both the “Related Issues” subscale and the “Emotions” subscale of the “Ability to Identify Students with Mental Health Issues” scale. The highest correlation was found to be between the “Faculty Role” subscale of the “Willingness to Help Students with Mental Health Issues” scale and the “Related Issues” subscale of the “Ability to Identify Students with Mental Health Issues” scale ( $r = .23$ ,  $p < .001$ ). Using Davis’ (1971) Descriptors the correlations between “Willingness to Help Students with Mental Health Issues – Faculty Role” and “Ability to Identify Students with Mental Health Issues – Related Issues” ( $r = .23$ ,  $p < .001$ ), “Ability to Identify Students with Mental Health Issues – Emotions” ( $r = .17$ ,  $p = .006$ ),

and “Ability to Help Students with Mental Health Issues” ( $r = .12$ ,  $p = .058$ ) were described as “low” associations.

Table 52

Relationship Between “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale and Other Selected Perceptual Measures of Currently Employed Faculty of Four Year Public Universities

Scale/Subscale	$r$	$n$	$p$	Descriptor <sup>a</sup>
Ability to Identify Students with Mental Health Issues – Related Issues	.23	261	<.001	Low Association
Ability to Identify Students with Mental Health Issues – Emotions	.17	259	.006	Low Association
Ability to Help Students with Mental Health Issues	.12	253	.058	Low Association

*Note.* <sup>a</sup> Davis’ Descriptors (1971): .00 to .09 = Negligible Association, .10 to .29 = Low Association, .30 to .49 = Moderate Association, .50 to .69 = Substantial Association, and .70 or higher = Very Strong Association

### Objective Nine Results

Objective nine was to determine if a relationship exists between ability to identify students with mental health issues among currently employed faculty of four year public universities and ability to help students with mental health issues. This analysis was accomplished using Pearson’s Product Moment Correlation Coefficients calculated between the scales. Factor analysis determined that the ability to identify students with mental health issues contained two subscales; therefore the subscale scores were used in this analysis.

**Ability to identify students with mental health issues – Related issues subscale.** There was a significant correlation between the “Related Issues” subscale of the “Ability to Identify Students with Mental Health Issues” scale and the “Ability to Help Students with Mental Health Issues” scale ( $r = .34$ ,  $n = 253$ ,  $p < .001$ ). This correlation was positive meaning that faculty with

higher scores on the “Related Issues” subscale of the “Ability to Identify Students with Mental Health Issues” scale tended to have higher scores on the “Ability to Help Students with Mental Health Issues” scale. According to Davis’ Descriptors (1971), this correlation is classified as a “moderate association”.

**Ability to identify students with mental health issues – Emotions subscale.** There was a significant correlation between the “Emotions” subscale of the “Ability to Identify Students with Mental Health Issues” scale and the “Ability to Help Students with Mental Health Issues” scale ( $r = .27$ ,  $n = 253$ ,  $p < .001$ ). This correlation was positive meaning that faculty with higher scores on the “Emotions” subscale of the “Ability to Identify Students with Mental Health Issues” scale tended to have higher scores on the “Ability to Help Students with Mental Health Issues” scale. According to Davis’ Descriptors (1971) this correlation is classified as a “low association.”

### **Objective Ten Results**

Objective ten was to determine if a model exists explaining a significant portion of the variance in attitudes toward and perceptions of selected mental health issues among currently employed faculty of four year public universities from the following personal and professional demographic characteristics:

- a. Age
- b. Gender
- c. Race/Ethnicity
- d. University
- e. Years of experience as a faculty member
- f. Employment status

- g. Faculty rank
- h. Actual job duties
- i. Typical class size
- j. College/Department
- k. Mental health experience
- l. Knowledge of university mental health services available to students
- m. Beliefs about university's role in mental health services

To accomplish this objective multiple regression analyses were performed. This was accomplished using “Attitude toward Mental Health” scores, “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores, “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores, “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores, “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores, and “Ability to Help Students with Mental Health Issues” scores as dependent variables. The other variables were treated as independent variables and stepwise entry of the variables was used due to the exploratory nature of the study. In these regression equations variables were added that increased the explained variance by one percent or more as long as the overall regression model remained significant.

In conducting the multiple regression analyses, nine of the variables to be treated as independent variables which were categorical in nature had to be prepared as dichotomous variables in preparation for entry into the analysis. These variables included age, race/ethnicity, years of experience, employment status, faculty rank, actual job duties, typical class size, college/department, and knowledge of university mental health services available to students. Two other variables, gender and university, were also categorical but since they were both

dichotomous, they did not need to be restructured. Also the seven questions that made up the variable “Mental Health Experience” and the two questions that made up the variable “Beliefs about University’s Role in Mental Health Services” were yes/no questions and, therefore, did not need to be restructured as dichotomies. The first of these variables was “age.” Participants were originally asked to place themselves into the categories of “25 or under,” “26-35,” “36-45,” “46-55,” “56-65,” or “66 or older.” The group “25 or under” only had one participant which was not adequate as a separated variable of investigation so the “25 or under” category and “26-35” category were combined into a category called “35 or under.” Therefore participants were recorded as “35 or under,” “36-45,” “46-55,” “56-65,” or “66 or older” and each of these categories was used to create a dichotomous variable as being a member of the category or not. It was in this format that the variable “age” was entered into the analyses.

The next variable, “race/ethnicity,” originally had the following six categories: “American Indian or Alaskan Native,” “Asian,” “Black or African American,” “Native Hawaiian or Other Pacific Islander,” “White, Hispanic or Latino,” or “White, not Hispanic or Latino.” Two of these categories had frequencies that were not adequate to use them as separate variables of investigation. These included the category “American Indian or Alaskan Native” ( $n = 3$ ) and “Native Hawaiian or Other Pacific Islander” ( $n = 0$ ). Because of the low frequencies, these categories were removed before the variable “race/ethnicity” was entered into the analysis. Therefore participants were recorded as “Asian,” “Black or African American,” “White, Hispanic or Latino,” or “White, not Hispanic or Latino” and each of these categories was used to create a dichotomous variable as being a member of the category or not. It was in this format that the variable “race/ethnicity” was entered into the analyses.

The next variable, “years of experience as a faculty member,” had the following six categories: “0-9,” “10-19,” “20-29,” “30-39,” “40-49,” and “50+.” Two of the categories, “40-49” ( $n = 8$ ) and “50+” ( $n = 0$ ) had frequencies that were not adequate to use them as separate variables of investigation and the categories “30-39,” “40-49,” and “50+” were combined to create a new category called “30+.” Therefore participants were coded as “0-9,” “10-19,” “20-29,” or “30+” and each of these categories was used to create a dichotomous variable as being a member of the category or not. It was in this format that the variable “years of experience as a faculty member” was entered into the analyses.

The next variable, “employment status,” originally had the following five categories: “Part-Time,” “Adjunct,” “Full-Time, Non-Tenure Track,” “Full-Time, Tenure Track,” and “Tenured.” The category “Part-Time” ( $n = 3$ ) had a frequency that was not adequate to use this as a separate variable of investigation so this category was removed before the variable “employment status” was entered into the analysis. Therefore participants were coded as “Adjunct,” “Full-Time, Non-Tenure Track,” “Full-Time, Tenure Track,” or “Tenured” and each of these categories was used to create a dichotomous variable as being a member of the category or not. It was in this format that the variable “employment status” was entered into the analyses.

The next variable, “faculty rank,” had the following four categories: “Instructor,” “Assistant Professor,” “Associate Professor,” and “Professor.” Since all of these categories had frequencies that were adequate to use as separate variables of investigation, participants were recorded as “Instructor,” “Assistant Professor,” “Associate Professor,” or “Professor” and each of these categories was used to create a dichotomous variable as being a member of the category or not. It was in this format that the variable “faculty rank” was entered into the analyses.

The next variable, “actual job duties,” which asked participants to describe the amount of time they spend teaching (including preparation and office hours) versus the amount of time they spend doing research, originally had the following five categories: “About equal,” “Spend more time teaching,” “Spend more time doing research,” “Do not teach at all,” and “Do not do research at all.” The category “Do not teach at all” ( $n = 1$ ), however, had a frequency that was not adequate to use this as a separate variable of investigation so this category was removed before the variable “actual job duties” was entered into the analysis. Therefore participants were recorded as “About equal,” “Spend more time teaching,” “Spend more time doing research,” or “Do not do research at all” and each of these categories was used to create a dichotomous variable as being a member of the category or not. It was in this format that the variable “actual job duties” was entered into the analyses.

The next variable, “typical class size,” originally had the following five categories: “0-24,” “25-49,” “50-74,” “75-99,” “100+.” The categories “75-99” ( $n = 7$ ) and “100 +” ( $n = 5$ ), however, had frequencies that were not adequate to use as separate variables of investigation so these categories were combined to create a new category called “75+.” Therefore participants were coded as “0-24,” “25-49,” “50-74,” or “75+” and each of these categories was used to create a dichotomous variable as being a member of the category or not. It was in this format that the variable “typical class size” was entered into the analyses.

The next variable “college/department” had the following six categories: “Art,” “Business,” “Education,” “Engineering,” “Humanities & Social Sciences,” and “Science.” Since all of these categories had frequencies that were adequate to use as separate variables of investigation, participants were recorded as “Art,” “Business,” “Education,” “Engineering,” “Humanities & Social Sciences,” or “Science” and each of these categories was used to create a

dichotomous variable as being a member of the category or not. It was in this format that the variable “college/department” was entered into the analyses.

Finally, the variable “knowledge of university mental health services available to students” originally had the following four categories: “Very aware of services,” “Somewhat aware of services,” “Somewhat unaware of services,” and “Very unaware of services.” Since all of these categories had frequencies that were adequate to use as separate variables of investigation, participants were recorded as “Very aware of services,” “Somewhat aware of services,” “Somewhat unaware of services,” or “Very unaware of services” and each of these categories was used to create a dichotomous variable as being a member of the category or not. It was in this format that the variable “knowledge of university mental health services available to students” was entered into the analyses.

Each of the dichotomous variables were examined for correlation with the scale/subscale scores and due to the excessively large number of variables those with very small correlations with the dependent variable were eliminated from the regression analysis. Each original variable had at least one of the dichotomous categories included in the analysis.

**Attitude toward mental health scale.** The first step in conducting the regression analysis was to examine the bivariate correlations. Two-way correlations between factors used as independent variables and “Attitude toward Mental Health” are presented in Table 53.

Fifteen of the 26 correlations were found to be statistically significant. The highest correlations with the “Attitude toward Mental Health” scale scores were found to be with the category “Asian” ( $r = -.30$ ,  $p < .001$ ) of the variable “Race/Ethnicity” and the variable “Had



Training” ( $r = .29$ ,  $p < .001$ ) which asked participants whether or not they have ever had training on mental health issues or suicide prevention.

To ensure that variables entered into the regression analysis did not have excessive collinearity or that any combination of the independent variables formed a singularity, the variance inflation factor (VIF) was examined. According to Hair et al. (2006), “A common cutoff threshold is a tolerance value of .10 which corresponds to a VIF value of 10,” (p. 230). The VIF values for this analysis ranged from 1.017 to 1.386. Therefore no excess multicollinearity was present in the data.

Table 53

Relationship Between Selected Demographic Characteristics and “Attitude toward Mental Health” Scale Scores Among Currently Employed Faculty Members of Four Year Public Universities

Variable	<u>r</u>	<u>p</u>
Race/Ethnicity - Asian	-.30	<.001
Had Training <sup>a</sup>	.29	<.001
Friend/Family <sup>b</sup>	.24	<.001
Race/Ethnicity – White, not Hispanic or Latino	.24	<.001
Offer Training <sup>c</sup>	.21	.001
Gender <sup>d</sup>	.21	.001
Diagnosis <sup>e</sup>	.19	.002
Know Anyone <sup>f</sup>	.17	.006
Religion <sup>g</sup>	-.17	.007
Services – Somewhat Unaware	-.16	.009

(Table 53 continued)

Variable	<u>r</u>	<u>p</u>
College/Department – Business	-.14	.018
College/Department – Humanities & Social Sciences	.14	.019
College/Department – Engineering	-.14	.021
Duties – Teach More	.13	.031
Services – Somewhat Aware	.12	.042
College/Department – Education	.11	.050
College/Department – Science Degree <sup>h</sup>	-.11 .10	.058 .065
Effort <sup>i</sup>	.10	.068
Typical Class Size – 75+	-.10	.078
Suicide <sup>j</sup>	.09	.084
University <sup>k</sup>	-.09	.101
Age – 66 or Older	.06	.181
Rank – Instructor	.06	.184
Status – Adjunct	.04	.294
Experience – 10-19 (years)	-.02	.364

*Note.* n = 225

<sup>a</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>b</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>c</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>d</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>e</sup> Have you ever received a mental health diagnosis?

(Table 53 continued)

<sup>f</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>g</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>h</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>i</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>j</sup> Have you ever contemplated or attempted suicide?

<sup>k</sup> The university that is described in the Carnegie Classification as a large, master's university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

Table 54 presents the results of the multiple regression analysis utilizing “Attitude toward Mental Health” scores as the dependent variable.

The variable which entered the regression model first was the “race/ethnicity” category of “Asian.” Considered alone, this variable explained 8.8% of the variance in “Attitude toward Mental Health” scores of currently employed faculty members of public four year universities.

Seven additional variables explained an additional 16.9% of the variance in “Attitude toward Mental Health” scores. These variables included having previous mental health training, having a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide, believing that their university should offer training on how to identify students struggling with mental health issues, the “race/ethnicity” category “white,” having a typical class size of 75 or more students, practicing a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling, and gender. These eight variables explained a total of 25.7% of the variance in “Attitude toward Mental Health” scores among currently employed faculty members of public four-year universities. The nature of the influence of these variables was such that participants that identified as “Asian,” reported

having a typical class size of 75 or more students, reported practicing a religion that forbids or discourages the use of mental health services such as counseling, and identified as “Male” tended to be associated with lower “Attitude toward Mental Health” scores. On the other hand participants that reported having previous training on mental health issues or suicide prevention, reported having a close friend or family member who has been diagnosed with a mental illness or who has attempted or completed suicide, believed their university should offer training on how to identify students struggling with mental health issues, and identified as “White” tended to be associated with higher “Attitude toward Mental Health” scores.

