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Danielle Aming

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ACADEMIC ADVISORS' ATTITUDES TOWARD STUDENTS EXPERIENCING MENTAL  
HEALTH ISSUES

by

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A dissertation submitted in partial fulfillment of the requirements  
for the degree of Doctor of Education  
in the Department of Educational Leadership and Higher Education  
in the College of Community Innovation and Education  
at the University of Central Florida  
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2018

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2018

## ABSTRACT

As students continue to pursue higher education, the potential for them to experience mental health issues will exist (National Alliance on Mental Illness, 2011; Center for Collegiate Mental Health, 2012; Gruttadaro & Crudo, 2012; Salzer, 2012; Center for Collegiate Mental Health, 2013). When entering a new environment, students will look to make connections with the institution; one of these connections can be with an academic advisor (Harper & Peterson, 2005; Harper & Wilson, 2010; Kuh, 2011; Pearson, 2012). It is important for individuals experiencing mental health issues to make connections to the institution so that they are more likely to remain and feel a sense of connection (Kadison & DiGeronimo, 2004).

This dissertation outlines a quantitative study to examine the attitudes of academic advisors towards mental health. Using the Relational-Cultural Theory (Miller 1986; Jordan, 2000) as a framework, this study sought to determine attitudes of academic advisors and how this may affect their relationship with students.

Results from 133 participants revealed that attitudes toward mental health issues do not impact the building of a mutual relationship between student and academic advisors from the academic advisors' perspective. However, characteristics such as age and personal experience with mental health issues impacted this type of relationship between the academic advisor and student.

This dissertation is dedicated to my wonderful parents Don Aming and Flora Murray-Aming.

## ACKNOWLEDGMENTS

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## LIST OF ACRONYMS AND ABBREVIATIONS

CAMI	Community Attitudes toward Mental Illness
CAS	Council for the Advancement of Standards in Higher Education
CCMH	Center for Collegiate Mental Health
IRB	Institutional Review Board
MPDQ	Mutual Psychological Development Questionnaire
NACADA	National Academic Advising Association
NAMI	National Alliance on Mental Illness
RCT	Relational Cultural Theory

## CHAPTER 1 INTRODUCTION

Formal higher education in the United States began at Harvard University in 1636 and has undergone numerous changes (Brubacher & Rudy, 2008). From educating the clergy and elites, to expanding access through the Morrill Land Grant Acts of 1862, to providing even more access to students with the induction of the Servicemen’s Readjustment Act of 1944 – more commonly known as the G.I. Bill – higher education looks different from its roots at Harvard University (Brubacher & Rudy, 2008). Today, higher education is an important tool for social and economic mobility (Baum, Ma, & Payea, 2010; Julian & Kominski, 2011). As long as higher education is seen as a benefit, students will continue to pursue it.

Students grow and develop throughout their time in school, which includes their time in college. Students will experience many different transitional issues such as moving into a new environment, creating new relationships, understanding a new academic culture (Compas, Wagner, Slavin, & Vannatta, 1986; Arnett, 2004). While attending college, students may also experience a mental health issue. Mental health illnesses are typically diagnosed from ages 18 to 25 (Unger, 1992; Sharpe, Bruinkinks, Blacklock, Benson, & Johnson, 2004; Cook, 2007; Substance Abuse and Mental Health Services Administration, 2009). “An estimated 26% of Americans ages 18 and older – or about 1 in 4 adults – live with a “diagnosable mental health disorder” (Kessler, Chui, Demler, & Walters, 2005, p. 620). Even though universities recognize that students may suffer from mental health issues, there is still a disconnect with how to help these students in the college environment (Megivern, Pellerito, & Mowbray, 2003). This disconnect presents a particular challenge as the number of students seeking higher education continues to rise. According to the U.S. Department of Education (2017), there are over 20

million students projected to attend American colleges and universities, with the majority being traditional aged students ranging from 18 to 24 years old. Since students will continue to pursue higher education, colleges must be aware of issues that impact students while at the institution.

Due to the increase in students, colleges and universities have provided additional resources such as counseling centers, health centers, and other departments to help students adapt to the college environment. These resources, as well as faculty and staff, are all working toward helping students finish and complete their degree (Crookston, 1972; Winston, Enders, & Miller, 1982; PBS Teleconference, 1999; Kuhn, 2008; Miller, 2012). A resource that may be overlooked, but has the capacity to contribute to the retention and persistence of students, is the academic advisor, often cited as “a key ingredient in the ultimate student outcome: retention” (Smith & Allen, 2014, p. 50). The academic advisor is usually one of the first people from the institution the student encounters (Kuhn, Gordon, & Webber, 2006). These professional staff members help students understand the policies of the institution, how to complete the degree program, and how to develop as an individual while in the college environment (Crookston, 1972; Winston et al., 1982; PBS Teleconference, 1999; Kuhn, 2008; Miller, 2012). Since the academic advisor is one of the first people students interact with, it is extremely important that the academic advisor is aware of all issues that students may encounter while at the institution, including mental health issues.

### Statement of the Problem

As students continue to pursue higher education, the potential for students to experience mental health issues will also exist. There are several articles that demonstrate an increase in students arriving with mental health issues (National Alliance on Mental Illness, 2011; Center for Collegiate Mental Health, 2012; Gruttadaro & Crudo, 2012; Salzer, 2012; Center for Collegiate

Mental Health, 2013). When entering a new environment, students will look to make connections with the institution; one of these connections is often an academic advisor (Harper & Peterson, 2005; Harper & Wilson, 2010; Kuh, 2011; Pearson, 2012). One important aspect of academic advising is to create a relationship between the academic advisor and the student (Winston & Sandor, 1984; Kelley & Lynch, 1991; Love & Tinto, 1995; Schnell, 1998; Shapiro & Levine, 1999; Gallagher & Allen, 2000; Zhao & Kuh, 2004). As a result of this relationship, the academic advisor is able to help the student on their academic and personal journey while at the university. “An advisor’s ability to communicate and develop a relationship with a student provides a foundation for meaningful dialog and interactions” (Hughey, 2011, p. 22). “Academic advisors have an increasingly important responsibility to recognize and refer students who face mental health issues” (Backels & Wheeler, 2001, p. 174).

According to Nadler and Simerly (2006), a relationship between an academic advisor and a student is generally built “when a student perceives the advisor as being concerned with his or her specific situation” (p. 216). It is safe to assume that if the opposite is occurring then a relationship would be damaged. If there are negative attitudes held about one’s behavior, a relationship will be difficult to form. This is especially true in the case of students experiencing mental health issues. These students may encounter some type of stigma associated with having a mental health issue. If these students experience negative attitudes from an academic advisor, they will not engage that person (Kessler, Foster, Saunders, & Stang, 1995; Gruttadaro & Crudo, 2012; Salzer, 2012). Academic advisors need to be aware of their own attitudes regarding mental health issues. “Perhaps recognizing and managing their own level of discomfort in working with students with disabilities are most challenging for advisors” (Peerce, Roberts, Beecher, Rash, Shwalb, & Martinelli, 2007, p. 61). If an academic advisor holds negative attitudes towards

students with mental health issues, this may impact the relationship between the student and academic advisor. As a result of having awareness of their attitudes toward mental health issues, academic advisors will be better prepared to handle their own reactions and responses. More positive attitudes toward students with mental health issues can positively impact the relationship with the student, who may now view the academic advisor as a source of support (Peerce et al., 2007).