Table 54

Multiple Regression Analysis of “Attitude toward Mental Health” Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities

ANOVA					
Source of Variation	df	MS	F	p	
Regression	8	1.922	9.340	<.001	
Residual	216	.206			
Total	224				
Model Summary					
Model	R Square	R Square Change	F Change	Sig. F Change	Standardized Coefficients Beta
Race/Ethnicity - Asian	.088	.088	21.403	<.001	-.140
Had Training <sup>a</sup>	.150	.063	16.340	<.001	.200
Friend/Family <sup>b</sup>	.180	.030	8.186	.005	.154
Offer Training <sup>c</sup>	.203	.023	6.347	.012	.171

(Table 54 continued)

Model Summary					
Model	R Square	R Square Change	F Change	Sig. F Change	Standardized Coefficients Beta
Race/Ethnicity – White, not Hispanic or Latino	.220	.017	4.728	.031	.138
Typical Class Size – 75+	.233	.013	3.732	.055	-.113
Religion <sup>d</sup>	.245	.011	3.289	.071	-.117
Gender <sup>e</sup>	.257	.012	3.531	.062	.115
Variables not in the Equation					
Variables	<u>t</u>		<u>p</u>		
Duties – Teach More	1.394		.165		
Services – Somewhat Aware	1.393		.165		
College/Department – Science	1.374		.171		
Age – 66+	1.357		.176		
Diagnosis <sup>f</sup>	1.357		.176		
Services – Somewhat Unaware	1.311		.191		
College/Department – Humanities & Social Sciences	1.242		.216		
Know Anyone <sup>g</sup>	.990		.323		
College/Department – Business	.782		.435		
Effort <sup>h</sup>	.544		.587		
Rank – Instructor	.490		.625		
College/Department – Engineering	.451		.652		
Suicide <sup>i</sup>	.415		.679		

(Table 54 continued)

Variables	Variables not in the Equation	
	<u>t</u>	<u>p</u>
Status – Adjunct	.366	.715
Degree <sup>j</sup>	.271	.786
College/Department – Education	.230	.818
Experience – 10-19 (years)	.148	.882
University <sup>k</sup>	.081	.936

*Note.* <sup>a</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>b</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>c</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>d</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>e</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>f</sup> Have you ever received a mental health diagnosis?

<sup>g</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>h</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>i</sup> Have you ever contemplated or attempted suicide?

<sup>j</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>k</sup> The university that is described in the Carnegie Classification as a large, master’s university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

**Willingness to help students with mental health Issues – Involvement subscale.** The first step in conducting the regression analysis was to examine the bivariate correlations. Two-way correlations between factors used as independent variables and the “Involvement” subscale of the “Willingness to Help Students with Mental Health Issues” scale are presented in Table 55.

Eleven of the 22 correlations were found to be statistically significant. The highest correlations with the “Willingness to Help Students with Mental Health Issues - Involvement” subscale scores were found to be with the variable “Had Training” ( $r = .37, p < .001$ ) which asked participants if they ever had training on mental health issues or suicide prevention and with the variable “Offer Training” ( $r = .34, p < .001$ ) which asked participants if they think their university should offer training on how to identify students struggling with mental health issues.

To ensure that variables entered into the regression analysis did not have excessive collinearity or that any combination of the independent variables formed a singularity, the variance inflation factor (VIF) was examined. According to Hair et al. (2006), “A common cutoff threshold is a tolerance value of .10 which corresponds to a VIF value of 10,” (p. 230). The VIF values for this analysis ranged from 1.030 to 1.311. Therefore no excess multicollinearity was present in the data.

Table 55

Relationship Between Selected Demographic Characteristics and “Willingness to Help Students with Mental Health Issues - Involvement” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities

Variable	<u>r</u>	<u>p</u>
Had Training <sup>a</sup>	.37	<.001
Offer Training <sup>b</sup>	.34	<.001
Effort <sup>c</sup>	.22	<.001
Degree <sup>d</sup>	.22	<.001
Services – Very Unaware	-.21	.001
Know Anyone <sup>e</sup>	.20	.001
Gender <sup>f</sup>	.18	.004

(Table 55 continued)

Variable	<u>r</u>	<u>p</u>
Race/Ethnicity – Asian	-.17	.006
Age – 36-45	-.14	.017
Diagnosis <sup>g</sup>	.14	.019
Services – Somewhat Unaware	-.12	.037
Experience – 20-29 (years)	.11	.050
Age – 56-65	.11	.055
Suicide <sup>h</sup>	.10	.068
College/Department – Engineering	-.10	.071
Friend/Family <sup>i</sup>	.09	.093
University <sup>j</sup>	.07	.137
Duties – Research More	.07	.154
Status – Adjunct	.07	.156
Rank – Assistant Professor	-.06	.178
Typical Class Size – 0-24	.02	.374
Religion <sup>k</sup>	-.02	.379

*Note.* n = 225

<sup>a</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>b</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>c</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>d</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>e</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>f</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>g</sup> Have you ever received a mental health diagnosis?



(Table 55 continued)

<sup>h</sup> Have you ever contemplated or attempted suicide?

<sup>i</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>j</sup> The university that is described in the Carnegie Classification as a large, master's university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

<sup>k</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

Table 56 presents the results of the multiple regression analysis utilizing “Willingness to Help Students with Mental Health Issues - Involvement” subscale scores as dependent variable.

The variable which entered the regression model first was the variable “had training” which asked participants if they ever had training on mental health issues or suicide prevention. Considered alone, this variable explained 13.6% of the variance in “Willingness to Help Students with Mental Health Issues - Involvement” subscale scores of currently employed faculty members of public four year universities.

Table 56

Multiple Regression Analysis of “Willingness to Help Students with Mental Health Issues - Involvement” Subscale Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities

ANOVA				
Source of Variation	<u>df</u>	MS	F	<u>p</u>
Regression	6	6.240	13.708	<.001
Residual	218	.455		
Total	224			

(Table 56 continued)

Model Summary					
Model	R Square	R Square Change	F Change	Sig. F Change	Standardized Coefficients Beta
Had Training <sup>a</sup>	.136	.136	35.206	<.001	.244
Offer Training <sup>b</sup>	.206	.070	19.518	<.001	.217
Services – Very Unaware	.238	.032	9.139	.003	-.168
University <sup>c</sup>	.251	.013	3.828	.052	.120
Race/Ethnicity – Asian	.264	.013	3.998	.047	-.128
Degree <sup>d</sup>	.274	.010	2.920	.089	.127
Variables not in the Equation					
Variables	<u>t</u>		<u>p</u>		
Effort <sup>e</sup>	1.653		.100		
Age – 36-45	1.641		.102		
Experience – 20-29 (years)	1.549		.123		
Age – 56-65	1.412		.160		
Diagnosis <sup>f</sup>	1.285		.200		
Rank – Assistant Professor	1.199		.232		
Gender <sup>g</sup>	1.189		.236		
Know Anyone <sup>h</sup>	1.188		.236		
Status – Adjunct	.838		.403		
Friend/Family <sup>i</sup>	.803		.423		
Services – Somewhat Unaware	.776		.439		
Suicide <sup>j</sup>	.549		.584		

(Table 56 continued)

Variables not in the Equation		
Variables	<u>t</u>	<u>p</u>
Religion <sup>k</sup>	.528	.598
Duties – Research More	.461	.646
College/Department – Engineering	.431	.667
Typical Class Size – 0-24	.333	.739

*Note.* <sup>a</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>b</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>c</sup> The university that is described in the Carnegie Classification as a large, master's university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

<sup>d</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>e</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>f</sup> Have you ever received a mental health diagnosis?

<sup>g</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>h</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>i</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>j</sup> Have you ever contemplated or attempted suicide?

<sup>k</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

Five additional variables explained an additional 13.8% of the variance in “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores. These variables included believing their university should offer training on how to identify students struggling with mental health issues, being very unaware of mental health services available to students, university, belonging to the “race/ethnicity” category “Asian,” and having one or more degrees in psychology, social work, or counseling. These six variables explained a total of 27.4% of the variance in “Willingness to Help Students with Mental Health Issues - Involvement” subscale

scores among currently employed faculty members of public four-year universities. The nature of the influence of these variables was such that participants that had training on mental health issues or suicide prevention, believed their university should offer training on how to identify students struggling with mental health issues, and had a psychology, social work, or counseling degree tended to be associated with higher “Willingness to Help Students with Mental Health Issues- Involvement” subscale scores. On the other hand, participants that reported being very unaware of mental health services available to students, were faculty members of the university that is described in the Carnegie Classification as a large, master’s university, and identified as “Asian” tended to be associated with lower “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores.

**Willingness to help students with mental health issues – Faculty role subscale.** The first step in conducting the regression analysis was to examine the bivariate correlations. Two-way correlations between factors used as independent variables and the “Faculty Role” subscale of the “Willingness to Help Students with Mental Health Issues” scale are presented in Table 57.

Ten of the 21 correlations were found to be statistically significant. The highest correlations with the “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores were found to be with the variable “Offer Training” ( $r = .46, p < .001$ ) which asked participants if they thought their university should offer training on how to identify students struggling with mental health issues and with the variable “Effort” ( $r = .36, p < .001$ ) which asked participants if they thought their university should make more of an effort to ensure that faculty members are aware of mental health services available to students.

Table 57

Relationship Between Selected Demographic Characteristics and “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities

Variable	<u>r</u>	<u>p</u>
Offer Training <sup>a</sup>	.46	<.001
Effort <sup>b</sup>	.36	<.001
Had Training <sup>c</sup>	.25	<.001
Services – Very Aware	.23	<.001
Suicide <sup>d</sup>	.17	.006
Age – 36-45	-.13	.024
Diagnosis <sup>e</sup>	.12	.036
College/Department – Education	.12	.043
Services – Somewhat Unaware	-.11	.044
Know Anyone <sup>f</sup>	.11	.048
Gender <sup>g</sup>	.11	.051
Typical Class Size – 75+	.10	.071
Rank – Associate Professor	-.10	.078
Degree <sup>h</sup>	.09	.083
Experience – 20-29 (years)	.09	.098
Religion <sup>i</sup>	-.08	.112
Friend/Family <sup>j</sup>	.07	.159
Status – Adjunct	.06	.179
Race/Ethnicity – Asian	-.05	.226

(Table 57 continued)

Variable	<u>r</u>	<u>p</u>
Duties – Teach More	.05	.237
University <sup>k</sup>	-.04	.295

*Note.* n = 225

<sup>a</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>b</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>c</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>d</sup> Have you ever contemplated or attempted suicide?

<sup>e</sup> Have you ever received a mental health diagnosis?

<sup>f</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>g</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>h</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>i</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>j</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>k</sup> The university that is described in the Carnegie Classification as a large, master’s university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

To ensure that variables entered into the regression analysis did not have excessive collinearity or that any combination of the independent variables formed a singularity, the variance inflation factor (VIF) was examined. According to Hair et al. (2006), “A common cutoff threshold is a tolerance value of .10 which corresponds to a VIF value of 10,” (p. 230). The VIF values for this analysis ranged from 1.018 to 1.209. Therefore no excess multicollinearity was present in the data.

Table 58 presents the results of the multiple regression analysis utilizing “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores as the dependent variable.

The variable which entered the regression model first was the variable “offer training” which asked participants if they thought their university should offer training on how to identify students struggling with mental health issues. Considered alone, this variable explained 20.7% of the variance in “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores of currently employed faculty members of public four year universities.

Table 58

Multiple Regression Analysis of “Willingness to Help Students with Mental Health Issues – Faculty Role” Subscale Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities

ANOVA					
Source of Variation	<u>Df</u>	MS	F	<u>p</u>	
Regression	6	6.002	16.733	<.001	
Residual	218	.359			
Total	224				
Model Summary					
Model	R Square	R Square Change	F Change	Sig. F Change	Standardized Coefficients Beta
Offer Training <sup>a</sup>	.207	.207	58.269	<.001	.337
Services – Very Aware	.240	.033	9.683	.002	.209
Effort <sup>b</sup>	.274	.034	10.398	.001	.191
Suicide <sup>c</sup>	.290	.015	4.744	.030	.129
Religion <sup>d</sup>	.303	.013	4.148	.043	-.125
College/Department – Education	.315	.012	3.938	.048	.122

(Table 58 continued)

Variables not in the Equation		
Variables	<u>t</u>	<u>p</u>
Typical Class Size – 75+	1.706	.090
Degree <sup>e</sup>	1.317	.189
Gender <sup>f</sup>	1.306	.193
Age – 36-45	1.106	.270
Had Training <sup>g</sup>	1.004	.317
Experience – 20-29 (years)	.934	.351
Status – Adjunct	.796	.427
Diagnosis <sup>h</sup>	.786	.432
University <sup>i</sup>	.637	.524
Know Anyone <sup>j</sup>	.621	.535
Duties – Teach More	.507	.613
Services – Somewhat Unaware	.229	.819
Friend/Family <sup>k</sup>	.147	.905
Race/Ethnicity – Asian	.120	.905
Rank – Associate Professor	.104	.917

*Note.* <sup>a</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>b</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>c</sup> Have you ever contemplated or attempted suicide?

<sup>d</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>e</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>f</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>g</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>h</sup> Have you ever received a mental health diagnosis?



(Table 58 continued)

<sup>i</sup> The university that is described in the Carnegie Classification as a large, master's university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

<sup>j</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>k</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

Five additional variables explained an additional 10.8% of the variance in “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores. These variables included being very aware of mental health services available to students, believing their university should make more of an effort to ensure that faculty members are aware of mental health services available to students, having contemplated or attempted suicide, practicing a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling, and working in the college/department of education. These six variables explained a total of 31.5% of the variance in “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores among currently employed faculty members of public four-year universities. The nature of the influence of these variables was such that participants that believed their university should offer training on how to identify students struggling with mental health issues, were very aware of mental health services available to students, believed their university should make more of an effort to ensure that faculty members are aware of mental health services available to students, had contemplated or attempted suicide, and worked in the college/department of education tended to be associated with higher “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores while participants who reported practicing a religion, spirituality, or faith that forbids or discourages the use of mental

health services such as counseling tended to be associated with lower “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores.

**Ability to identify students with mental health issues – Related issues subscale.** The first step in conducting the regression analysis was to examine bivariate correlations. Two-way correlations between factors used as independent variables and the “Related Issues” subscale of the “Ability to Identify Students with Mental Health Issues” scale are presented in Table 59.

Seventeen of the 27 correlations were found to be statistically significant. The highest correlations with the “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores were found to be with the variable “Race/Ethnicity – Asian” ( $r = -.34, p < .001$ ) and with the variable “Had Training” ( $r = -.32, p < .001$ ) which asked participants if they had ever had training on mental health issues or suicide prevention.

To ensure that variables entered into the regression analysis did not have excessive collinearity or that any combination of the independent variables formed a singularity, the variance inflation factor (VIF) was examined. According to Hair et al. (2006), “A common cutoff threshold is a tolerance value of .10 which corresponds to a VIF value of 10,” (p. 230). The VIF values for this analysis ranged from 1.040 to 1.627. Therefore no excess multicollinearity was present in the data.

Table 60 presents the results of the multiple regression analysis utilizing “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores as the dependent variable.

Table 59

Relationship Between Selected Demographic Characteristics and “Ability to Identify Students with Mental Health Issues – Related Issues” Subscale Scores Among Currently Employed Faculty Members of Four Year Public Universities

Variable	<u>r</u>	<u>p</u>
Race/Ethnicity – Asian	-.34	<.001
Had Training <sup>a</sup>	.32	<.001
Degree <sup>b</sup>	.28	<.001
Know Anyone <sup>c</sup>	.27	<.001
Race/Ethnicity – White	.25	<.001
Gender <sup>d</sup>	.21	.001
College/Department – Science	-.20	.001
College/Department – Engineering	-.19	.003
Diagnosis <sup>e</sup>	.15	.012
Friend/Family <sup>f</sup>	.15	.013
College/Department – Art	.14	.016
College/Department – Humanities & Social Sciences	.14	.016
Rank – Associate Professor	.13	.027
Suicide <sup>g</sup>	.13	.027
Rank – Assistant Professor	-.12	.037
Services – Very Unaware	-.11	.045
Duties – Teach More	.11	.048
Services – Somewhat Unaware	-.11	.050

(Table 59 continued)

Variable	<u>r</u>	<u>p</u>
Services – Somewhat Aware	.11	.051
Age – 46-55	-.09	.101
Typical Class Size – 50-74	-.08	.116
Experience – 30+ (years)	-.08	.121
Offer Training <sup>h</sup>	.08	.123
Effort <sup>i</sup>	.06	.193
Status – Full-Time, Tenure-Track	-.05	.235
Religion <sup>j</sup>	-.02	.371
University <sup>k</sup>	-.01	.415

*Note.* n = 225

<sup>a</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>b</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>c</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>d</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>e</sup> Have you ever received a mental health diagnosis?

<sup>f</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>g</sup> Have you ever contemplated or attempted suicide?

<sup>h</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>i</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>j</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>k</sup> The university that is described in the Carnegie Classification as a large, master’s university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

The variable which entered the regression model first was the “race/ethnicity” category “Asian.” Considered alone, this variable explained 11.7% of the variance in “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores of currently employed faculty members of public four year universities.

Six additional variables explained an additional 17.4% of the variance in “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores. These variables included having previous training in mental health or suicide prevention, having a degree in psychology, social work, or counseling, identifying as “white, not Hispanic or Latino,” and working in one of the following colleges/departments: science, engineering, or art. These seven variables explained a total of 29.1% of the variance in “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores among currently employed faculty members of public four-year universities. The nature of the influence of these variables was such that participants that had previous training in mental health or suicide prevention, had degrees in psychology, social work, or counseling, identified as “White, not Hispanic or Latino,” and worked in the college/department of art, tended to be associated with higher “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores. On the other hand, participants that identified as “Asian,” and worked in either the college/department science or engineering tended to be associated with lower “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores.

Table 60

Multiple Regression Analysis of “Ability to Identify Students with Mental Health Issues – Related Issues” Subscale Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities

ANOVA					
Source of Variation	<u>Df</u>	MS	F	<u>p</u>	
Regression	11	1.699	9.283	<.001	
Residual	213	183			
Total	224				
Model Summary					
Model	R Square	R Square Change	F Change	Sig. F Change	Standardized Coefficients Beta
Race/Ethnicity – Asian	.117	.117	29.631	<.001	-.185
Had Training <sup>a</sup>	.194	.077	21.253	<.001	.177
College/Department – Science	.224	.030	8.570	.004	-.153
Degree <sup>b</sup>	.252	.028	8.155	.005	.198
College/Department – Engineering	.267	.014	4.271	.040	-.092
College/Department – Art	.279	.012	3.649	.057	.118
Race/Ethnicity – White, not Hispanic or Latino	.291	.013	3.869	.050	.134

(Table 60 continued)

Variables not in the Equation		
Variables	<u>t</u>	<u>p</u>
Typical Class Size – 50-74	1.638	.103
Rank – Associate Professor	1.598	.111
Services – Somewhat Aware	1.558	.121
Experience – 30+ (years)	1.543	.124
Gender <sup>c</sup>	1.541	.125
Suicide <sup>d</sup>	1.534	.126
Know Anyone <sup>e</sup>	1.472	.143
Diagnosis <sup>f</sup>	1.347	.179
Rank – Assistant Professor	1.251	.212
Friend/Family <sup>g</sup>	.990	.323
Age – 46-55	.985	.326
Services – Somewhat Unaware	.904	.367
Services – Very Unaware	.762	.447
Effort <sup>h</sup>	.752	.453
Duties – Teach More	.631	.529
Department – Humanities & Social Sciences	.557	.578
Offer Training <sup>i</sup>	.412	.681
University <sup>j</sup>	.337	.737
Status – Full-Time, Tenure-Track	.217	.829
Religion <sup>k</sup>	.199	.843

(Table 60 continued)

*Note.* <sup>a</sup>Have you ever had training on mental health issues or suicide prevention?

<sup>b</sup>Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>c</sup>“Male” was coded as 0 while “Female” was coded as 1

<sup>d</sup>Have you ever contemplated or attempted suicide?

<sup>e</sup>Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>f</sup>Have you ever received a mental health diagnosis?

<sup>g</sup>Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>h</sup>Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>i</sup>Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>j</sup>The university that is described in the Carnegie Classification as a large, master’s university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

<sup>k</sup>Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

Ability to identify students with mental health issues – Emotions. The first step in conducting the regression analysis was to examine the bivariate correlations. Two-way correlations between factors used as independent variables and the “Emotions” subscale of the “Ability to Identify Students with Mental Health Issues” scale are presented in Table 61. Thirteen of the 23 correlations were found to be statistically significant. The highest correlations with the “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were found to be with the variable “Had Training” ( $r = .24, p < .001$ ) and the variable “Race/Ethnicity - Asian” ( $r = .23, p < .001$ ).



Table 61

Relationship Between Selected Demographic Characteristics and “Ability to Identify Students with Mental Health Issues – Emotions” Subscale Scores Among Currently Employed Faculty Members of Public Four Year Universities

Variable	<u>r</u>	<u>p</u>
Had Training <sup>a</sup>	.24	<.001
Race/Ethnicity – White, not Hispanic or Latino	.23	<.001
Diagnosis <sup>b</sup>	.21	.001
Race/Ethnicity – Asian	-.21	.001
Status – Tenured	.19	.002
Degree <sup>c</sup>	.16	.010
Rank – Instructor	-.15	.012
Know Anyone <sup>d</sup>	.14	.015
Status – Full-Time, Non-Tenure Track	-.14	.020
College/Department – Science	-.13	.028
Rank – Associate Professor	.12	.033
Age – 66+	.12	.041
Religion <sup>e</sup>	-.11	.048
Experience – 10-19 (years)	.09	.084
Services – Somewhat Unaware	-.09	.091
Friend/Family <sup>f</sup>	.08	.112
University <sup>g</sup>	-.06	.174
Typical Class Size – 25-49	.06	.175

(Table 61 continued)

Variable	<u>r</u>	<u>p</u>
Gender <sup>h</sup>	.06	.183
Offer Training <sup>i</sup>	.06	.193
Duties – Teach More	.06	.195
Suicide <sup>j</sup>	-.05	.229
Effort <sup>k</sup>	.01	.416

*Note.* n = 225

<sup>a</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>b</sup> Have you ever received a mental health diagnosis?

<sup>c</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>d</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>e</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>f</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>g</sup> The university that is described in the Carnegie Classification as a large, master's university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

<sup>h</sup> "Male" was coded as 0 while "Female" was coded as 1

<sup>i</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>j</sup> Have you ever contemplated or attempted suicide?

<sup>k</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

To ensure that variables entered into the regression analysis did not have excessive collinearity or that any combination of the independent variables formed a singularity, the variance inflation factor (VIF) was examined. According to Hair et al. (2006), "A common cutoff threshold is a tolerance value of .10 which corresponds to a VIF value of 10," (p. 230). The VIF values for this analysis ranged from 1.018 to 1.649. Therefore no excess multicollinearity was present in the data.

Table 62 presents the results of the multiple regression analysis utilizing “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores as the dependent variable.

Table 62

Multiple Regression Analysis of “Ability to Identify Students with Mental Health Issues – Emotions” Subscale Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Four Year Public Universities

ANOVA					
Source of Variation		df	MS	F	p
Regression		6	3.702	10.260	<.001
Residual		218	.361		
Total		224			
Model Summary					
Model	R Square	R Square Change	F Change	Sig. F Change	Standardized Coefficients Beta
Had Training <sup>a</sup>	.057	.057	13.452	<.001	.245
Race/Ethnicity – White, not Hispanic or Latino	.120	.063	15.904	<.001	.233
Status – Tenured	.161	.041	10.707	.001	.206
Diagnosis <sup>b</sup>	.191	.031	8.358	.004	.198
Experience – 10-19 (years)	.207	.015	4.280	.040	.142
Age – 66+	.220	.013	3.742	.054	.118
Variables not in the Equation					
Variables	t			P	
College/Department – Science	1.302			.194	
Rank – Instructor	1.086			.279	

(Table 62 continued)

Variables not in the Equation		
Variables	t	P
Status – Full-Time, Non-Tenure Track	1.043	.298
Religion <sup>c</sup>	.949	.344
Race/Ethnicity – Asian	.849	.397
Offer Training <sup>d</sup>	.822	.412
Suicide <sup>e</sup>	.804	.422
Services – Somewhat Unaware	.760	.448
Typical Class Size – 25-49	.554	.580
University <sup>f</sup>	.480	.631
Effort <sup>g</sup>	.452	.652
Gender <sup>h</sup>	.226	.821
Degree <sup>i</sup>	.197	.844
Rank – Associate Professor	.156	.876
Know Anyone <sup>j</sup>	.091	.928
Friend/Family <sup>k</sup>	.083	.934
Duties – Teach More	.024	.981

*Note.* <sup>a</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>b</sup> Have you ever received a mental health diagnosis?

<sup>c</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>d</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>e</sup> Have you ever contemplated or attempted suicide?

<sup>f</sup> The university that is described in the Carnegie Classification as a large, master's university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

(Table 62 continued)

<sup>g</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>h</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>i</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>j</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>k</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

The variable which entered the regression model first was the variable “had training” which asked participants if they had any training in mental health or suicide prevention. Considered alone, this variable explained 5.7% of the variance in “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores of currently employed faculty members of public four year universities.

Five additional variables explained an additional 16.3% of the variance in “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores. These variables included identifying with the racial/ethnic category “White, not Hispanic or Latino,” being tenured, having previously received a mental health diagnosis, having 10-19 years of experience as a faculty member, and being over 66 years old. These six variables explained a total of 22% of the variance in “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores among currently employed faculty members of public four-year universities. The nature of the influence of these variables was such that participants that had previous training in mental health or suicide prevention, identified as “White, not Hispanic or Latino,” were tenured, had previously received a mental health diagnosis, had 10-19 years of experience as a faculty member, and were over 66 years old tended to be associated with higher “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores.

**Ability to help students with mental health issues.** The first step in conducting the regression analysis was to examine the bivariate correlations. Two-way correlations between factors used as independent variables and the “Ability to Help Students with Mental Health Issues” scale are presented in Table 63.

Fifteen of the 24 correlations were found to be statistically significant. The highest correlations with the “Ability to Help Students with Mental Health Issues” scale scores were found to be with the category “Asian” of the variable “race/ethnicity” ( $r = -.33$ ,  $p < .001$ ) and the variable “Gender” ( $r = .23$ ,  $p < .001$ ).

To ensure that variables entered into the regression analysis did not have excessive collinearity or that any combination of the independent variables formed a singularity, the variance inflation factor (VIF) was examined. According to Hair et al. (2006), “A common cutoff threshold is a tolerance value of .10 which corresponds to a VIF value of 10,” (p. 230). The VIF values for this analysis ranged from 1.015 to 1.518. Therefore no excess multicollinearity was present in the data.

Table 63

Relationship Between Selected Demographic Characteristics and “Ability to Help Students with Mental Health Issues” Scale Scores Among Currently Employed Faculty Members of Public Four Year Universities

Variable	<u>r</u>	<u>p</u>
Race/Ethnicity – Asian	-.33	<.001
Gender <sup>a</sup>	.23	<.001
Know Anyone <sup>b</sup>	.21	.001
Race/Ethnicity – White, not Hispanic or Latino	.20	.001

(Table 63 continued)

Variable	<u>r</u>	<u>p</u>
Diagnosis <sup>c</sup>	.18	.003
Services – Very Unaware	-.18	.003
College/Department – Humanities & Social Sciences	.17	.005
Had Training <sup>d</sup>	.16	.008
Degree <sup>e</sup>	.15	.012
College/Department – Science	-.13	.027
Services – Somewhat Aware	.12	.034
Duties – Do not do research at all	.12	.036
Rank – Assistant Professor	-.12	.042
Experience – 30+ (years)	-.11	.047
Typical Class Size – 25-49	.11	.059
Status – Full-Time, Tenure Track	-.10	.071
Age – 46-55	-.08	.126
Friend/Family <sup>f</sup>	.07	.136
Suicide <sup>g</sup>	.06	.202
Religion <sup>h</sup>	-.05	.217
Offer <sup>i</sup>	.03	.327
University <sup>j</sup>	-.02	.358
Effort <sup>k</sup>	-.01	.427

(Table 63 continued)

*Note.* n = 225

<sup>a</sup> “Male” was coded as 0 while “Female” was coded as 1

<sup>b</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>c</sup> Have you ever received a mental health diagnosis?

<sup>d</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>e</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>f</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>g</sup> Have you ever contemplated or attempted suicide?

<sup>h</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>i</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

<sup>j</sup> The university that is described in the Carnegie Classification as a large, master’s university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

<sup>k</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students

Table 64 presents the results of the multiple regression analysis utilizing “Willingness to Help Students with Mental Health Issues – Emotions” subscale scores as the dependent variable.