### Purpose and Significance of the Study

The purpose of this study was to identify academic advisors' attitudes toward students who are experiencing mental health issues. If academic advisors demonstrate negative attitudes toward those who are experiencing mental health issues, a relationship with these students will be more difficult to create (Becker, Martin, Wajeeh, Ward, & Shern, 2002). By determining where academic advisors' attitudes lie regarding this population of students, academic advisors will be able to gauge their responses to students with mental health issues and have the opportunity to make changes if their attitudes are negative. Previous studies have been conducted regarding attitudes toward students with mental health issues that are expressed by faculty and staff (Fuller, Healey, Bradley, & Hall, 2004; Brockelman, Chadsey, & Loeb, 2006; Quinn, Wilson, MacIntyre, & Tinklin, 2009; Salzer, 2012) but only a few have focused on academic advisors.

This study looked at multiple factors to determine if an academic advisor's attitudes impact their ability to work with students they may see in advising appointments who are experiencing mental health issues. One factor that was looked at was to determine what the academic advisors' attitudes toward mental health issues are. A focus on attitudes specifically

was chosen since attitudes have the ability to impact how an individual relates to someone else (Corrigan & Penn, 1999; Penny, Kasar, & Sinay, 2000; Wahl, Wood, & Richards, 2002; Cotton, 2004). Since an important aspect of an academic advisors' job is to build relationships with students, it is important to determine how attitudes may impact this ability. This study also looked at the relationship an academic advisor builds with a student. Based on academic advising frameworks such as Appreciative Advising and Developmental Advising, building a positive relationship with a student impacts the student and provides the opportunity for the academic advisor to grow as a professional (Bloom, Hutson, & He, 2008). In order to determine if mutuality was achieved from the academic advisor's point of view, the following aspects were tested: empathy, engagement, authenticity, empowerment, zest, and diversity (Genero, Miller, Surrey, & Baldwin, 1992). Mutuality is defined as the "ability to grow toward an individual with an emphasis on developing empathy, engagement, authenticity, empowerment, zest, and diversity" (Jordan, 2010, p. 50). These aspects make up mutuality according to the Relational Cultural Theory (Miller 1986; Jordan, 2000). Academic advisors' characteristics such as age, ethnicity, educational level, gender, race, years in advising, professional training for mental health issues, and personal experience with mental health issues were also measured to determine if these aspects impact the academic advisors' attitudes or ability to build a relationship based on mutuality with students. Demographic variables may indirectly impact attitudes towards mentally ill people (Neff & Husaini, 1985; Wolff, Pathare, Craig, & Leff, 1996). "Variables often measured in studies include gender, age, socioeconomic status (SES) and attitudes/behaviors" (Creswell, 2014, p. 52). Due to the mixed findings surrounding the impact of demographics, this study adds to literature surrounding the impact of demographics on attitudes toward mental health and impact on building a mutual relationship. This study focused

on if relationships between academic advisors' characteristics and their attitudes toward students with mental health issues were able to be identified. By focusing on relationships, the researcher attempted to determine if there was a correlation between specific characteristics of the academic advisors' attitudes and the academic advisors' ability to connect with students. By determining if a relationship exists and if that relationship is positive or negative, additional professional development and education can occur to provide an inclusive environment for students experiencing mental health issues.

### Theoretical Framework

This study utilized the Relational-Cultural Theory (RCT) theoretical framework developed by Jean Baker Miller in 1976. Relational-Cultural Theory was developed to explain the importance of connections and relationships in human development (Miller, 1976). According to RCT, a focus on developing and creating mutually growth fostering relationships is key to ones self-growth and development (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991). By developing a mutually beneficial relationship, both parties will experience healthy and flourishing functioning. Miller posited that growth-fostering relations are defined by five essential attributes or the "Five Good Things": 1) "a desire to move into more relationships (connections); 2) a sense of zest; 3) increased knowledge of oneself and the other person (clarity); 4) a desire to take action (productivity); and 5) overall increased sense of worth" (Jordan et al., 1991; Miller & Stiver, 1997; Jordan, 2010).

The Relational Cultural Theory has similar components to academic advising such as relational awareness, mutual empathy, and authenticity (Purgason, Avent, Cashwell, Jordan, & Reese, 2016). This theoretical framework focuses on the factors that impact a relationship and how dissonance between individuals can impact and create an unhealthy relationship. An

important facet of academic advising is the relationship created between advisor and student. It is important that an academic advisor create a relationship with the student, as this may impact the student's overall relationship with the university. One of the core competencies of the National Academic Advising Association (NACADA) is 'relational'. This competency highlights the importance of building a relationship with students and how academic advisors can establish these relationships. It is important that academic advisors understand how "effective academic advising serves to build long-term, satisfactory relationships" (Kim & Feldman, 2011, p. 222). This theory was used to explore the manner in which academic advisors perceive the mutuality in their relations with students. A more in-depth discussion of RCT will be presented in Chapter 2.

### Research Questions

In this study, the research questions were:

1. What is the relationship between academic advisors' characteristics and their attitudes toward mental health issues as measured by the *Community Attitudes toward the Mentally Ill* Questionnaire?
2. What is the relationship between academic advisors' characteristics and the "Five Good Things" as measured by the *Mutual Psychological Development Questionnaire*?
3. What is the relationship between academic advisors' attitudes toward mental health issues as measured by the *Community Attitudes toward the Mentally Ill* Questionnaire and the mutuality of a Growth Fostering Relationships as measured by the *Mutual Psychological Development Questionnaire*?

## Definition of Terms

The following terms held these definitions throughout the research study:

*Mental Health.* “Condition that affects a person’s thinking, feeling or mood. Such conditions may affect someone’s ability to relate to others and function each day” (National Alliance on Mental Illness, 2016, p. 1).

*Academic Advising.* “Both stimulates and supports students in their quest for an enriched quality of life; it is a systematic process based on a close student-advisor relationship intended to aid students in achieving educational and personal goals through the utilization of the full range of institutional and community resources” (Winston et al., 1982, p. 8).

*Academic Advisor.* “Advisors serve as adult role models and mentors” (Winston et al., 1982, p. 7). Academic advisors assist students with career exploration, selecting courses, navigating the institution, and serve as a liaison between the student and other campus offices and resources.

*Attitudes.* “A learned, global evaluation of an object (person, place, or issue) that influences thought and action either positively or negatively” (Perloff, 2003, p. 39).

*Mutuality:* “Ability to grow toward an individual with an emphasis on developing empathy, engagement, authenticity, empowerment, zest, and diversity” (Jordan, 2010, p. 50).

## Organization of the Study

This dissertation is organized into five chapters, followed by appendices and references. Chapter Two contains a review of the literature regarding academic advisors, students with mental health issues, the theoretical framework, and attitudes. Chapter Three contains the methodology of data collection used for this study. Chapter Four contains the results of the

study. Chapter Five contains the implications and recommendations as well as recommendations for future research.

### Summary

While students have experienced mental health issues in college, it was not until 1910 that the administrators at Princeton University noticed that these students experienced hardships in their studies (Kraft, 2011). As institutions began looking more closely at this population of students, it became apparent that students with mental health issues were leaving or withdrawing from the institution. Institutions then began to provide additional resources and support for these students.

Academic advisors are one of the first people students will interact with on behalf of the institution (Kuhn et al., 2006). A main component of the academic advising job is to develop relationships with students (Winston & Sandor, 1984; Kelley & Lynch, 1991; Love & Tinto, 1995; Schnell, 1998; Shapiro & Levine, 1999; Gallagher & Allen, 2000; Zhao & Kuh, 2004). If the academic advisor has negative attitudes towards the student, the relationship may not be able to develop (Peerce et al., 2007). With the framework of Relational-Cultural Theory, this dissertation explored the importance of building a relationship with students and how attitudes toward students who are experiencing mental health issues may affect the student-advisor relationship.