Table 64

Multiple Regression Analysis of “Ability to Help Students with Mental Health Issues” Scores and Selected Personal and Professional Demographics of Currently Employed Faculty Members of Public Four Year Universities

Source of Variation	ANOVA			
	<u>df</u>	MS	F	<u>p</u>
Regression	8	5.910	7.473	<.001
Residual	216	.791		
Total	224			



(Table 64 continued)

Model Summary					
Model	R Square	R Square Change	F Change	Sig. F Change	Standardized Coefficients Beta
Race/Ethnicity - Asian	.106	.106	26.419	<.001	-.230
Gender <sup>a</sup>	.132	.026	6.728	.010	-.086
Services – Very Unaware	.150	.018	4.727	.031	-.128
Diagnosis <sup>b</sup>	.165	.015	3.865	.051	.126
Degree <sup>c</sup>	.181	.016	4.280	.040	.132
College/Department - Engineering	.194	.013	3.408	.066	-.135
College/Department – Science	.207	.013	3.671	.057	-.133
Experience – 30+ (years)	.217	.010	2.672	.104	-.093
Variables not in the Equation					
Variables	<u>t</u>		<u>p</u>		
Duties – No Research	1.464		.145		
Rank – Assistant Professor	1.437		.152		
Age – 46-55	1.408		.161		
Typical Class Size – 25-49	1.302		.194		
Status – Full-Time, Tenure Track	1.007		.315		
Services – Somewhat Aware	.603		.547		
Religion <sup>d</sup>	.436		.663		
University <sup>e</sup>	.434		.665		
College/Department – Humanities & Social Sciences	.358		.720		

(Table 64 continued)

Variables not in the Equation		
Variables	<u>t</u>	<u>p</u>
Effort <sup>f</sup>	.307	.759
Had Training <sup>g</sup>	.292	.770
Friend/Family <sup>h</sup>	.286	.775
Race/Ethnicity – White, not Hispanic or Latino	.259	.795
Know Anyone <sup>i</sup>	.246	.806
Suicide <sup>j</sup>	.188	.851
Offer Training <sup>k</sup>	.042	.967

*Note.* <sup>a</sup>“Male” was coded as 0 while “Female” was coded as 1

<sup>b</sup> Have you ever received a mental health diagnosis?

<sup>c</sup> Do you have one or more degrees in any of the following areas: psychology, social work, or counseling?

<sup>d</sup> Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?

<sup>e</sup> The university that is described in the Carnegie Classification as a large, master’s university was coded as 0 while the university that is described in the Carnegie Classification as a medium research university was coded as 1

<sup>f</sup> Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

<sup>g</sup> Have you ever had training on mental health issues or suicide prevention?

<sup>h</sup> Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>i</sup> Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?

<sup>j</sup> Have you ever contemplated or attempted suicide?

<sup>k</sup> Do you think your university should offer training on how to identify students struggling with mental health issues?

The variable which entered the regression model first was the category “Asian” of the original variable “race/ethnicity.” Considered alone, this variable explained 10.6% of the variance in “Ability to Help Students with Mental Health Issues” scale scores of currently employed faculty members of public four year universities.

Seven additional variables explained an additional 11.1% of the variance in “Ability to Help Students with Mental Health Issues” scale scores. These variables included gender, being very unaware of mental health services available to students, having previously received a mental health diagnosis, having a degree in psychology, social work, or counseling, working in the colleges/department engineering or science, and having 30 or more years of experience as a faculty member. These eight variables explained a total of 21.7% of the variance in “Ability to Help Students with Mental Health Issues” scale scores among currently employed faculty members of public four-year universities. The nature of the influence of these variables was such that participants that identified as “female,” and had previously received a mental health diagnosis, had a degree in psychology, social work, or counseling tended to be associated with higher “Ability to Help Students with Mental Health Issues” scale scores. On the other hand, participants who identified with the category “Asian” of the variable “race/ethnicity,” reported being very unaware of mental health services available to students, working in either the college/department engineering or science, and who had 30 or more years of experience as a faculty member tended to be associated with lower “Ability to Help Students with Mental Health Issues” scale scores.

## **CHAPTER 5**

### **SUMMARY, CONCLUSIONS, IMPLICATIONS, & RECOMMENDATIONS**

#### **Summary**

**Purpose statement.** The primary purpose of this study was to determine the influence of selected personal and professional demographic characteristics on the attitudes toward and perceptions of selected mental health issues among currently employed faculty of four year public universities.

#### **Objectives.**

1. To describe currently employed faculty of four year public universities on the following personal and professional demographic characteristics:
  - a. Age
  - b. Gender
  - c. Race/Ethnicity
  - d. University
  - e. Years of experience as a faculty member
  - f. Employment status
  - g. Faculty rank
  - h. Actual job duties
  - i. Typical class size
  - j. College/Department
  - k. Mental health experience
  - l. Knowledge of university mental health services available to students
  - m. Beliefs about university's role in mental health services

2. To describe currently employed faculty of four year public universities on their attitude toward mental health as measured by a researcher designed scale.
3. To describe currently employed faculty of four year public universities on their willingness to help students with mental health issues as measured by a researcher designed scale.
4. To describe currently employed faculty of four year universities on their ability to identify students with mental health issues as measured by a researcher designed scale.
5. To describe currently employed faculty of four year universities on their ability to help students with mental health issues as measured by a researcher designed scale.
6. To determine if a relationship exists between selected personal and professional demographic characteristics of currently employed faculty of four year public universities and the following perceptual measures:
  - a. Attitude toward mental health
  - b. Willingness to help students with mental health issues
  - c. Ability to identify students with mental health issues, and
  - d. Ability to help students with mental health issues.
7. To determine if a relationship exists between attitude toward mental health among currently employed faculty of four year public universities and the following perceptual measures:
  - a. Willingness to help students with mental health issues
  - b. Ability to identify students with mental health issues, and
  - c. Ability to help students with mental health issues.

8. To determine if a relationship exists between willingness to help students with mental health issues among currently employed faculty of four year public universities and the following perceptual measures:
  - a. Ability to identify students with mental health issues, and
  - b. Ability to help students with mental health issues.
9. To determine if a relationship exists between ability to identify students with mental health issues among currently employed faculty of four year public universities and ability to help students with mental health issues.
10. To determine if a model exists explaining a significant portion of the variance in attitudes toward and perceptions of selected mental health issues among currently employed faculty of four year public universities from the following personal and professional demographic characteristics:
  - a. Age
  - b. Gender
  - c. Race/Ethnicity
  - d. University
  - e. Years of experience as a faculty member
  - f. Employment status
  - g. Faculty rank
  - h. Actual job duties
  - i. Typical class size
  - j. College/Department
  - k. Mental health experience

- l. Knowledge of university mental health services available to students
- m. Beliefs about university's role in mental health services

## **Summary of Methodology**

**Population and sample.** The target population for this study was faculty members of four year public universities in the Southeastern United States. The accessible population of this study was faculty members at two four year public universities in Southern Louisiana. E-mail addresses for all faculty listed on each university's website were obtained using general departmental searches. Only e-mail addresses accessible to anyone visiting these websites were used; no list was obtained directly from the university and no access codes were used.

**Instrumentation.** This study used a researcher-designed instrument. The content validity of this instrument was established through a review by a panel of experts in the field of mental health and necessary revisions based on their feedback were made. The final version of this instrument consisted of 55 questions and was divided into five categories. The first three sections included a total of 30 statements designed to measure attitude toward mental health, willingness to help students with mental health issues, and ability to identify students with mental health issues. Participants were given the following response options: strongly disagree, disagree, slightly disagree, slightly agree, agree, and strongly agree. The fourth section consisted of five multiple-choice questions and was designed to measure ability to help students with mental health issues. These questions were vignettes which participants read and were asked to select one option which they believed would be the best action to take, given the specifics of the vignette. Finally the last section consisted of demographic questions that assessed a variety of personal and professional characteristics.

**Data collection.** The researcher obtained permission from the Institutional Review Boards at all universities involved before any surveys were distributed. The survey was distributed using Survey Monkey© online survey software. An e-mail containing the IRB-required informed consent information was sent to all participants requesting that they complete the survey. Follow-ups occurred weekly for three weeks giving participants a total of four weeks to respond to the instrument. A total of 281 respondents began the survey and 261 provided usable responses.

### **Summary of Findings**

**Objective one.** Objective one was to describe currently employed faculty of four year public universities on a variety of personal and professional demographic characteristics. The majority of participants were female ( $\underline{n} = 142$ , 56.5%), White, not Hispanic or Latino ( $\underline{n} = 189$ , 76.5%), spend more time teaching than doing research ( $\underline{n} = 165$ , 65.5%), have a typical class size as being between 25 and 49 students ( $\underline{n} = 140$ , 55.6%), know someone who has been diagnosed with a mental illness or has attempted or completed suicide ( $\underline{n} = 217$ , 86.5%), have a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide ( $\underline{n} = 165$ , 65.7%), have not had previous training on mental health issues or suicide prevention ( $\underline{n} = 171$ , 68.4%), have not received a mental health diagnosis personally ( $\underline{n} = 202$ , 80.5%), do not have a degree in psychology, social work, or counseling ( $\underline{n} = 223$ , 88.8%), have not contemplated or attempted suicide ( $\underline{n} = 223$ , 89.2%), do not practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling ( $\underline{n} = 237$ , 95.2%), think their university should offer training on how to identify students with mental health ( $\underline{n} = 215$ , 86.7%), and think their university should make more of an effort to ensure that faculty members are aware of mental health services available to students ( $\underline{n} = 218$ , 87.6%).



Additionally the largest portion of participants were between 56 and 65 years old ( $\underline{n} = 75$ , 29.5%), had 10-19 years of experience ( $\underline{n} = 91$ , 36.1%), were tenured ( $\underline{n} = 107$ , 42.3%), were instructors ( $\underline{n} = 90$ , 35.9%), worked in the college/department “Humanities & Social Sciences” ( $\underline{n} = 87$ , 34.5%), and reported being somewhat aware of services ( $\underline{n} = 121$ , 48.4%).

**Objective two.** Objective two was to describe currently employed faculty of four year public universities on their attitude toward mental health as measured by a researcher designed scale. Factor analysis determined that there were no underlying constructs in this scale. An overall “Attitude toward Mental Health” score was computed for all participants. Scores could range from 1.00 indicating a highly negative attitude to 6.00 indicating a highly positive attitude. The mean score for this scale was 5.27 ( $SD = .53$ ) and participant scores ranged from 3.40 to 6.00.

**Objective three.** Objective three was to describe currently employed faculty of four year public universities on their willingness to help students with mental health issues as measured by a researcher designed scale. Factor analysis determined that there were two factors present in this scale. Therefore two subscales were extracted and titled “Involvement” which was made up of six items and “Faculty Role” which was made up of four items. Subscale scores for all participants were computed as a mean score of all the items in each subscale. Scores could range from 1.00 indicating very little willingness to 6.00 indicating very great willingness. The mean score for the “Involvement” subscale was 4.15 ( $SD = .79$ ) and scores ranged from 1.67 to 5.83. The mean score for the “Faculty Role” subscale was 4.97 ( $SD = .73$ ) and scores ranged from 2.25 to 6.00.

**Objective four.** Objective four was to describe currently employed faculty of four year universities on their ability to identify students with mental health issues as measured by a researcher designed scale. Factor analysis determined that there were two factors present in this scale. Therefore, two subscales were extracted and titled “Related Issues” which contained six items and “Emotions” which contained four items. Subscale scores for all participants were computed as a mean score of all the items in each subscale. Scores could range from 1.00 indicating very little ability to identify to 6.00 indicating very great ability to identify. The mean score for the “Related Issues” subscale was 4.56 (SD = .52) and scores ranged from 3.00 to 6.00. The mean score for the “Emotions” subscale was 4.51 (SD = .66) and scores ranged from 2.25 to 6.00.

**Objective five.** Objective five was to describe currently employed faculty of four year universities on their ability to help students with mental health issues as measured by a researcher designed scale. An overall scale score was computed for each participant by assigning all correct responses a value of 1 and all other responses a value of 0. Therefore participant scores could range from 0.00 indicating little ability to help to 5.00 indicating great ability to help, since there were five items in this scale. The mean score for this scale was 3.35 (SD = .98) and scores ranged from 1.00 to 5.00.

**Objective six.** Objective six was to determine if a relationship exists between selected personal and professional demographic characteristics of currently employed faculty of four year public universities and the following perceptual measures: attitude toward mental health, willingness to help students with mental health issues, ability to identify students with mental health issues, and ability to help students with mental health issues.

Examination of the computed t-tests revealed that “Attitude toward Mental Health” scores were significantly related to whether or not participants had training on mental health issues or suicide prevention ( $t_{222.354} = 5.445, p < .001$ ), whether or not participants had ever received a mental health diagnosis ( $t_{101.791} = 3.852, p < .001$ ), whether or not participants had a close friend or family member who had been diagnosed with a mental illness or had attempted or completed suicide ( $t_{145.467} = 3.747, p < .001$ ), whether or not participants knew anyone who had been diagnosed with a mental illness or had attempted or completed suicide ( $t_{38.081} = 3.223, p = .003$ ), whether or not participants had a degree in psychology, social work, or counseling ( $t_{249} = 2.047, p = .042$ ), and whether or not participant practiced a religion, spirituality, or faith that forbids or discourages the use of mental health services ( $t_{247} = -2.027, p = .044$ ). Additionally a one-way analysis of variance (ANOVA) determined that “Attitude toward Mental Health” scores were significantly related to race/ethnicity ( $F_{3, 240} = 7.998, p < .001$ ) and college/departments ( $F_{5, 246} = 3.927, p = .002$ ). Finally, Kendall’s Tau Correlation Coefficient procedure determined that “Attitude toward Mental Health” scores were significantly related to how much participants reported knowing about the mental health services available to students at their university ( $r = .15, p = .002$ ).

Examination of the computed t-tests revealed that “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores were significantly related to whether or not participants had training on mental health issues or suicide prevention ( $t_{248} = 6.303, p < .001$ ), whether or not participants believed their university should offer training on how to identify students struggling with mental health issues ( $t_{246} = 4.908, p < .001$ ), whether or not participants had a degree in psychology, social work, or counseling ( $t_{249} = 3.681, p < .001$ ), whether or not participants knew anyone who had been diagnosed with a mental illness or had attempted or

completed suicide ( $t_{249} = 3.345, p = .001$ ), whether or not participants believed their university should make more of an effort to ensure that faculty members are aware of mental health services available to students ( $t_{247} = 2.932, p = .004$ ), and gender ( $t_{249} = -2.570, p = .011$ ). Additionally a one-way analysis of variance (ANOVA) determined that “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores were significantly related to race/ethnicity ( $F_{3, 240} = 2.710, p = .046$ ). Finally, Kendall’s Tau Correlation Coefficient procedure determined that “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores were significantly related to how much participants reported knowing about the mental health services available to students at their university ( $r = .27, p < .001$ ).

Examination of the computed t-tests revealed that “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores were significantly related to whether or not participants believed their university should offer training on how to identify students struggling with mental health issues ( $t_{38.523} = 6.259, p < .001$ ), whether or not participants had training on mental health issues or suicide prevention ( $t_{248} = 3.821, p < .001$ ), whether or not participants believed their university should make more of an effort to ensure that faculty members are aware of mental health services available to students ( $t_{34.215} = 3.804, p = .001$ ), whether or not participants knew anyone who had been diagnosed with a mental illness or had attempted or completed suicide ( $t_{249} = 2.508, p = .013$ ), and whether or not participants had a degree in psychology, social work, or counseling ( $t_{249} = 2.189, p = .030$ ). Additionally, Kendall’s Tau Correlation Coefficient procedure determined that “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores were significantly related to how much

participants reported knowing about the mental health services available to students at their university ( $r = .20$ ,  $p < .001$ ).

Examination of the computed t-tests revealed that “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores were significantly related to whether or not participants had training on mental health issues or suicide prevention ( $t_{248} = 5.046$ ,  $p < .001$ ), whether or not participants knew anyone who had been diagnosed with a mental illness or had attempted or completed suicide ( $t_{249} = 4.763$ ,  $p < .001$ ), whether or not participants had a degree in psychology, social work, or counseling ( $t_{249} = 3.966$ ,  $p < .001$ ), gender ( $t_{249} = -2.959$ ,  $p = .003$ ), whether or not participants had ever received a mental health diagnosis ( $t_{90.791} = 2.679$ ,  $p = .009$ ), whether or not participants had a close friend or family member who had been diagnosed with a mental illness or had attempted or completed suicide ( $t_{249} = 2.337$ ,  $p = .020$ ), and whether or not participants had ever contemplated or attempted suicide ( $t_{248} = 1.993$ ,  $p = .047$ ). Additionally a one-way analysis of variance (ANOVA) determined that “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores were significantly related to race/ethnicity ( $F_{3, 240} = 11.607$ ,  $p < .001$ ) and college/department ( $F_{5, 246} = 5.086$ ,  $p < .001$ ). Finally, Kendall’s Tau Correlation Coefficient procedure determined that “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores were significantly related to how much participants reported knowing about the mental health services available to students at their university ( $r = .14$ ,  $p = .007$ ).

Examination of the computed t-tests revealed that “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were significantly related to whether or not participants had training on mental health issues or suicide prevention ( $t_{248} = 3.527$ ,  $p = .001$ ), whether or not participants had ever received a mental health diagnosis ( $t_{249} = 3.175$ ,  $p = .002$ ),

and whether or not participants had a degree in psychology, social work, or counseling ( $t_{249} = 2.679$ ,  $p = .008$ ). Additionally a one-way analysis of variance (ANOVA) determined that “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were significantly related to race/ethnicity ( $F_{3, 240} = 4.662$ ,  $p = .003$ ). Finally, Kendall’s Tau Correlation Coefficient procedure determined that “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were significantly related to rank as a faculty member ( $r = .13$ ,  $p = .010$ ) and how much participants reported knowing about the mental health services available to students at their university ( $r = .14$ ,  $p = .007$ ).

Examination of the computed t-tests revealed that “Ability to Help Students with Mental Health Issues” scores were significantly related to gender ( $t_{248} = -3.507$ ,  $p = .001$ ), whether or not participants knew anyone who had been diagnosed with a mental illness or had attempted or completed suicide ( $t_{249} = 3.027$ ,  $p = .003$ ), whether or not participants had training on mental health issues or suicide prevention ( $t_{248} = 2.504$ ,  $p = .013$ ), whether or not participants had ever received a mental health diagnosis ( $t_{249} = 2.194$ ,  $p = .029$ ), and whether or not participants had a degree in psychology, social work, or counseling ( $t_{249} = 2.127$ ,  $p = .034$ ). Additionally a one-way analysis of variance (ANOVA) determined that “Ability to Help Students with Mental Health Issues” scores were significantly related to race/ethnicity ( $F_{3, 240} = 8.583$ ,  $p < .001$ ) and college/departments ( $F_{5, 246} = 2.937$ ,  $p = .014$ ). Finally, Kendall’s Tau Correlation Coefficient procedure determined that “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores were significantly related to how much participants reported knowing about the mental health services available to students at their university ( $r = .11$ ,  $p = .048$ ).

**Objective seven.** Objective seven was to determine if a relationship exists between attitude toward mental health among currently employed faculty of four year public universities and the following perceptual measures: willingness to help students with mental health issues, ability to identify students with mental health issues, and ability to help students with mental health issues. This was accomplished using Pearson's Product Moment Correlation Coefficients calculated between the scale/subscales. Overall there were significant, positive correlations between the "Attitude toward Mental Health" scale and all other scales/subscales. The highest correlation with the "Attitude toward Mental Health" scale was found to be with the "Ability to Identify Students with Mental Health Issues – Related Issues" subscale ( $r = .49, p < .001$ ).

**Objective eight.** Objective eight was to determine if a relationship exists between willingness to help students with mental health issues among currently employed faculty of four year public universities and the following perceptual measures: ability to identify students with mental health issues and ability to help students with mental health issues. Since factor analysis determined there were two factors present in the "Willingness to Help Students with Mental Health Issues" scale, the two subscales "Involvement" and "Faculty Role," were considered separately to accomplish this objective. Using Pearson's Product Moment Correlation Coefficient it was determined that there were significant, positive correlations between the "Willingness to Help Students with Mental Health Issues – Involvement" subscale and all other scales/subscales and between the "Willingness to Help Students with Mental Health Issues – Faculty Role" subscale and both of the subscales of the "Ability to Identify Students with Mental Health Issues" scale. The highest correlation with the "Willingness to Help Students with Mental Health Issues – Involvement" subscale was found to be with the "Ability to Identify Students with Mental Health Issues – Related Issues" subscale ( $r = .46, p < .001$ ) and the highest

correlation with the “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale was found to be with the “Ability to Help Students with Mental Health Issues – Related Issues” subscale ( $r = .23$ ,  $p < .001$ ) also.

**Objective nine.** Objective nine was to determine if a relationship exists between ability to identify students with mental health issues among currently employed faculty of four year public universities and ability to help students with mental health issues. Since factor analysis determined there were two factors present in the “Ability to Identify Students with Mental Health Issues” scale, the two subscales “Related Issues” and “Emotions,” were considered separately to accomplish this objective. Using Pearson’s Product Moment Correlation Coefficient it was determined that there was a significant, positive correlation between the “Ability to Identify Students with Mental Health Issues – Related Issues” subscale and the “Ability to Help Students with Mental Health Issues” scale ( $r = .34$ ,  $p < .001$ ) as well as between the “Ability to Identify Students with Mental Health Issues – Emotions” subscale and the “Ability to Help Students with Mental Health Issues” scale ( $r = .27$ ,  $p < .001$ ).

**Objective ten.** Objective ten was to determine if a model exists explaining a significant portion of the variance in attitudes toward and perceptions of selected mental health issues among currently employed faculty of four year public universities from a variety of personal and professional demographic characteristics. In order to accomplish this objective multiple regression analyses were performed. “Attitude toward Mental Health” score, “Willingness to Help Students with Mental Health Issues – Involvement” subscale score, “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale score, “Ability to Identify Students with Mental Health Issues – Related Issues” subscale score, “Ability to Identify Students with Mental Health Issues – Emotions” subscale score, and “Ability to Help Students with Mental



Health Issues” score were treated as dependent variables while the personal and professional demographic characteristics were treated as independent variables. Stepwise entry was used for the independent variables in the multiple regression analyses due to the exploratory nature of this study.

The regression model for “Attitude toward Mental Health” consisted of eight variables which explained a total of 25.7% of the variance in “Attitude toward Mental Health” scores among currently employed faculty members of public four year universities. These variables included whether or not participants identified with the “race/ethnicity” category of “Asian,” whether or not participants had training on mental health issues or suicide prevention, whether or not participants had a close friend or family member who had been diagnosed with a mental illness or had attempted or completed suicide, whether or not participants believed their university should offer training on how to identify students struggling with mental health issues, whether or not participants identified with the “race/ethnicity” category “White, not Hispanic or Latino,” whether or not participants have a typical class size of 75 or more students, whether or not participant practiced a religion, spirituality, or faith that forbids or discourages the use of mental health services, and gender. The nature of the influence of these variables was such that participants that identified as “Asian,” reported having a typical class size of 75 or more students, reported practicing a religion that forbids or discourages the use of mental health services such as counseling, and identified as “Male” tended to be associated with lower “Attitude toward Mental Health” scores while participants that reported having previous training on mental health issues or suicide prevention, reported having a close friend or family member who has been diagnosed with a mental illness or who has attempted or completed suicide, believed their university should offer training on how to identify students struggling with mental

health issues, and identified as “White, not Hispanic or Latino” tended to be associated with higher “Attitude toward Mental Health” scores.

The regression model for the “Willingness to Help Students with Mental Health Issues – Involvement” subscale consisted of six variables which explained a total of 27.4% of the variance in “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores among currently employed faculty members of public four year universities. These variables included whether or not participants had training on mental health issues or suicide prevention, whether or not participants believed their university should offer training on how to identify students struggling with mental health issues, whether or not participants rated themselves as being “very unaware” of mental health services available to students at their university, which university the participants were employed at, whether or not participants identified with the “race/ethnicity” category “Asian,” and whether or not participants had a degree in psychology, social work, or counseling. The nature of the influence of these variables was such that participants that had training on mental health issues or suicide prevention, believed their university should offer training on how to identify students struggling with mental health issues, and had a psychology, social work, or counseling degree tended to be associated with higher “Willingness to Help Students with Mental Health Issues- Involvement” subscale scores while participants that reported being very unaware of mental health services available to students, were faculty members of the university that is described in the Carnegie Classification as a large, master’s university, and identified as “Asian” tended to be associated with lower “Willingness to Help Students with Mental Health Issues – Involvement” subscale scores.

The regression model for the “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale consisted of six variables which explained a total of 31.5% of the

variance in “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores among currently employed faculty members of public four year universities. These variables included whether or not participants believed their university should offer training on how to identify students struggling with mental health issues, whether or not participants rated themselves as being “very aware” of mental health services available to students at their university, whether or not participants believed their university should make more of an effort to ensure that faculty members are aware of mental health services available to students, whether or not participants had ever contemplated or attempted suicide, whether or not participant practiced a religion, spirituality, or faith that forbids or discourages the use of mental health services, and whether or not participants were employed in the college/department of education. The nature of the influence of these variables was such that participants that believed their university should offer training on how to identify students struggling with mental health issues, were very aware of mental health services available to students, believed their university should make more of an effort to ensure that faculty members are aware of mental health services available to students, had contemplated or attempted suicide, and worked in the college/department of education tended to be associated with higher “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores while participants who reported practicing a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling tended to be associated with lower “Willingness to Help Students with Mental Health Issues – Faculty Role” subscale scores.

The regression model for the “Ability to Identify Students with Mental Health Issues – Related Issues” subscale consisted of seven variables which explained a total of 29.1% of the variance in “Ability to Identify Students with Mental Health Issues – Related Issues” subscale

scores among currently employed faculty members of public four year universities. These variables included whether or not participants identified with the “race/ethnicity” category “Asian,” whether or not participants had training on mental health issues or suicide prevention, whether or not participants work in the college/department of science, whether or not participants had a degree in psychology, social work, or counseling, whether or not participants work in the college/department of engineering, whether or not participants work in the college/department of art, and whether or not participants identified with the “race/ethnicity” category of “White, not Hispanic or Latino.” The nature of the influence of these variables was such that participants that had previous training in mental health or suicide prevention, had degrees in psychology, social work, or counseling, identified as “White, not Hispanic or Latino,” and worked in the college/department of art tended to be associated with higher “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores while participants that identified as “Asian,” and worked in either the college/department of science or engineering tended to be associated with lower “Ability to Identify Students with Mental Health Issues – Related Issues” subscale scores.

The regression model for the “Ability to Identify Students with Mental Health Issues – Emotions” subscale consisted of six variables which explained a total of 22% of the variance in “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores among currently employed faculty members of public four year universities. These variables included whether or not participants had training on mental health issues or suicide prevention, whether or not participants identified with the “race/ethnicity” category of “White, not Hispanic or Latino,” whether or not participants were tenured, whether or not participants have ever received a mental health diagnosis, whether or not participants have 10-19 years of experience as a faculty

member, and whether or not participants are 66 years of age or older. The nature of the influence of these variables was such that participants that had previous training in mental health or suicide prevention, identified as “White, not Hispanic or Latino,” were tenured, had previously received a mental health diagnosis, had 10-19 years of experience as a faculty member, and were over 66 years old tended to be associated with higher “Ability to Identify Students with Mental Health Issues – Emotions” subscale scores.

The regression model for the “Ability to Help Students with Mental Health Issues” scale consisted of eight variables which explained a total of 21.7% of the variance in “Ability to Help Students with Mental Health Issues” scores among currently employed faculty members of public four year universities. These variables included whether or not participants identified with the “race/ethnicity” category “Asian,” gender, whether or not participants rated themselves as being “very unaware” of mental health services available to students at their university, whether or not participants have ever received a mental health diagnosis, whether or not participants had a degree in psychology, social work, or counseling, whether or not participants work in the college/department of engineering, whether or not participants work in the college/department of science, and whether or not participants had 30 or more years of experience as a faculty member. The nature of the influence of these variables was such that participants that identified as “female,” had previously received a mental health diagnosis, and had a degree in psychology, social work, or counseling tended to be associated with higher “Ability to Help Students with Mental Health Issues” scale scores while participants who identified with the category “Asian” of the variable “race/ethnicity,” reported being very unaware of mental health services available to students, working in either the college/department engineering or science, and who had 30 or

more years of experience as a faculty member tended to be associated with lower “Ability to Help Students with Mental Health Issues” scale scores.

### **Conclusions, Implications, & Recommendations**

The researcher has derived the following conclusions, implications, and recommendations based on the findings of this study:

**Conclusion one.** The first conclusion of this study is that faculty members generally have positive attitudes towards student mental health. This conclusion is based on the finding that, out of a range of scores from one, indicating an extremely negative attitude toward mental health, to six, indicating an extremely positive attitude toward mental health, the mean score of participants in this study was 5.27. Additionally, on the “Attitude toward Mental Health” scale, participants indicated the highest level of disagreement to the statement “If I found out that one of my students was going to counseling, I would think less of them” ( $M = 1.23$ ,  $SD = .51$ ). Furthermore, in conducting the regression analysis it was determined that the only personal or professional demographic variables that had a significant negative relationship were identifying as “Asian” ( $r = -.30$ ,  $p < .001$ ), practicing a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling ( $r = -.17$ ,  $p = .007$ ), being “somewhat unaware” of university mental health services available to students ( $r = -.16$ ,  $p = .009$ ), working in the college/department of business ( $r = -.14$ ,  $p = .018$ ), and working in the college/department of engineering ( $r = -.14$ ,  $p = .021$ ). All of these categories were the minority of participants with only 7.3% of participants identifying as “Asian” ( $n = 18$ ), 4.8% of participants reporting practicing a religion, spirituality, or faith that forbids or discourages the use of mental health services ( $n = 12$ ), 17.2% of participants rating themselves as being

“somewhat unaware” of university mental health services available to students (n = 43), 11.1% of participants working in the college/department of business (n = 28), and 4.0% of participants working in the college/department of engineering (n = 10).