## CHAPTER 2 LITERATURE REVIEW

### Overview of the Literature Review

This literature review examined the historical and practical elements of academic advising, as well as students with mental health issues, how attitudes impact students with mental health issues, and the Relational-Cultural Theory. Academic advising is defined, the professionalization of the field is discussed, as is the role academic advisors play in higher education. Regarding students with mental health issues, attention is paid to how mental health is defined, impact on the institution, factors affecting students, and stigma. Attitudes, specifically empathy and stigma and how they impact students who have mental health issues, is discussed. The theoretical framework and how this impacts the relationship between academic advisor and student with mental health issues is also discussed.

### History of Academic Advising

Formal higher education in the United States began with Harvard University in 1636 (Brubaker & Rudy, 2008). For the first 200 years of higher education, faculty members filled multiple roles, including what is now known as academic advising (Doyle, 2004). Once additional students began to attend college, faculty's roles began to focus more on teaching. There was a need for someone to take over academic advising.

Looking back at the evolution of academic advising, academic advising history can be divided into four eras: 1) before 1870; 2) between 1870 and 1970; 3) from 1970 to 2003; and 4) 2003 to present day (Frost, 2000; Kuhn, 2008). During the First Advising Era (1620-1870),

academic advising was not defined and occasionally faculty would take on this role (Frost, 2000; Kuhn, 2008). During this era, the term advisor, used at Kenyon College, referred to someone entrusted to offer students counseling in academic, social, or personal matters (Hayes & Williams, 1922).

The Second Advising Era (1870 to 1970) saw the creation of the advisor role, but there were no standards or techniques this individual was required to use in their job (Frost, 2000). In the 1880s, The John Hopkins University began utilizing undergraduate degrees, which contained multiple elective options. Harvard University instituted elective options in the curriculum as well. As more and more electives and opportunities were offered to students, the need for individuals to help students process the best path forward arose (White & Khakpour, 2006). “As the American college curricula expanded, academic planning became more complex and demanded a more involved and expanded role for academic advising” (Grites & Gordon, 2009, p. 41).

The Third Advising Era (1970 to 2003) saw a more distinct role for academic advisors and the development of theories and techniques to apply to the academic advising field (Frost, 2000). During this era, more and more individuals were attending colleges and institutions with the help of the G.I. Bill (Brubacher & Rudy, 2008). Individuals with counseling and human services backgrounds began to be employed by colleges and institutions (Frost, 2000). As academic advising becoming more of a profession, a body of theory emerged, including works by Burns Crookston (1972) and Terry O’Banion (1972). Also during this era, the National Academic Advising Association (NACADA) formed in 1979. The Carnegie Commission on Higher Education emphasized the need for academic advising in 1972 when it stated, “advising was as an increasingly important function in higher education” (Grites & Gordon, 2009, p. 41).

During the most current era, the Fourth Advising Era (2003 to Present), there is a more focused effort in clarifying the role of academic advising and associating value to the profession (Frost, 2000). Initiatives started during this era include the defining and creation of competencies by NACADA (Cate & Miller, 2015), an emphasis on learning and teaching by the Council for the Advancement of Standards in Higher Education (Cook, 2009), and clarification of roles of the academic advisor (Schulenberg & Lindhorst, 2008).

### Academic Advising Definitions

The role of academic advisor has been taken on by various individuals. From professional staff, to faculty, to students, academic advising over the years has been conducted by multiple people (Frost, 2000). Even though academic advising has been conducted by different people, at its core, advising has always remained the same. “The ultimate goal of every academic advisor seems clear: Help each student achieve his or her own success” (Grites, Miller, & Voller, 2016, p. 1).

The field of academic advising has been very fluid regarding definitions and concepts of academic advising (NACADA, 2006). Every academic advisor can have a different definition of what academic advising looks like and each academic advisor could be correct in that definition. Table 1 below captures some of the variation in the definitions of academic advising.

*Table 1*

*Definitions of Academic Advising*

Reference	Definition
O'Banion (1972)	“Advising is a process in which an advisor and advisee enter a dynamic relationship respectful of the student’s concerns. Ideally the advisor serves as teacher and guide in an interactive partnership aimed at enhancing the student’s self-awareness and fulfillment” (p. 63)
Crookston (1972)	“Developmental Advising – A definition: A systematic process based on close student advisor relationship intended to aid students in achieving educational, career, and personal goals through the use of the full range of institutional and community resources” (p. 13)
Winston, Enders, Miller (1982)	“Academic advising is a developmental process which assists students in the clarification of their life/career goals and in the development of educational plans for the realization of these goals. It is a decision-making process by which students realize their maximum educational potential through communication and information exchanges

Reference	Definition
	with an advisor; it is ongoing, multifaceted, and the responsibility of both student and advisor. The advisor serves as a facilitator of communication, a coordinator of learning experiences through course and career planning and academic progress review, and an agent of referral to other campus agencies as necessary” (p. 2)
American College Testing Program (ACT) (1984)	“Academic advising is a developmental process which assists students in the clarification of their life/career goals and in the development of educational plans for the realization of these goals. It is a decision-making process by which students realize their maximum educational potential through communication and information exchanges with an advisor; it is ongoing, multifaceted, and the responsibility of both student and the advisor” (p. 15)
Crockett (1987)	“Academic advising is a collaborative relationship between a student and an academic advisor. The intent of this collaboration is to assist the student in the development of meaningful educational goals that are consistent with personal interests, values

Reference	Definition
Crockett (1987)	<p>and abilities. Although many individuals on campus, including academic advisors, may assist the student in making decisions and accomplishing goals, the academic advisor is granted formal authority by an academic unit (college, school, department) to approve the student's academic program of study and assist the student in progressing toward the appropriate degree" (p. 41)</p> <p>"Academic advising is a process in which students seek and receive guidance with academic program planning, usually from a faculty advisor.</p> <p>Meaningful educational planning is compatible with a student's life goals, therefore academic advising encompasses discussion of life goals and assistance with the developmental process of life goals clarification. The ultimate responsibility for making decisions about educational plans and life goals rests with the individual student. Assistance with the clarification of life goals is not limited to the academic advising relationship, and may include staff in areas such as career development, residential life, and counseling. For academic</p>

Reference	Definition
	<p>advisors, assisting students in the clarification of life goals means helping students explore and define their educational and career goals in an atmosphere of mutual respect and learning.</p> <p>Advising, while non-prescriptive, encourages students to think critically, seek out resources, and develop action steps. The desired result is that students will feel a sense of connection with the advisor and a sense of guidance, while realizing personal responsibility for exploring options and making decisions” (p. 7)</p>
<p>Cremer and Cremer (1994)</p>	<p>“Developmental academic advising is the use of interactive teaching, counseling, and administrative strategies to assist students to achieve specific learning, developmental, career, and life goals. These goals are set by students in partnership with advisors and are used to guide all interactions between advisor and student” (p. 19)</p>
<p>Chickering (1994)</p>	<p>“The fundamental purpose of academic advising is to help students become effective agents for their own lifelong learning and personal development. Our relationships with students the questions we</p>

Reference	Definition
Frost (1994)	<p>raise, the perspectives we share, the resources we suggest, the short-term decisions and long-range plans we help them think through all should aim to increase their capacity to take charge of their own existence” (p. 50)</p> <p>“Developmental advisors revealed that attitude is more important than practice, process is more important than product. These advisors use the advising relationship to” (p.54):</p> <ul style="list-style-type: none"> <li>• “Involve students in their college experiences” (p.16)</li> <li>• “Explore with students the facts that lead to success, and” (p. 16)</li> <li>• “Show interest in students' academic progress and extracurricular achievements” (Frost, 1994, p. 16)</li> </ul> <p>“Show interest in students' academic progress and extracurricular achievements” (Frost, 1994)</p>
Noel-Levitz (1997)	<p>“Academic advising is a planning process that helps students to approach their education in an organized and meaningful way. Advising brings together all of the major dynamics in a student’s life” (p. 1 &amp; 3)</p>
Noel-Levitz (1997)	<p>“Academic advising is a process of teaching students how to become responsible consumers of</p>