The implication of this conclusion is that faculty bias toward or discrimination of students based on their mental health is not a major concern for the majority of faculty members. Furthermore, the negative attitudes towards mental health that were found in this study seemed to be concentrated to a few identifiable groups. Asian faculty members, for example, seem to hold more negative view of mental health than other racial/ethnic groups in the campus community but they are also a minority of faculty members. Additionally, faculty in departments such as business and engineering also seem to have more negative attitudes. Although these groups do not necessarily make up the majority of faculty members at the university in general, it is worth noting that students in these departments that do struggle with their mental health may end up with a majority of their professors/instructors having negative attitudes towards mental illness and therefore fear seeking help.

Based on this conclusion the researcher recommends that universities regularly assess their faculty members for negative attitudes toward student mental health. This could be accomplished by using online survey software to assess faculty members annually for their attitudes towards student mental health issues. Beyond being willing or able to help, faculty attitudes towards students with mental health issues may contribute to faculty discriminating against students unlawfully, putting the university at risk legally. More importantly, negative attitudes may contribute to a campus environment in which students do not feel comfortable seeking help for any mental health issues they are struggling with. Regularly assessing faculty

members would allow the university to easily identify those faculty members who show bias or prejudice against students with mental health issues.

In order to create a more accepting campus environment the researcher further recommends that universities develop educational programs aimed at raising awareness about mental health issues, removing stigma from mental illness, and promoting mental health. These programs could be developed by campus mental health personnel and although all faculty members should be invited to attend, those that appear to have negative attitudes in the assessment discussed earlier should be required to attend.

**Conclusion two.** The second conclusion of this study is that faculty members generally have good instincts about the warning signs of mental health issues and how to help students that are struggling with their mental health. This conclusion is based on the finding that, on the “Ability to Identify Students with Mental Health Issues” scale, with a score of one indicating very little ability to identify students with mental health issues and a score of six indicating very great ability to identify students with mental health issues, the average score was a 4.51. Additionally, on the “Ability to Help Students with Mental Health Issues” scale, with a score of one indicating very little ability to help and a score of five indicating very great ability to help, the average score was 3.35. In fact, the correct answer to each of the five vignettes which make-up the “Ability to Help Students with Mental Health Issues” scale were chosen by the majority of participants with 72.2% of participants choosing the correct answer to Vignette One, 62.2% of participants choosing the correct answer to Vignette Two, 59% of participants choosing the correct answer to Vignette Three, 90.8% of participants choosing the correct answer to Vignette Four, and 55.8% of participants choosing the correct answer to Vignette Five.



The implication of this conclusion is that many faculty members may already be able to effectively identify and help students struggling with mental health issues. Perhaps either through life experience or media attention to mental health issues, faculty seem to have at least a basic understanding, when it comes to mental health, of who needs help and how to help them. This means that universities who want to train their faculty to effectively address student mental health concerns would not necessarily need to start this training at the most basic level. While faculty members are by no means mental health experts, the goal of any mental health training program should be to expand upon the basic awareness and understanding faculty members already seem to have.

Based on this conclusion, the researcher recommends that future researchers investigate further into what faculty members do and do not know about mental health. The “Ability to Identify Students with Mental Health Issues” scale of this study contained 10 items and the “Ability to Help Students with Mental Health Issues” scale contained five items. Although these scales offered a good sense of faculty members’ general abilities to identify and help, future researchers should look more specifically at when faculty members do and do not know when to step in and do and do not know how to help. Additionally future researchers should attempt to develop different ways of measuring these constructs in order to develop a more complete and thorough understanding. This information would be beneficial when designing mental health training programs for faculty.

**Conclusion three.** The third conclusion of this study is that faculty members are best able to identify what to do in extreme circumstances when it comes to student mental health issues. This conclusion is based on the finding that, as part of the “Ability to Help Students with Mental Health Issues” scale, the largest majority of participants responded correctly to the

following vignette: “A student comes to your office and says that, because of a low grade you gave them, they are planning to kill themselves. The student says they have a gun at home and plan to shoot themselves if you do not change their grade. You ask the student to walk with you to the mental health center and they refuse.” When asked what they would do, 90.8% of participants ( $n = 226$ ) chose the correct response, call the police. On the other hand the vignette with the lowest number of correct responses was “One of your students has gotten consistently poor grades in your course. You ask to talk to them after class and they seem genuinely unconcerned about their poor grades.” When asked what they would do 55.8% of participants ( $n = 135$ ) chose the correct response, do nothing. This finding aligns with literature such as the work of Knox and Roberts (2005), Kraft (2009), and Mier, Boone, and Shropshire (2009) who pointed out that recent, highly publicized tragedies involving university students such as the killing spree of Seung Hui Cho at Virginia Tech and the movie theater shootings of former University of Colorado student James Holmes have drawn a lot of attention to the importance of having strategies and protocols in place in order to prevent similar tragedies from occurring in the future. Perhaps faculty members, out of perceived necessity, have worked out what they would do in these extreme circumstances but have not yet considered what they would do in less dire circumstances.

The implication of this finding is that faculty members may actually be uncomfortable not doing anything if they do have concerns about a student’s mental health. In other words, faculty members seem to be clearer and more decisive about what to do in extreme circumstances because they have seen, through recent tragedies, the consequences of not taking action but remain uncertain about what to do when a student’s mental health struggles are not blatant. Obviously one of the goals of having faculty members participate in identifying and

addressing student mental health concerns is to try to prevent tragedies involving students from occurring and therefore identifying and helping students in the early stages of a mental health issue should be a priority.

Based on this conclusion, the researcher recommends that universities design and implement programs whereby faculty members are able to consult with campus mental health professionals about what to do when they have concerns about a student's mental health. Although this may simply involve faculty members calling the campus mental health center during business hours there should also be a 24-hour crisis line available to faculty. As most universities have night classes, only having representatives from the campus mental health center to consult with during business hours is not sufficient. Staff members at the campus mental health center could alternate days or weeks which they are on-call and available to faculty members for consultations. This way faculty will not have to decide alone what is and is not a warning sign that a student is struggling with their mental health or what the appropriate action to take would be.

**Conclusion four.** The fourth conclusion of this study is that faculty members believe their university should do more to address student mental health. This conclusion is based on the findings that 86.7% of participants believed their university should offer training on how to identify students with mental health issues and 87.6% of participants believed their university should make more of an effort to ensure faculty members are aware of mental health services available to students. In fact, when asked how much they knew about their university's mental health services available to students, 32% of participants rated themselves as either "Somewhat Unaware" or "Very Unaware." This conclusion aligns with literature such as the study by Yorgason, Linville, and Zitzman (2008) who found that only 32% of students participating in

their study reported being adequately informed about the mental health services available to students at their university and the majority of students who were informed about these services reported learning this information through a friend or fellow student.

The implication of this finding is that the majority of faculty members have a desire for more to be done to address student mental health issues at their university. Furthermore, most faculty members seem to be willing to participate in this endeavor. This desire for more to be done could actually be the manifestation of fears faculty may have regarding what might happen if student mental health issues are not addressed. They could fear for the safety of themselves, their students, or the campus in general or even fear the legal ramifications if they fail to act when warning signs are present.

Based on this conclusion the researcher recommends that future researchers investigate further into what types of mental health training faculty would be interested in taking part in as well as what suggestions faculty members may have for universities to better address student mental health. Faculty members interact with students daily and may be useful untapped resources for designing strategies. Also, by finding out, specifically, what mental health topics are of interest to faculty members, universities can be more confident when allocating money to training programs that these programs will actually be utilized by faculty members.

**Conclusion five.** The fifth conclusion of this study is that the majority of faculty members do not have mental health training or education. This conclusion is based on the findings that only 31.6% of participants reported having previous training in mental health and only 11.2% reported having a degree in psychology, social work, or counseling. This conclusion aligns with literature such as the work of Cukrowicz et al. (2011) who reported that many of the

people on college campuses that could potentially help students who are struggling with mental health issues are unlikely to have mental health training.

The implication of this finding is that faculty members may potentially do the wrong thing when attempting to help students with mental health issues. Depending on the situation, these mistakes could put students and potentially the entire campus community at risk. Mistakes by faculty members with good intentions could lead to violence on the part of students with mental health issues or even put the university at risk financially if legal boundaries are crossed.

Based on this conclusion, the researcher recommends that future researchers develop a tool to assess which faculty members are most in need of mental health training and what false beliefs, specifically, are held by faculty members. This assessment of faculty should be required annually and utilize technology for two purposes. First, this assessment should be an online survey so that faculty members are able to complete the survey in their own time. Second, this survey should utilize technology like video vignettes so that faculty members can be asked what they would do in more realistic scenarios rather than after simply reading a typed vignette. Having faculty members participate in this assessment will allow universities to identify faculty members most in need of mental health training.

**Conclusion six.** The sixth conclusion of this study is that mental health education and training significantly impacts faculty members' perceptions of mental health issues. This conclusion is based on the finding that the variable "Had Training" which asked participants whether or not they had previous mental health training and the variable "Degree" which asked participants whether or not they had a degree in psychology, social work, or counseling were found to be significantly related to the scores of faculty members on all scales/subscales.

Furthermore, the variable “Had Training” was part of the regression model for four of the six scales/subscales including “Attitude toward Mental Health,” Willingness to Help Students with Mental Health Issues – Involvement,” “Ability to Identify Students with Mental Health Issues – Related Issues,” and “Ability to Identify Students with Mental Health Issues – Emotions” and the variable “Degree” (whether or not the participant had a degree in psychology, social work, or counseling) was part of the regression model for three of the six scales/subscales including “Willingness to Help Students with Mental Health Issues – Involvement,” “Ability to Identify Students with Mental Health Issues – Related Issues,” and “Ability to Help Students with Mental Health Issues.”

The implication of this finding is that mental health training and education could help participants to become more understanding and accepting of those with mental health issues and also make them more confident, willing, and able to help. Without having faculty members who are properly trained in how to identify and help students with mental health issues the university risks faculty members failing to act appropriately, sufficiently, or at all in these situations. This could lead to further deterioration of the mental health of student and possibly even danger for the student or others in the campus community.

Based on this conclusion, the researcher recommends that universities require their faculty to take part in annual mental health training. This training could be designed and implemented by the campus mental health center and could either be a traditional face-to-face training program or utilize online training technology. As an annual training, the mental health center should seek to cover new ground with each training session, alternating through a series of topics and improving constantly according to advances in information and technology. Furthermore the researcher recommends that these training sessions include feedback from

faculty participants on how to expand or improve training as well as take suggestions for future topics to cover.

**Conclusion seven.** The seventh conclusion of this study is that faculty members are willing to help students with mental health issues. This conclusion is based on the finding that on the “Willingness to Help Students with Mental Health Issues” scale the mean score of participants was 4.15 out of a possible 6.00 on the “Involvement” subscale and 4.97 out of a possible 6.00 on the “Faculty Role” subscale, both indicating willingness to help. Furthermore, the statement on this scale that received the highest level of disagreement was the statement “I wouldn’t get involved in student mental health concerns, no matter the circumstances” ( $M = 2.10$ ,  $SD = 1.02$ ). In fact the willingness of participants was quite evident in this scale with major levels of agreement to the statements “I am willing to learn more about warning signs for mental illness” ( $M = 5.09$ ,  $SD = .87$ ), “I am willing to learn more about campus mental health services available to students” ( $M = 5.05$ ,  $SD = .84$ ), “I would intervene if I knew a student was struggling with a mental health issue,” ( $M = 4.35$ ,  $SD = 1.16$ ), “I am willing to attend a training seminar on mental health” ( $M = 4.21$ ,  $SD = 1.35$ ), and “Helping students with mental health issues is part of my job” ( $M = 4.00$ ,  $SD = 1.30$ ).

The implication of this conclusion is that faculty members may actually be willing to go above and beyond any required mental health training. Based on this conclusion the researcher recommends that universities offer faculty members access to additional, voluntary mental health training programs. Like any required mental health training this program could be designed by the campus mental health center. The researcher further recommends that these voluntary training programs be primarily web-based so that they can be easily accessed by faculty at their

convenience. Additionally, the researcher recommends that future researchers investigate further into what mental health topics faculty members are most interested in learning more about.

**Conclusion eight.** The final conclusion of this study is that mental health issues have impacted the lives of the majority of faculty members. This conclusion is based on the finding that 86.5% of faculty members report knowing someone who has been diagnosed with a mental illness or has attempted or contemplated suicide and 65.7% report having a friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide. Furthermore, 19.5% of faculty members report having received a mental health diagnosis personally and 10.8% report contemplating or attempting suicide at some point in their lives. This conclusion aligns with literature which stated that mental health issues affect a large number of people every year (WHO, 2010; CDC, 2011b, NAMI, 2012). WHO (2010), in fact, reports that more than 450 million people worldwide currently meet criteria for diagnosable mental illnesses while the CDC (2011b) reported that approximately one in four adults in the United States has a mental illness. Additionally suicide is currently the tenth leading cause of death in the United States among all age groups with 36,909 reported suicides in 2009, the last year for which statistics are published (AAS, 2012a, 2012b). Therefore it is reasonable to conclude that most people's lives have in some way been impacted by mental illness.

The implication of this conclusion is that faculty, by participating in addressing student mental health concerns, may be reminded of painful experiences in their own lives. Based on this conclusion, the researcher recommends that universities ensure that faculty mental health is prioritized along with student mental health. This does not necessarily mean that universities need to provide mental health services to faculty members but the university should, however, ensure that faculty members are aware of their mental health benefits available through the



university's employee health plan as well as other community resources. Faculty members struggling with their own mental health may be of little help in addressing student mental health concerns.