Reference	Definition
	<p>their own educations. It's also a process that involves teaching students how to make viable academic decisions" (p. 1 &amp; 3)</p>
Noel-Levitz (1997)	<p>"Advising is a process of giving students guidance, support and encouragement" (p.3)</p>
Noel-Levitz (1997)	<p>"Advising is a process of helping students diminish the confusion that comes with a new environment, clarify their goals and get the most out of their education" (p. 3)</p>
Noel-Levitz (1997)	<p>"Academic advising is an interactive process in which the advisor helps the student set and achieve academic goals, acquire relevant information and services, and make responsible decisions consistent with interests, goals, abilities, and degree requirements. Decisions concerning careers and/or graduate study may be part of the advising process. Advising should be personalized to consider the special needs of each student, which may include appropriate referral services" (p. 3)</p>
Ramos (1999)	<p>"Gordon's description of three vectors for delivering academic advising should enhance his point that advisors must focus on educational,</p>

Reference	Definition
PBS Teleconference (1999)	<p>career and student growth needs of students and also focus on advising as teaching” (p. 1):</p> <ul style="list-style-type: none"> <li>• “Developing competence, or increasing the intellectual, physical, and social skills that lead to the knowledge that one is capable of handling and mastering a range of tasks” (p. 1).</li> <li>• “Developing autonomy, or confronting a series of issues leading ultimately to the recognition of one’s independence” (p. 1).</li> <li>• “Developing purpose, or assessing and clarifying interests, educational and career options, and lifestyle preferences and using these factors to set a coherent direction for life” (p. 1)</li> </ul> <p>“Academic advising is a process of information exchange that empowers students to realize their maximum educational potential. The advising process is student-centered and will result in the student gaining a clearer understanding of himself/herself, and the experience of higher education” (p. 1)</p>
Kuhn (2008)	<p>Academic advising takes place in “situations in which an institutional representative gives insight or direction to a college student about an academic, social, or personal matter. The nature of this direction might be to inform, suggest, counsel, discipline, coach, mentor, or even teach” (p. 3)</p>

Reference	Definition
Miller (2012)	“Advisors teach students how to make the most of their college experience” (p. 2)

NACADA (2003a). *Paper presented to the Task force on defining academic advising*. Retrieved from NACADA Clearinghouse of Academic Advising Resources website

Academic advising is a field that has many definitions for what an academic advisor is required to do. There are many facets to the job such as understanding institutional policies, program progression, providing support, personal and academic goal development, building relationships, providing information about resources, and other aspects (NACADA, 2006). The definitions provided in Table 1 cover all of these duties and more. None of the definitions are the same, but they all capture some aspect of academic advising. By analyzing the differences and similarities between the definitions, an understanding of what the academic advisor is responsible for can be established.

Based on the above multiple definitions of academic advising, there are numerous similarities. One commonality is the importance of building a collaborative relationship (O’Banion, 1972; Crookston, 1972; Winston et al., 1982; American College Testing Program, 1984; Crockett, 1987; Creamer & Creamer, 1994; Chickering, 1994; Frost, 1994; Kuhn, 2008). These authors that defined academic advising as a collaborative relationship are placing importance on how the advisor and student must work together in order for the student to succeed. As a result, working together, the opportunity to discuss what is important to the student and how the institution can help in achieving what the student wants to accomplish is made possible through a collaborative relationship. The academic advisor in turn gets to know students more personally and help them progress through the institution.

Another commonality is the importance of teaching, specifically teaching the student how to engage within the college environment (O'Banion, 1972; Creamer & Creamer, 1994; Noel-Levitz, 1997; PBS Teleconference, 1999; Kuhn, 2008; Miller, 2012). Students' first coming to the university may not know how to interact with the new environment they have been placed into (Compas et al., 1986; Arnett, 2004). The academic advisor has the opportunity to teach the student how to engage with and navigate within the institution (Crookston, 1972; Frost, 1994; Noel-Levitz, 1997; PBS Teleconference, 1999; Miller 2012). Advisors still have the ability to teach students how to engage with the university beyond the student's first year. This occurs in the form of referrals to other resources that will provide students opportunities such as internships, volunteering, and study abroad.

Another commonality between the academic advising definitions is supporting academic, career, and personal goals (Crookston, 1972; American College Testing Program, 1984; Winston et al., 1982; Crockett, 1987; Creamer & Creamer, 1994; Noel-Levitz, 1997; Ramos, 1999; Kuhn, 2008). By incorporating academic, career, and personal goals in an academic advising session, the advisor is focusing on the whole student (Kuh, 2008). The authors including these aspects within the definitions demonstrate the importance of how personal goals affect academic and career goals.

Exchanging information is another commonality found throughout several of the academic advising definitions (Winston et al., 1982; American College Testing Program, 1984; Noel-Levitz, 1997; PBS Teleconference, 1999). An exchange of information benefits both the academic advisor and the student. The student is able to investigate resources that advisor has suggested; the advisor is able to hear about these experiences. Furthermore, the advisor could potentially follow up with a resource if the interaction was negative or suggest the resource or

referral to additional students if the experience was positive. Both academic advisor and student gain information that benefits both parties.

Clarity is another commonality found among the academic advising definitions (O'Banion, 1972; Winston et al., 1982; American College Testing Program, 1984; Crockett, 1987; Noel-Levitz, 1997; Ramos, 1999; PBS Teleconference, 1999). By providing clarity to students, the academic advisor is explaining an aspect of the institution the student is having difficulty with. Clarity can also come in the form of providing a different perspective on a situation or on goals that students want to accomplish at the institution.

The final commonality is productivity (Winston et al., 1982; Noel-Levitz, 1997; Kuhn, 2008). Productivity refers to the student and academic advisor establishing and achieving goals within an academic advising session. This provides the student the chance to take what is done in the advising session and utilize this information in other arenas while at college.

There are two main differences between the above academic advising definitions. The first one has to do with developmental timeframe. One group of definitions focuses on student development while in college (Crookston, 1972; Winston et al., 1982; Frost, 1994; Noel-Levitz, 1997; PBS Teleconference, 1999; Kuhn, 2008; Miller, 2012). The other group focuses on overall development that will affect the student for the rest of their life (O'Banion, 1972; Crockett, 1987; Chickering, 1994; Ramos, 1999). The first group narrows the experiences and development to the college or university the student is attending. Based on the idea that each college and university has its own campus culture, this has the potential to change if the student attends another college or university. In contrast, the definitions that focus on development as a whole demonstrate the ability for the student to look at what they want to achieve in their lifetime and how the college environment can assist in the process. The main difference between the two is

that one makes the college environment the main focus of the development, and in the other, the college environment merely assists the student in developing.

The other difference between the academic advising definitions is a focus on building a relationship with a student (O'Banion, 1972; Crookston, 1972; Wilson, Enders, & Miller, 1982; American College Testing Program, 1984; Crockett, 1987; Creamer & Creamer, 1994; Chickering, 1994; Frost, 1994, Kuhn, 2008) versus those definitions that do not mention a relationship (Noel-Levitz, 1997; PBS Teleconference, 1999; Ramos, 1999; Miller, 2012). The definitions that focus on the importance of building a relationship demonstrate the importance of the relationship between the student and the academic advisor, and how that relationship will influence how the student interacts and develops at the university. This relationship plays a role in how the student will develop and engage in the college environment. The other definitions focus on the student and the journey the student takes. The academic advisor is present but does not take on an influential role in these definitions. The main difference between the two is the idea that one group focuses on the relationship between the academic advisor and student and the importance that relationship brings and the other group focuses on the student's journey and the academic advisor as a guide but not a participant.

There are several academic advising definitions that indirectly relate to mental health issues (American College Testing Program, 1984; Crockett, 1987; Chickering, 1994; Noel-Levitz, 1997; Ramos, 1999; PBS Teleconference, 1999). These definitions focus on the personal development of the student, how their abilities affect their goals, and students gaining an understanding of himself/herself. In these instances, academic advising deals with the whole student, not just their academics. Since these pieces are developmental and focus on the student's abilities, these definitions indirectly are related to mental health issues.

For the purposes of this study, mental health is defined as “condition that affects a person’s thinking, feeling or mood. Such conditions may affect someone’s ability to relate to others and function each day” (National Alliance on Mental Illness, 2016, p.1). This definition of mental health demonstrates how the individual is impacted on a developmental level. Furthermore, these aspects align with the academic advising definitions of personal development and how students’ abilities affect their goals. There are several studies (Kessler et al., 1995; Weiner & Weiner, 1997; Mowbray & Megivern, 1999; Megivern et al., 2003; Corrigan, 2004) that focus on students who are experiencing mental health issues and how their academics and development are affected while in the college environment. Due to the overlap in academic advising definitions with this definition of mental health, it is important to focus on how students are impacted by mental health issues and in turn how academic advisors and other institutional stakeholders are impacted by working with students who are experiencing mental health issues.

As mentioned above, developmental advising, advising as teaching, and proactive advising all focus on creating a relationship with a student (Vianden & Barlow, 2015). Appreciative Advising is another framework that also builds upon creating a relationship with a student. Appreciative Advising provides academic advisors the opportunity to intentionally collaborate with students by asking positive, open-ended questions that help students realize and achieve their educational experiences, goals, and potential (Bloom et al., 2008). Appreciative Advising places an emphasis on the student’s cognitive development, metacognitive skills, and affective skills through interactions with academic advisors (Bloom et al., 2008). The opportunity to enhance these skills are woven throughout the six-phase model academic advisors facilitate with the student.

The six-model consists of the following: 1) begin creating a relationship with one another through trust and rapport (disarm); 2) uncover strengths and abilities (discover); 3) discuss hopes and goals with one another (dream); 4) construct a plan to achieve goals (design); 5) provide mutual support and accountability while achieving goals (deliver); and 6) challenge each other to set higher expectations for other educational and personal experiences (don't settle) (Bloom et al., 2008).

The disarm phase is centered on helping academic advisors make a positive first impression with students (Bloom et al., 2008). It is important that the academic advisor be aware that at this point in time the student is unsure of the relationship with the academic advisor, expectations of both the student and academic advisors, and a general idea of how the interaction will occur. The student is only aware of previous interactions with other professionals from high school which may have been positive or negative. It is important that the academic advisor provide an open, positive, first impression when first engaging the student.

The discover phase is centered on continuing to build rapport with students and to learn their individual strengths and abilities (Bloom et al., 2008). Each student has come to college with a compilation of experiences, strengths and growth areas. Academic advisors must investigate these aspects through the use of open ended questions to learn about each student

The dream phase is centered on academic advisors examining with the student the student's hopes and dreams (Bloom et al., 2008). Dreams are personal and rarely shared because of how personal dreams are, they are considered extremely precious and difficult to share. "Dream activities bring a radical shift in energy and approach. More important, they stimulate creativity" (Whitney & Trosten-Bloom as cited in Bloom et al., 2008, p. 55). Trustworthiness must be established by the academic advisor so that students feel comfortable in order to reveal

these dreams (Bloom et al., 2008). The importance of dreams reinforces the importance of the first two phases, disarm and discover. Without creating a relationship with a student and building that rapport and trust, the student will be less inclined to share their dreams.

The design phase allows the academic advisor and student to co-create a plan to make the established dreams come true (Bloom et al., 2008). It is important that the academic advisor and student work collaboratively on this plan. The student is the one who ultimately must commit and act on the plan but the academic advisor provides knowledge about the institution as well as resources for the student to utilize along the way.

The deliver phase is when the student will implement the plan that was created in the design phase (Bloom et al., 2008). The academic advisor still participates in this phase, as support and encouragement. The academic advisor also discusses any roadblocks or obstacles the student may encounter during this phase. During this phase, it is important that the academic advisor provides the student with a sense of positive thinking about academic abilities and knowledge on problem solving otherwise known as academic hope (Chang, 1998). The academic advisor also provides follow up and check-ins with the student during the deliver phase.

The last phase, don't settle, focuses on the academic advisor providing continued support and challenging the student when necessary (Bloom et al., 2008). The academic advisor has shown the student that they are an advocate and willing to help in any way possible. Because of this foundation, the ability of the academic advisor to challenge the student can be viewed as a form of support and not out of malice. This also provides the opportunity for the academic advisor to lift the bar of expectations as the student continues to grow at the institution. The ability for the student and academic advisor to meet multiple times allows for a relationship to be established where successes and roadblocks can be discussed and celebrated.

### *Concepts of Academic Advising*

As previously discussed, there are several definitions of academic advising. This stems from NACADA preferring the concept of academic advising as opposed to a clearly stated definition (NACADA, 2006), because there is no one definition able to encompass all that academic advising entails. Academic advising is multi-layered in the roles, duties, and techniques used by the advisor. This makes academic advising responsive to a multitude of situations encountered when dealing with a student. As a consequence of not having a singular definition of academic advising, it is more difficult to explain to others not familiar with higher education.

According to NACADA (2006) the following are the concepts of academic advising:

- a. Curriculum of Academic Advising  
Ideals in higher education to practicality of enrollment  
Institution's mission, culture, and expectations; institution's curriculum; academic programs; development of career goals; resources; policies and procedures; transferability of skills
- b. Pedagogy of Academic Advising  
Preparation, facilitation, documentation, and assessment of advising interactions
- c. Student Learning Outcomes of Academic Advising  
What students will demonstrate, know, value, and do as a result of participating in academic advising (p. 4)

Each of these concepts has the ability to be translated as each institution and academic advisor sees fit. The curriculum of academic advising refers to the individual institutions. Everything from policies to academic programs to the culture of the institution is by this concept.

The pedagogy of academic advising refers to how academic advisors implement and document interactions with students. The student learning outcomes of academic advising refers to the goals of the meeting and what takeaways the student should leave with. As a result of focusing on concepts instead of a clear definition, the academic advising field has the ability to provide students different responses for any situation they may approach the advisor with.

### *Advising and Counseling*

An important feature of academic advising is the association it has with the field of counseling. Due to the amount of overlap between the two professions, discussion regarding the similarities and differences is important to this study. Academic advisors and counselors utilize similar techniques and have the ability to set goals with their students (Kuhn et al., 2006). Advising and counseling are used interchangeably in articles, at institutions and on the NACADA website (Kuhn et al., 2006). The lack of clarification regarding what academic advisors are responsible for vis-à-vis what counselors are responsible for has been a constant discussion in the field of academic advising (Kuhn et al., 2006; NACADA, 2006).

Due to the ambiguity of what occurs during the intercommunication between the academic advisor and the counselor, different interactions and responsibilities could develop. The five interactions of responsibility are: informational advising, explanatory advising, developmental advising, mentoring, and counseling (Kuhn et al., 2006). These five interactions present a way to distinguish what occurs at each level. Overlap of duties and interventions can still occur between levels but the majority of interventions will remain in that particular level. Each interaction and what occurs during that interaction are discussed in more detail below.