## REFERENCES

- Ackerman, R., DiRamio, D., & Mitchell, R. L. G. (2009). Transitions: Combat veterans as college students. *New Directions for Student Services*, 126, 5-14. doi: 10.1002/ss
- Ægisdóttir, S., O'Heron, M. P., Hartong, J. M., Haynes, S. A., & Linville, M. K. (2011). Enhancing attitudes and reducing fears about mental health counseling: An analogue study. *Journal of Mental Health Counseling*, 33(4), 327-346.
- American Association of Suicidology. (2012a). Suicide in the USA based on current (2009) statistics. Retrieved from [http://www.suicidology.org/c/document\\_library/get\\_file?folderId=262&name=DLFE-532.pdf](http://www.suicidology.org/c/document_library/get_file?folderId=262&name=DLFE-532.pdf)
- American Association of Suicidology. (2012b). U.S.A. suicide: 2009 official final data. Retrieved from [http://www.suicidology.org/c/document\\_library/get\\_file?folderId=228&name=DLFE-494.pdf](http://www.suicidology.org/c/document_library/get_file?folderId=228&name=DLFE-494.pdf)
- American College Health Association. (2010). Considerations for integration of counseling and health services on college and university campuses. *Journal of American College Health*, 58(6), 583-596.
- American College Health Association. (2012). National College Health Assessment (NCHA) II: Fall 2011 reference group executive summary. Retrieved from [http://www.acha-ncha.org/docs/ACHA-NCHA-II\\_ReferenceGroup\\_ExecutiveSummary\\_Fall2011.pdf](http://www.acha-ncha.org/docs/ACHA-NCHA-II_ReferenceGroup_ExecutiveSummary_Fall2011.pdf)
- American Foundation for Suicide Prevention. (n.d.a). College student depression and suicide: Fact sheet. Retrieved from [http://www.afsp.org/files/College\\_Film/factsheets.pdf](http://www.afsp.org/files/College_Film/factsheets.pdf)
- American Foundation for Suicide Prevention. (n.d.b). Recommendations for reporting on suicide. Retrieved from [http://www.afsp.org/files/Misc\\_/recommendations.pdf](http://www.afsp.org/files/Misc_/recommendations.pdf)
- Benton, S. A., Robertson, J. M., Tseng, W. C., Newton, F. B., & Benton, S. L. (2003). Changes in counseling center client problems across 13 years. *Professional Psychology: Research and Practice*, 34(1), 66-72. doi: 10.1037/0735-7028.34.1.66
- Byrd, D. R., & McKinney, K. J. (2012). Individual, interpersonal, and institutional level factors associated with the mental health of college students. *Journal of American College Health*, 60(3), 185-193.
- Cable News Network. (2006). U.S. population now 300 million and growing. Retrieved from [http://articles.cnn.com/2006-10-17/us/300.million.over\\_1\\_total-population-households-census-bureau?\\_s=PM:US](http://articles.cnn.com/2006-10-17/us/300.million.over_1_total-population-households-census-bureau?_s=PM:US)

- Centers for Disease Control and Prevention. (2009). Suicide prevention. Retrieved from [http://www.cdc.gov/violenceprevention/pub/youth\\_suicide.html](http://www.cdc.gov/violenceprevention/pub/youth_suicide.html)
- Centers for Disease Control and Prevention. (2011a). Mental health basics. Retrieved from <http://www.cdc.gov/mentalhealth/basics.htm>
- Centers for Disease Control and Prevention. (2011b). U.S. adult mental illness surveillance report. Retrieved from <http://www.cdc.gov/Features/MentalHealthSurveillance/>
- Chung, H., Klein, M. C., Silverman, D., Corson-Rickert, J., Davidson, E., Ellis, P., & Kasnakian, C. (2011). A pilot for improving depression care on college campuses: Results of the college breakthrough series-depression (CBS-D) project. *Journal of American College Health, 59*(7), 628-639.
- Cleveland Clinic. (1995). Emotional wellbeing. Retrieved from [http://my.clevelandclinic.org/healthy\\_living/stress\\_management/hic\\_warning\\_signs\\_of\\_emotional\\_stress\\_when\\_to\\_see\\_your\\_doctor.aspx](http://my.clevelandclinic.org/healthy_living/stress_management/hic_warning_signs_of_emotional_stress_when_to_see_your_doctor.aspx)
- Coffman, K. (2012). James Holmes, accused Colorado gunman, saw 3 mental health experts prior to deadly shootings. Retrieved from [http://www.huffingtonpost.com/2012/08/21/james-holmes-mental-health-colorado\\_n\\_1820450.html](http://www.huffingtonpost.com/2012/08/21/james-holmes-mental-health-colorado_n_1820450.html)
- Cook, L. J. (2007). Striving to help college students with mental health issues. *Journal of Psychosocial Nursing, 45*(4), 40-44.
- Cukrowicz, K. C., Schlegel, E. R., Smith, P. N., Jacobs, M. P., VanOrden, K. A., Paukert, A. L., Pettit, J. W., & Joiner, T. E. (2011). Suicide ideation among college students evidencing subclinical depression. *Journal of American College Health, 59*(7), 575-581.
- Currin, J. B., Hayslip, B., Schneider, L. J., & Kooker, R. A. (1998). Cohort differences in attitudes toward mental health services among older persons. *Psychotherapy: Theory, Research, Practice, Training, 35*(4), 506-518.
- Davidson, M. M., Yakushka, O. F., & Sanford-Martens, T. C. (2004). Racial and ethnic minority clients' utilization of a university counseling center: An archival study. *Journal of Multicultural Counseling and Development, 32*, 259-271.
- Davis, J. A. (1971). *Elementary survey analysis*. Englewood Cliffs, NJ: Prentice-Hall.
- Dewa, C. S., McDaid, D., & Ettner, S. L. (2007). An international perspective on worker mental health problems: Who bears the burden and how are costs addressed? *The Canadian Journal of Psychiatry, 52*(6), 346-356.
- Dewa, C. S., Thompson, A. H., & Jacobs, P. (2011). The association of treatment of depressive episodes and work productivity. *The Canadian Journal of Psychiatry, 56*(12), 743-750.

- Dillman, D. A., Smyth, J. D., & Christian, L. M. (2009). *Internet, mail, and mixed-mode surveys: The tailored design method* (3rd ed.). Hoboken, NJ: John Wiley & Sons, Inc.
- Gallagher, R. P. (2005). National survey of counseling center directors. Retrieved from [http://www.collegecounseling.org/pdf/2005\\_survey.pdf](http://www.collegecounseling.org/pdf/2005_survey.pdf)
- Gonzales, J., Alegría, M., Prihoda, T., Copeland, L., & Zeber, J. (2011). How the relationship of attitudes toward mental health treatment and service use differs by age, gender, ethnicity/race and education. *Social Psychiatry & Psychiatric Epidemiology*, 46(1), 45-57. doi: 10.1007/s00127-009-0168-4
- Graham, R., Hall, R., & Gilmer, W. G. (2008). Connecting the dots...: Information sharing by post-secondary educational institutions under the Family Education Rights and Privacy Act (FERPA). *Education and the Law*, 20(4), 301-316. doi: 10.1080/09539960903450548
- Greenberg, P. E., Kessler, R. C., Birnbaum, H. G., Leong, S. A., Lowe, S. W., Berglund, P. A., & Corey-Lisle, P. K. (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000? *Journal of Clinical Psychiatry*, 64(12), 1465-1475.
- Haaz, E. J., Maynard, J., Petrica, S. C., & Williams, C. E. (2003). Employee assistance program accreditation: History and outlook. *Employee Assistance Quarterly*, 19(1), 1-26. doi: 10.1300/J022v19n01\_01
- Hair, J. F., Anderson, R. E., Tatham, R. L., & Black, W. C. (2006). *Multivariate data analysis*. New Jersey: Prentice Hall International, Inc.
- Hamrick, J., Goldman, R. L., Sapp, G. L., & Kohler, M. P. (2004). Educator effectiveness in identifying symptoms of adolescents at risk for suicide. *Journal of Instructional Psychology*, 31(3), 246-252.
- Harvard Medical School. (2010). Mental health problems in the workplace. *Harvard Mental Health Letter*, 26(8), 1-3.
- Hilton, M. F., Scuffham, P. A., Vecchio, N., & Whiteford, H. A., (2010). Using the interaction of mental health symptoms and treatment status to estimate lost employee productivity. *Australian and New Zealand Journal of Psychiatry*, 44, 151-161.
- Hilton, M. F., Sheridan, J., Cleary, C. M., & Whiteford, H. A. (2009). Employee absenteeism measures reflecting current work practices may be instrumental in a re-evaluation of the relationship between psychological distress/mental health and absenteeism. *International Journal of Methods in Psychiatric Research*, 18(1), 37-47. doi: 10.1002/mpr.275
- Keyes, C. L. M., Eisenberg, D., Perry, G. D., Dube, S. R., Kroenke, K., & Dhingra, S. S. (2012). The relationship of level of positive mental health with current mental disorders in

- predicting suicidal behaviors and academic impairment in college students. *Journal of American College Health*, 60(2), 126-133.
- Klein, M. C., Ciotoli, C., & Chung, H. (2011). Primary care screening of depression and treatment engagement in a university health center: A retrospective analysis. *Journal of American College Health*, 59(4), 289-295.
- Knox, K. L., Litts, D. A., Talcott, G. W., Feig, J. C., & Caine, E. D. (2003). Risk of suicide and related adverse outcomes after exposure to a suicide prevention programme in the US Air Force: Cohort study. *British Medical Journal*, 327(7428), 1376-1378.
- Knox, K. S., & Roberts, A. (2005). *Crisis intervention and crisis team models in schools. Children & Schools*, 27(2), 93-100.
- Kraft, D. P. (2009). Mens sana: The growth of mental health in the American college health association. *Journal of American College Health*, 58(3), 267-275.
- Kraft, D. P. (2011). One hundred years of college mental health. *Journal of American College Health*, 59(6), 477-481.
- Leavitt, M. O., Spellings, M., & Gonzales, A. R. (2007). Report to the president: On issues raised by the Virginia Tech tragedy. Retrieved from <http://www.hhs.gov/vtreport.pdf>
- Louisiana Licensed Professional Counselor Board of Examiners. (n.d.). Rules: Chapter 21: Code of conduct for licensed professional counselors. Retrieved from [http://www.lpcboard.org/46v60.html#Chapter\\_21.\\_Code\\_of\\_Conduct\\_for\\_Licensed\\_Professional\\_Counselors\\_](http://www.lpcboard.org/46v60.html#Chapter_21._Code_of_Conduct_for_Licensed_Professional_Counselors_)
- Louisiana Social Work Board of Examiners. (2011). Professional and occupational standards. Retrieved from <http://www.labswe.org/pdf/labswe-rules.pdf>
- Martin, J. M. (2010). Stigma and student mental health in higher education. *Higher Education Research & Development*, 29(3), 259-274. doi: 10.1080/07294360903470969
- Mier, S., Boone, M., & Shropshire, S. (2009). Community consultation and intervention: Supporting students who do not access counseling services. *Journal of College Student Psychotherapy*, 23, 16-29. doi: 10.1080/87568220802367602
- Mori, S. C. (2000). Addressing the mental health concerns of international students. *Journal of Counseling & Development*, 78, 137-144.
- National Alliance on Mental Illness (2004). Mental illness prolific among college students. Retrieved from [http://www.nami.org/Content/ContentGroups/Press\\_Room1/20041/August3/Mental\\_Illness\\_Prolific\\_Among\\_College\\_Students.htm](http://www.nami.org/Content/ContentGroups/Press_Room1/20041/August3/Mental_Illness_Prolific_Among_College_Students.htm)

- National Alliance on Mental Illness. (2006). A snapshot of college mental health centers. Retrieved from [http://www.nami.org/Content/NavigationMenu/Advocate\\_Magazine/E-Newsletter/20065/A\\_Snapshot\\_of\\_College\\_Mental\\_Health\\_Centers.htm](http://www.nami.org/Content/NavigationMenu/Advocate_Magazine/E-Newsletter/20065/A_Snapshot_of_College_Mental_Health_Centers.htm)
- National Alliance on Mental Illness. (2012). What is mental illness: Mental illness facts. Retrieved from [http://www.nami.org/template.cfm?section=about\\_mental\\_illness](http://www.nami.org/template.cfm?section=about_mental_illness)
- National Institute on Mental Health. (2003). Mental health expenditures as a percent of all health care expenditures. Retrieved from <http://www.nimh.nih.gov/statistics/4EXP2003.shtml>
- National Institute of Mental Health. (2006). Mental healthcare cost data for all Americans. Retrieved from [http://www.nimh.nih.gov/statistics/4COST\\_AM2006.shtml](http://www.nimh.nih.gov/statistics/4COST_AM2006.shtml)
- Osberg, T. M. (2004). A business case for increasing college mental health services. *Behavioral Health Management*, 24(5), 33-36.
- Public Broadcasting Service. (2007). *Griswold v. Connecticut* (1965). Retrieved from [http://www.pbs.org/wnet/supremecourt/rights/landmark\\_griswold.html](http://www.pbs.org/wnet/supremecourt/rights/landmark_griswold.html)
- Reynolds, E. K., MacPherson, L., Tull, M. T., Baruch, D. E., & Lejuez, C. W. (2011). Integration of the brief behavioral activation treatment for depression (BATD) into a college orientation program: Depression and alcohol outcomes. *Journal of Counseling Psychology*, 58(4), 555-564. doi: 10.1037/a0024634
- Ritter, C., Teller, J. L. S., Munetz, M. R., & Bonfine, N. (2010). Crisis intervention team (CIT) training: Selecting effects and long-term changes in perceptions of mental illness and community preparedness. *Journal of Police Crisis Negotiations*, 10(1/2), 133-152. doi: 10.1080/15332581003756992
- Roth, D., Antony, M. M., Kerr, K. L., Downie, F., & Antony, M. M. (2000). Attitudes toward mental illness in medical students: Does personal and professional experience with mental illness make a difference? *Medical Education*, 34(3), 234-236. doi: 10.1046/j.1365-2923.2000.00478.x
- Sanderson, K., & Andrews, G. (2006). Common mental disorders in the workforce: Recent findings from descriptive and social epidemiology. *Canadian Journal of Psychiatry*, 51(2), 63-74.
- Silverman, M. M., Meyer, P. M., Sloane, F., Raffel, M., & Pratt, D. M. (1997). The big ten student suicide study: A 10-year study of suicides on Midwestern university campuses. *Suicide and Life-Threatening Behavior*, 27(3), 285-303.
- Srivastava, M., & Tiwari, R. (2012). A comparative study of attitude of mental health versus nonmental professionals toward suicide. *Indian Journal of Psychological Medicine*, 34(1), 66-69.