Informational advising refers to when the academic advisor provides information to the student (Kuhn et al., 2006). This can take the form of basic questions about resources on campus

or directions on where to locate individuals. Explanatory advising refers to when an academic advisor clarifies information regarding goals for students to complete or actions the student must take (Kuhn et al., 2006). This may take the form of a discussion surrounding institution policies or going through the major, progression of courses, and curriculum questions. Developmental advising refers to a more supportive and meaningful relationship being created between academic advisor and student (Kuhn et al., 2006). This may take the form of providing a resource to students and explaining how that particular resource aligns with their goals and/or personal situations. Mentoring refers to a relationship that is created between an advisor and student where the advisor acts as a role model for the student (Kuhn et al., 2006). This may take the form of an ongoing relationship where the academic advisor gives time, support and takes a general interest in the student. Counseling refers to a situation where the student divulges information such as eating disorders, substance use, or other adjustment issues that the academic advisor is unable to handle (Kuhn et al., 2006). In these situations, the academic advisor is unable to provide the support the student requires due to the situation being outside of the advisor's role and expertise. Instead the academic advisor will refer the student to a counselor or therapist.

Each of the previously described levels provides a different experience for the student. Depending on what the student is seeking, the academic advisor is able to provide one or multiple interactions. However, if what the student is seeking is out of the expertise and range of the advisor, the advisor has an obligation not to attempt to help the student, but instead provide referrals and support for seeking those referrals.

Although academic advisors are not trained to provide counseling to students, these individuals are traditionally the first ones to encounter students who may be experiencing any

type of mental health issue (Peerce et al., 2007; Drake, 2013). Student issues can be difficult and complex with a combination of personal and academic elements, which make defining responsibilities for academic advisors versus counselors difficult. At some point a cutoff needs to be established between academic advising and counseling (Shane, 1981). Since academic advising focuses on all facets of the student, personal and emotional issues that may be affecting the student's academic progress can be discussed in an academic advising appointment. "The severity of the issue (problem) and the student's coping abilities should be factors in deciding whether the problem is best handled by the advisor or if the student should be referred to a counselor" (Kuhn et al., 2006, p. 26). Even though a distinction can be made about when to refer to other campus entities, academic advisors still have the responsibility to provide guidance for students when the referral is made and after to check in with the student (Hughey, 2011).

Due to advisors and counselors helping students with similar concerns, the opportunity to use similar techniques and strategies is available for both professions (Jordan, 2000). Techniques and strategies used by both academic advisors and counselors include: 1) "establishing a caring relationship with the student; 2) exhibit clear communication and listening skills; 3) possess knowledge of campus and community resources; 4) engage students in inquiry and problem solving; and 5) encourage and reinforce positive goals and behaviors" (Grites et al., 2016, p.31). Both academic advisors and counselors utilize the same skills in order to work with students and build relationships with students.

Although academic advisors are typically not mental health counselors, their roles require frequent interaction with students and therefore they may be the first to recognize or be informed that the student is experiencing some form of distress (Harper & Peterson, 2005). Table 2

provides a list of issues students may bring to an academic advisor. Some of the issues or concerns can be handled by either the academic advisor, the counselor or both parties.

*Table 2*

*Issues students bring to academic advisors*

Issue	Academic Advisor	Either Individual	Counselor
Academic Concerns	X		
Registration for Courses	X		
Progression in Major	X		
Withdrawing/Removal from a course	X		
Degree Requirements	X		
Academic Probation	X		
Unfair grade from professor	X		
Exiting Institution	X		
Establishing a caring relationship with the student		X	
Time management		X	
Family Issues		X	
Financial Issues		X	
Decision Making		X	
Academic Goals		X	
Personal Goals		X	
Career Goals		X	
Interpersonal Relationships		X	
Substance Abuse			X
Eating Disorders			X
Physical/Emotional Abuse			X
Sexual Orientation			X
Suicide			X

Kuhn, T., Gordon, N. V., & Webber, J. (2006). The advising and counseling continuum: Triggers for referral. *NACADA Journal*, 26(1), 24-31.

These issues have the potential to affect a student’s progression and retention at the university and makes it appropriate for the academic advisor to discuss with the student (Tuttle, 2000; Smith & Allen, 2014; Darling, 2015).

### *Importance of Relationships*

As discussed previously, an important part of academic advising is building relationships between advisors and students (Winston & Sandor, 1984; Kelley & Lynch, 1991; Love & Tinto, 1995; Schnell, 1998; Shapiro & Levine, 1999; Gallagher & Allen, 2000; Zhao & Kuh, 2004). Several of the previous definitions for academic advising include creating or building a relationship (O'Banion, 1972; Crookston, 1972; Wilson, Enders, & Miller, 1982; American College Testing Program, 1984; Crockett, 1987; Creamer & Creamer, 1994; Chickering, 1994; Frost, 1994; Kuhn, 2008). By creating a relationship with the student, the academic advisor is providing a space for the student to develop academically and personally. "Through meaningful interaction, led by the advisor's reflection skills, advisees can experience self-discovery that will lead to clarification of priorities, strengths, career options, academic success, self-regulation, and perhaps a widening of their worldview for a lifetime" (Hughey, 2011, p. 25). Once the relationship is built between advisor and student, the student is able to seek out the academic advisor not only regarding decisions that affect their academic progress but also decisions that affect them personally. Students view the academic advisor as someone that can provide an institutional perspective on a situation (Drake, 2011). Similar to any relationship, once the student feels they are able to trust their academic advisor and their advisor will be there to support them, the student will continue to seek out the academic advisor (Rawlins & Rawlins, 2005).

According to Donnelly (2009), the more student-centered the advisor is, the greater their job satisfaction. "To be student-centered, advising can no longer be merely passing on information or advice; rather, it becomes focused on coaching the student toward the development of attitudes, skills, and behaviors as a learner, decision maker, and community

participant, with success measured in terms of learner outcomes” (Melander, 2002, p. 2). Student interaction is critical to the academic advisor taking a student-centered approach. The more academic advisors interact with their students, the more they are able to apply a student-centered approach to their daily job. When building a relationship, it is important to acknowledge that both parties receive something beneficial from the relationship (Jordan, 2010). Both individuals may receive something different from the relationship, and one could argue that one may be getting more out of the relationship compared to the other, but enough is happening between the exchanges that both individuals feel respected. In this instance, the academic advisor receives more fulfillment in their job when they have created a relationship with a student.

Komaraju, Musulkinm, and Bhattacharya (2010) discovered that when students feel close to one faculty or staff member at the institution, they are more likely to feel more satisfied at the institution and be more successful. Satisfied students will take more interest in the college community and will continue to create other connections with the institution and other individuals attending the institution (Harper & Wilson, 2010; Kuh, 2011; Pearson, 2012). The student also has a better chance of persisting and being retained at the institution (Vianden, 2016). Both students and academic advisors benefit from building a relationship with one another, even though academic advisor and student receive different benefits from this relationship.

CAS (2008) prioritizes “interpersonal competence” with dimensions of “meaningful relationships, interdependence, collaboration, and effective leadership” (p. 3). Accordingly, institutions will need to prioritize the importance of these skills and the building of relationships between academic advisors and students.

One important aspect of the academic advisor's responsibilities would be the advisor-to-advisee caseload. Based NACADA's 2011 National Survey of Academic Advising (Carlstrom & Miller, 2013), professional advisors would ideally like a caseload of 296 students per one advisor. At some institutions smaller caseloads are feasible and at other institutions, unless more academic advisors are hired, this type of caseload is not feasible. "Many advisors bear additional responsibilities to advising students, including teaching first year seminars, holding workshops, performing committee work, working at institutional events, and undertaking various other duties that take time away from direct advising with students" (Robbins, 2013, p. 1).

The number of students an advisor has to see and the time of year may also impact the relationship and approaches that are utilized in advising sessions. When academic advisors are limited on time, they will typically utilize a more prescriptive advising approach compared to one where a collaborative relationship can be built (Robbins, 2013). According to CAS (2009), "academic advising caseloads must be consistent with the time required for the effective performance of these activities such as discussing plans, programs, and other subjects and challenges related to their educational pursuits" (p. 5). Even though some academic advisors may have triple the ideal caseload, all academic advisors have a duty to provide services to students (Grites et al., 2016).