- Snedecor, G. W., & Cochran, W. G. (1980). *Statistical methods* (7th ed.). Ames, IA: The Iowa State University Press.
- Suicide Prevention Resource Center. (2004). Promoting mental health and preventing suicide in college and university settings. Retrieved from [http://www.sprc.org/sites/sprc.org/files/library/college\\_sp\\_whitepaper.pdf](http://www.sprc.org/sites/sprc.org/files/library/college_sp_whitepaper.pdf)
- Suicide Prevention Resource Center. (n.d.). The role of teachers in preventing suicide. Retrieved from <http://www.sprc.org/sites/sprc.org/files/Teachers.pdf>
- United States Department of Education. (2011). Family Education and Rights Privacy Act (FERPA). Retrieved from <http://www2.ed.gov/programs/racetothetop-district/index.html>
- United States Department of Labor. (2012). Occupational Outlook Handbook, 2012-2013 Edition. Retrieved from <http://www.bls.gov/ooh/>
- United States Office of Management and Budget. (1997). Revisions to the standards for the classification of federal data on race and ethnicity. Retrieved from [http://www.whitehouse.gov/omb/fedreg\\_1997standards/](http://www.whitehouse.gov/omb/fedreg_1997standards/)
- Vecchi, G. M. (2009a). Conflict & crisis communication: A methodology for influencing and persuading behavioral change. *Annals of the American Psychotherapy Association*, 12(1), 34-42.
- Vecchi, G. M. (2009b). Conflict & crisis communication: Methods of crisis intervention and stress management. *Annals of the American Psychotherapy Association*, 12(4), 54-63.
- Virginia Tech Cook Counseling Center. (n.d.). Identifying and referring the distressed student: A faculty/staff guide. Retrieved from <http://www.ucc.vt.edu/referringstudents.htm>
- Virginia Tech Review Panel. (2007). Summary of key findings. Retrieved from <http://www.governor.virginia.gov/tempcontent/techPanelReport-docs/4%20SUMMARY%20OF%20KEY%20FINDINGS.pdf>
- World Health Organization. (2001). Strengthening mental health promotion. Retrieved from <https://apps.who.int/inf-fs/en/fact220.html>
- World Health Organization. (2002). World report on violence and health. Retrieved from [http://whqlibdoc.who.int/publications/2002/9241545615\\_eng.pdf](http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf)
- World Health Organization. (2010). Mental health: Strengthening our response. Retrieved from <http://www.who.int/mediacentre/factsheets/fs220/en/index.html>
- Yorgason, J. B., Linville, D., & Zitzman, B. (2008). Mental health among college students: Do those who need services know about and use them? *Journal of American College Health*, 57(2), 173-181.

## APPENDIX A INSTRUMENT

*Using the following scale, please indicate how much you agree or disagree with the statements below.*

---

*1(Strongly Disagree) 2(Disagree) 3(Slightly Disagree) 4(Slightly Agree) 5(Agree) 6(Strongly Agree)*

### Attitude toward Mental Health

*(“A” means that agreeing would indicate a more positive attitude toward mental health and “D” means that disagreeing would indicate a more positive attitude toward mental health)*

1. Mental health is equally or more important than physical health (A)
2. Mental illnesses are more common in weak-minded people (D)
3. If I found out one of my friends or family members was going to counseling, I would think less of them (D)
4. If I found out that one of my students was going to counseling, I would think less of them (D)
5. Mental illness is just an obstacle in life that can be overcome with will power (D)
6. Mental health diagnoses are not “real” diagnoses (D)
7. People with mental health issues typically come from messed up families (D)
8. If I had a mental health diagnosis I would be ashamed for anyone to find out, even my closest family and friends (D)
9. I admire people who advocate for the rights of the mentally ill (A)
10. I admire people who seek help for mental health issues when needed (A)

### Willingness to Help

*(“A” means that agreeing would indicate more willingness to help and “D” means that disagreeing would indicate more willingness to help)*

1. Helping students who are struggling with mental health issues is part of my job (A)
2. I would intervene if I knew that a student was struggling with a mental health issue (A)
3. I wouldn't get involved in student mental health concerns, no matter the circumstances (D)
4. If one of my friends or family members were struggling with a mental health issue I would hope someone would identify the problem and offer help (A)
5. The campus mental health center is responsible for letting students know about services, not me (D)
6. I would only reach out to a student and offer help if their behavior was affecting their performance or participation in the class (D)



7. If a student's mental health prevents them from being a competent participant in class then they should not be in college(D)
8. I am willing to learn more about warning signs for mental illness (A)
9. I am willing to learn more about campus mental health services for students (A)
10. I am willing to attend a training seminar on mental health (A)

#### Ability to Identify

*("A" means that agreeing indicates a more accurate view of the warning signs of mental illness and "D" means that disagreeing indicates a more accurate view of the warning signs of mental illness)*

1. Extreme anger is always displayed by those with mental health issues (D)
2. If a student's mood turns from depression to happiness then there is no need for concern (D)
3. One of the best warning signs of mental illness is significant changes in mood or behavior (A)
4. Most people who are suicidal display warning signs (A)
5. Mental health issues and substance abuse issues do not commonly impact the same people, generally people will only have one or the other (D)
6. Many of the warning signs of mental health issues are normal emotions most people experience at one time or another (A)
7. The warning signs of mental health issues are clear-cut, someone struggling with a mental health issue can always be identified (D)
8. Recklessness is always a warning sign of mental illness (D)
9. People who tell others about wanting to harm or kill themselves are usually less serious than those who don't tell anyone (D)
10. Warning signs of mental health issues will be most obvious in those with more serious mental health issues (D)

***For the following five questions, please choose only one answer that you believe is the best option given the information provided.***

#### Ability to Help

1. A student comes to you and says they've been considering suicide for a long time. You talk to the student for a few minutes before they have to go to their next class and the student says they feel better and is no longer considering suicide. You suggest that the student talk to someone at the mental health center but the student says they don't want to get anyone else involved. Would you:
  - A. Contact the school mental health center and give them the student's name and ID number so that they can follow-up

- B. Keep the student's confidentiality by not telling anyone about the situation so they know they can trust you
  - C. Consult the mental health center without releasing the student's name for suggestions on what to do \*
  - D. Call the student later at home to check on them
2. A student comes to you and says they've just been through a major break-up and they have been unable to eat or sleep. Would you:
    - A. Attempt to empathize with the student's feelings \*
    - B. Assure the student that although the break-up may seem major now, it's very minor when compared to adult problems
    - C. Encourage the student to focus on the good things in life instead of the bad
    - D. Do not talk to the student about this; let the student work through this issue on their own
  3. A student comes to your office after missing a number of classes and assignments. The student explains that they missed class due to the sudden death of a parent. The student asks what they can do to make-up the work missed and you work out a plan. Would you:
    - A. Do nothing, the student did not exhibit any warning signs of distress
    - B. Call mental health services and see if they can see the student right away
    - C. Give the student information on campus mental health services \*
    - D. Ask the student to meet with you weekly to discuss how they are handling the loss
  4. A student comes to your office and says that, because of a low grade you gave them they are going to kill themselves. The student says they have a gun at home and plan to shoot themselves if you do not change their grade. You ask the student to walk with you to the mental health center and they refuse. If you are able, would you:
    - A. Call the student's parents
    - B. Call the police \*
    - C. Change the student's grade
    - D. Tell the student you don't change grades based on threats and ask them to leave
  5. One of your students has gotten **consistently** poor grades in your course. You ask to talk to them after class and they seem genuinely **unconcerned** about their poor grades. Would you:
    - A. Do nothing, the student just doesn't care about grades \*
    - B. Refer the student to the mental health center
    - C. Require the student to meet weekly with you weekly so that you can help them with class assignments

- D. Assume that something must be going on in the student's life and start giving them better grades

*Please select one answer to each of the following questions.*

Demographics

1. Please indicate your age range:
  - A. 25 or under
  - B. 26-35
  - C. 36-45
  - D. 46-55
  - E. 56-65
  - F. 66 or older
2. Please indicate your gender:
  - A. Male
  - B. Female
3. Please indicate your race/ethnicity:
  - A. American Indian or Alaskan Native
  - B. Asian
  - C. Black or African American
  - D. Native Hawaiian or Other Pacific Islander
  - E. White, Hispanic or Latino
  - F. White, not Hispanic or Latino
4. Which university are you a faculty member of:
  - A. [University A]
  - B. [University B]
5. Please indicate your total years of experience as a faculty member, combining all colleges and universities at which you may have worked:
  - A. 0-9
  - B. 10-19
  - C. 20-29
  - D. 30-39
  - E. 40-49
  - F. 50+
6. Please indicate the category that best describes your faculty status:
  - A. Part-time

- B. Adjunct
  - C. Full-Time, Non-Tenure Track
  - D. Full-Time, Tenure Track
  - E. Tenured
7. Please indicate which of the following best describes your rank as a faculty member:
- A. Instructor
  - B. Assistant Professor
  - C. Associate Professor
  - D. Professor
8. How would you describe the amount of time you spend teaching (including preparation and office hours) versus the amount of time you do research?
- A. About equal
  - B. Spend more time teaching
  - C. Spend more time doing research
  - D. Do not teach at all
  - E. Do not do research at all
9. Which of the following best describes the typical class size of the courses you teach?
- A. 0-24
  - B. 25-49
  - C. 50-74
  - D. 75-99
  - E. 100+
10. Which of the following best describes the college or department in which you teach:
- A. Art
  - B. Business
  - C. Education
  - D. Engineering
  - E. Humanities & Social Sciences
  - F. Science
11. Do you have one or more degrees in the following areas: psychology, social work, or counseling?
- A. Yes
  - B. No

12. Have you ever known anyone who has been diagnosed with a mental illness or has attempted or completed suicide?
- A. Yes
  - B. No
13. Have you ever had a close friend or family member who has been diagnosed with a mental illness or has attempted or completed suicide?
- A. Yes
  - B. No
14. Have you ever received a mental health diagnosis?
- A. Yes
  - B. No
15. Have you ever contemplated or attempted suicide?
- A. Yes
  - B. No
16. Do you practice a religion, spirituality, or faith that forbids or discourages the use of mental health services such as counseling?
- A. Yes
  - B. No
17. Have you ever had any training on mental health issues or suicide prevention?
- A. Yes
  - B. No
18. Do you think your university should offer training on how to identify students struggling with mental health issues?
- A. Yes
  - B. No
19. How much do you know about the mental health services available to students at your university?
- A. Very aware of options for students
  - B. Somewhat aware of options for students
  - C. Somewhat unaware of options for students
  - D. Very unaware of options for students

20. Do you think your university should make more of an effort to ensure that faculty members are aware of mental health services available to students?

A. Yes

B. No

Thank you for your participation in this study. If you or anyone you know is struggling with emotional distress please contact the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) or visit their website at [www.suicidepreventionlifeline.org](http://www.suicidepreventionlifeline.org). Please note that the National Suicide Prevention Lifeline does not just address suicide, but all types of emotional distress.

# APPENDIX B

## LOUISIANA STATE UNIVERSITY INSTITUTIONAL REVIEW BOARD (IRB) FOR PROTECTION OF HUMAN SUBJECTS

### Application for Exemption from Institutional Oversight

Unless qualified as meeting the specific criteria for exemption from Institutional Review Board (IRB) oversight, ALL LSU research/ projects using living humans as subjects, or samples, or data obtained from humans, directly or indirectly, with or without their consent, must be approved or exempted in advance by the LSU IRB. This Form helps the PI determine if a project may be exempted, and is used to request an exemption.

-- Applicant, Please fill out the application in its entirety and include the completed application as well as parts A-E, listed below, when submitting to the IRB. Once the application is completed, please submit two copies of the completed application to the IRB Office or to a member of the Human Subjects Screening Committee. Members of this committee can be found at



Institutional Review Board  
Dr. Robert Mathews, Chair  
131 David Boyd Hall  
Baton Rouge, LA 70803  
P: 225.578.8692  
F: 225.578.6792  
irb@lsu.edu  
lsu.edu/irb

-- A Complete Application Includes All of the Following:

(A) Two copies of this completed form and two copies of part B thru E.

(B) A brief project description (adequate to evaluate risks to subjects and to explain your responses to Parts 1&2)

(C) Copies of all instruments to be used.

\*If this proposal is part of a grant proposal, include a copy of the proposal and all recruitment material.

(D) The consent form that you will use in the study (see part 3 for more information.)

(E) Certificate of Completion of Human Subjects Protection Training for all personnel involved in the project, including students who are involved with testing or handling data, unless already on file with the IRB. Training link: ( )

(F) IRB Security of Data Agreement: ( )

1) Principal Investigator: Shannon Kuehne Walsdorf, LMSW

Rank: Doctoral Student

Dept: HRE

Ph: (985)373-8609

E-mail: skuehn1@lsu.edu

2) Co Investigator(s): please include department, rank, phone and e-mail for each  
\*If student, please identify and name supervising professor in this space

Michael Burnett, PhD  
Professor and Director, School of Human Resource Education and Workforce Development  
(225)578-5748  
voburn@lsu.edu

IRB# E6029 LSU Proposal #

☒ Complete Application

☒ Human Subjects Training

3) Project Title: University Faculty as Gatekeepers to Campus Mental Health Services

Study Exempted By:  
Dr. Robert C. Mathews, Chairman  
Institutional Review Board  
Louisiana State University  
203 B-1 David Boyd Hall  
225-578-8692 | www.lsu.edu/irb  
Exemption Expires: 7/12/2015

4) Proposal? (yes or no) No If Yes, LSU Proposal Number

Also, if YES, either

☐ This application completely matches the scope of work in the grant

OR

☐ More IRB Applications will be filed later

5) Subject pool (e.g. Psychology students)

\*Circle any "vulnerable populations" to be used: (children <18; the mentally impaired, pregnant women, the ages, other). Projects with incarcerated persons cannot be exempted.

6) PI Signature Shannon Walsdorf Date 6/18/12 (no per signatures)

\*\* I certify my responses are accurate and complete. If the project scope or design is later changes, I will resubmit for review. I will obtain written approval from the Authorized Representative of all non-LSU institutions in which the study is conducted. I also understand that it is my responsibility to maintain copies of all consent forms at LSU for three years after completion of the study. If I leave LSU before that time the consent forms should be preserved in the Departmental Office.

Screening Committee Action: Exempted ☒ Not Exempted ☐ Category/Paragraph 2

Reviewer Mathews

Signature Robert C Mathews

Date 7/13/12

## **VITA**

Shannon Kuehne Walsdorf was born in Metairie, Louisiana to Gene and Celeste Kuehne. In 2004, she graduated with honors from Mandeville high school. She went on to earn two degrees from Louisiana State University, a Bachelor of Science degree in psychology in 2008 and a Master of Social Work (MSW) degree in 2010. She is currently a candidate for the Doctor of Philosophy Degree in the School of Human Resource Education and Workforce Development at LSU to be awarded in May 2013. Shannon currently resides in Mandeville, Louisiana with her husband, Ian, and son, Jax.