Even though there is not one definition for academic advising, the field of academic advising is still able to persist and help students. By not having one definition, advisors are not limited in what can and cannot be discussed in an advising session. The student's development will affect their interaction with the institution and academics. The advisor is there to create a relationship with the student that is collaborative (O'Banion, 1972; Crookston, 1972; Winston et

al., 1982; American College Testing Program, 1984; Crockett, 1987; Creamer & Creamer, 1994; Chickering, 1994; Frost, 1994, & Kuhn, 2008).

### Professionalization of Academic Advising

To make academic advising a profession would require an overall criteria that could be applied to all academic advisors at all institutions. “Every profession establishes a language of practice, one that captures the important concepts and understandings shared by members of the profession” (Danielson, 2007, p. 16). According to Wilensky (1964) there are four stages an occupation must go through to achieve professionalization: 1) creation of full-time occupation, 2) establishment of schools for training new recruits, 3) formation of one or more professional associations, and 4) establishment of code of ethics for all members to follow.

Academic advising has achieved all four of these stages. As higher education changed and developed, the roles that used to be occupied by faculty now need to be filled by others. “The continuing expansion of the curriculum, along with the increasing specialization of faculty work, created a need that would ultimately be filled by professional academic advisors” (Shaffer, Zalewski, & Leveille, 2010, p. 70). With this void being filled, professional positions could be created. Throughout higher education institutions in the United States and all over the world, there are full-time academic advisors. The main job for these academic advisors is to assist students in completing their degree program, which can take a multitude of forms as described previously (Crookston, 1972; Winston et al., 1982; PBS Teleconference, 1999; Kuhn, 2008; Miller, 2012).

There are many graduate programs that cater to providing degrees in higher education and student affairs. These programs have the opportunity to train students in a multiple of fields, one of them being academic advising (Frost, 2000). The National Academic Advising

Association (NACADA) also offers the opportunity for certification in academic advising if individuals are interested in pursuing a specific certification. “We will define a profession as a white-collar occupation that confers on workers a relatively high level of prestige and that requires extensive formal education as a condition of entry-level employment” (Shaffer, Zalewski, & Leveille, 2010, p. 67). The majority of academic advising jobs require a minimum of a master’s degree or a bachelor’s degree and many years of experience (McMahan, 2008).

The National Academic Advising Association is a professional organization for academic advisors or those interested in learning about academic advising. NACADA evolved from the first National Conference on Academic Advising in 1977 and was chartered in 1979 (Thurmund & Miller, 2006, para 2). Academic advisors also have the opportunity to be a part of the National Student Affairs Professionals in Higher Education (NASPA). This professional organization focuses on all divisions under student affairs and academic advising is included as one of these divisions. Through NACADA, NASPA, and the Council for the Advancement of Standards in Higher Education (CAS), competencies and a code of ethics have been developed for all academic advisors to follow.

#### *NACADA Core Values*

The Core Values established by NACADA (2005) are the following:

- a. The Statement of Core Values provides a framework to guide professional practice and reminds advisors of their responsibilities to students, colleagues, institutions, society, and themselves.
- b. Advisors are responsible to the individuals they advise
- c. Advisors are responsible for involving others, when appropriate, in the advising process

- d. Advisors are responsible to their institutions
- e. Advisors are responsible to higher education
- f. Advisors are responsible to their educational community
- g. Advisors are responsible for their professional practices and for themselves personally (p. 6)

The above core values were determined by NACADA to provide standards for all academic advisors. These core values outline what academic advisors are responsible for, but now how these responsibilities will be implemented at institutions. These core values can be executed at any institution regardless of size, demographics, and location. By creating core values open to interpretation, each institution has the ability to incorporate these responsibilities to fit the institution's own mission. And all academic advisors have a guideline to assess their duties and roles.

The first core value focuses on the responsibility an academic advisor has to the advisee (NACADA 2005). There is a responsibility to those who the advisor advises. Regardless if a student is attending the institution for the first time, about to graduate or somewhere in the middle, students seek out academic advisement for different reasons. It is the responsibility of the academic advisor to assist anyone who comes for advisement.

The second core value focuses on the responsibility of involving other resources (NACADA, 2005). Academic advisors encounter all types of situations and concerns. These individuals can only help a student so much before exceeding the scope of their expertise. Because of this it is their responsibility to be aware of other resources on campus and involve these individuals when appropriate and necessary.

The third core value focuses on the responsibility to the institution (NACADA, 2005). Academic advisors are employed by a plethora of institutions. Each institution will have its own mission, values, and goals. The academic advisor must be aware of what the institution is asking of its employees and what direction that institution is taking. Without this awareness, the academic advisor may place themselves in a position that may jeopardize the institution or their standing with the institution.

The fourth core value focuses on a responsibility to higher education (NACADA, 2005). Academic advisors are individuals who help guide students through the field of higher education. Because of this, academic advisors also have a responsibility to the field of higher education. Academic advisors should be aware of what is happening throughout the world and throughout the country since these events will impact higher education.

The fifth core value focuses on a responsibility to the educational community (NACADA, 2005). Academic advisors are responsible to the educational community they come from. The profession has determined that there is no specified degree for the field, just a degree beyond a bachelor's. Due to this, academic advisors may come from multiple fields of study. Given this, each individual advisor has a responsibility to uphold the values of the discipline they came from.

The sixth and final core value has to do with the individual advisor personally and professionally (NACADA, 2005). Academic advisors have a responsibility to set a good example professionally as well as personally for students and colleagues. By continuing to educate themselves, academic advisors are able to provide the best guidance and help to those they encounter. Academic advisors have the potential to interact with a variety of students from a variety of backgrounds and it is their responsibility to be aware of any feelings and thoughts that

may negatively impact the interaction with the student. Personal awareness on the academic advisor's part allows for the opportunity for growth and the ability to best assist the student.

*Council for the Advancement of Standards in Higher Education (CAS)*

The Council for the Advancement of Standards in Higher Education (CAS) was founded in 1979 as a consortium between professional associations in higher education. CAS promotes standards for student affairs, student services, and student development by looking at different challenges occurring in that field and developing competencies to handle those challenges (CAS, 2005). Regarding the field of academic advising, CAS (2005) created the following standards: “a) helping students understand themselves (i.e. values, goals, and interests); b) helping students clarify and make decisions about educational and career goals; c) monitoring students’ academic progress; d) assisting students in monitoring their own progress toward established goals; e) helping students understand university policies and procedures; and f) offering referrals to people and departments who can assist students” (p. 3).

Similar to several definitions mentioned previously regarding what academic advising is, CAS has also provided direction regarding what is academic advising and how the academic advisor and student are building a relationship together. “In the case of the advising friendship, this common good involves the student's development as an informed, involved, and ethical participant in his or her own possibilities for learning, growth, and educational community as well as the world beyond” (Rawlins & Rawlins, 2005, p. 11). Through helping students understand themselves, academic advisors are providing support to students while they develop as individuals. By helping students clarify and make decisions about their goals, academic advisors are providing a different perspective on how the student is able to achieve their dreams. As a result of monitoring students’ academic progress, academic advisors are making sure the

student is still able to obtain their goals. By assisting students in monitoring their own progress, academic advisors are teaching students how manage and reevaluate their own goals. Through helping students navigate university policies and procedures, academic advisors are helping students decode and thrive in the college community. As a result of offering referrals to other resources, academic advisors are opening additional doors to students to help achieve and support their goals. All of these components set by CAS provide an outline on how academic advisors are able to interact with students.

### *NACADA Core Competencies*

One more aspect to consider regarding the professionalization of academic advising is the competencies the field deems important. The purpose of the Core Competencies model (NACADA, 2017) is to identify the broad range of understanding, knowledge, and skills that support academic advising, to guide professional development, and to promote the contributions of advising to student development, progress, and success. The three main competencies according to Habley (1987) are conceptual, informational, and relational.

Conceptual competency refers to the context of the delivery. This component contains “the history and role of academic advising in higher education; NACADA’s core values of academic advising; relevant theories to advising; approaches and strategies of academic advising; expected outcomes of advising; and how equitable and inclusive environments are created and maintained” (NACADA, 2017, p. 2). As a result of focusing on these conceptual components, academic advisors are in a position to explore and develop as professionals. By NACADA focusing on concepts and multiple definitions instead of just one definition of what academic advising should be, academic advisors have the opportunity to experiment with what best fits their own personal style and the students’ needs, while being responsible to the

academic advising profession. “Academic advisors need to develop an awareness of the role that theories can and should play in supporting their personal philosophy and approach to academic advising” (Williams, 2007, p. 7).

Informational competency refers to the substance of academic advising. This component contains “institution specific history, mission, vision, values, and culture; curriculum degree programs, and other academic requirements and options; institution specific policies, procedures, rules, and regulations; legal guidelines of advising practice, including privacy regulations and confidentiality; the characteristics, needs, and experiences of major and emerging student populations; campus and community resources that support student success; and information technology applicable to relevant advising roles” (NACADA, 2017, p. 2). As a result of focusing on these informational components, academic advisors have the opportunity to guide students through institutional policies, provide resources, and maintain confidentiality. Academic advisors are in a position to assist students in understanding how the institution works and how to align their goals with what the institution can provide for students. In this role, academic advisors help students navigate through the institution and provide support for what the student needs (Peerce et al., 2007).

Relational competency refers to the skills that enable academic advisors to convey concepts to students and build relationships with others. This component contains “articulate a personal philosophy of academic advising; create rapport and build academic advising relationships; communicate in an inclusive and respectful manner; plan and conduct successful advising interactions; promote student understanding of the logic and purpose of the curriculum; facilitate problem solving, decision-making, meaning-making, planning, and goal setting; and engage in on-going assessment and development of the advising practice” (NACADA, 2017, p.

2). As a result of focusing on the relational components, academic advisors have the opportunity to build a relationship with students. This component allows the academic advisor to focus on a relationship with the student. Through building this relationship, the academic advisor becomes someone the student can count on to support and provide help while at the institution (Lowenstein, 2005; Peerce et al., 2007).

According to Higginson (2000) the informational and relational competencies can be divided into two categories: entry-level advisor responsibilities and second year and beyond advisor responsibilities. In reference to the informational competency, year one advisors should have basic knowledge of institutional policies and regulations which are used most often and affect the most students, while year two and above advisors are aware of more complex and particular institutional policies and procedures and can evaluate a situation from different institutional angles. In reference to the relational competency, year one advisors ask appropriate questions and makes sure the student feels comfortable and has all their concerns taken care of, compared to year two and beyond advisors who are able to effectively implement triage techniques, delve deeper into conversation with students and fully integrates teaching aspects into the advising session. As a result of this article, institutions are able to distinguish how to evaluate entry level advisors compared to those how have been in the field longer. Competencies also allow for a standard level of evaluation to be created. Through the use of competencies, academic advisors as well as advising techniques can be assessed and measured effectively.

It is important to look at the professionalization of academic advising. Because academic advising has developed over time, faculty still hold some academic advising jobs, and may fulfill the role of academic advisor at some institutions, academic advising as a whole has sometimes been called into question regarding its credibility to the field of higher education. By focusing on

the pieces that define professionalization, an argument is made for academic advising being a profession.

### Role of Academic Advising in Higher Education

Academic advising in higher education is in constant transition. “At its most fundamental level, advising is informational and explanatory and progresses through developmental and mentoring phases” (Kuhn et al., 2006, p. 24). As students seek academic advisement for different reasons, the role of the academic advisor has the potential to change. The academic advisor has the opportunity to provide different aspects and guidance for what the student is seeking at any given time. Academic advising is a balance between student affairs and academic affairs (Tuttle, 2000). Academic advising is a part of student affairs since it deals with the developmental aspects of working with students. It is a part of academic affairs due to needing to know and understand the progression of the major as well as any institution policies and procedures that a student can experience at the institution. With a focus on development and life transitions, the academic advisor has the opportunity to be a support system and a guide for the student. “The advisor is arguably the most important person in the student’s education world” (Lowenstein, 2005, p. 72).

Another important role the academic advisor plays within higher education is that regarding retention and academic completion. Academic advisors play a role in supporting retention efforts, student involvement, career exploration, and life development (Tuttle, 2000; Darling, 2015). According to a study conducted by Smith and Allen (2006) important advising functions for students include: information, integration of various parts of the curriculum with academic, career and life goals, individuation, shared responsibility, and referral. These functions were extremely important for students who were financially needy, minority students, and new

students. These students have traditionally been harder to retain at the tertiary level. The role of academic advisors has the potential to support and provide direction for these students in need. Also the academic advisor continues his or her role in supporting the institutional mission and goals as a key player in helping with retention and academic completion (Tuttle, 2000; Darling, 2015).

### Summary

Academic advising is a field that is constantly in transition. The roles and responsibilities of academic advisors are always changing (NACADA, 2006). At any given time, an academic advisor can be a student's confidant, cheerleader, role model, pusher, and resource. Like a chameleon, the role and needs change to fit whatever problem is presented to the academic advisor at any given time. Due to the fluidity of this profession, roles may overlap with other professions, specifically counseling (Kuhn et al., 2006). Based on the multiple definitions and competencies used in the academic advising profession, one aspect of the profession is clear, the importance of relationship building with the student (Winston & Sandor, 1984; Kelley & Lynch, 1991; Love & Tinto, 1995; Schnell, 1998; Shapiro & Levine, 1999; Gallagher & Allen, 2000; Zhao & Kuh, 2004). Unsure of what role the academic advisor will need to play, they must constantly be aware of where they are at personally and if they harbor any thoughts or feelings that may prevent them from successfully helping a student. These thoughts and feelings may impact the relationship that is being built with the student (Peerce et al., 2007). The academic advisor is responsible for making sure a relationship occurs with the student.

## History of Mental Health in Higher Education

The treatment of mental health issues on college campuses has evolved over the last 150 years (Kraft, 2011). The first college health program began at Amherst College in 1861 (Kraft, 2011). The original focus was on physical illnesses. “These programs emphasized healthy exercise for students to avoid emotional problems” (Kraft, 2011, p. 479). It was not until 1910 at Princeton University that a focus on mental health services was established in response to the noticeable increase of students leaving the university due to emotional (depression, anxiety, anger) and personality (unstable relationships, self-harm, mood swings) issues (Kraft, 2011).

During the 1920s, the American College Health Association was established. At this meeting four reasons were outlined for establishing mental health programs (Farnsworth, 1957): 1) “the conservation of the student body, so that intellectually capable students may not be forced unnecessarily to withdraw, but may be retained”; 2) “the forestalling of failure in the form of nervous and mental diseases, immediate or remote”; 3) “the minimizing of partial failure in later mediocrity, inadequacy, inefficiency, and unhappiness”; and 4) “the making possible of a large individual usefulness by giving to each a fuller use of the intellectual capacity he possesses, through widening the sphere of conscious control and thereby widening the sphere of social control” (p. 56). This paved the way for how universities would handle mental health issues for college students.

With the passage of the GI Bill, an increase in individuals attending schools occurred which led to an increase in student services as well as mental health services (Brubacher & Rudy, 2008). Access to the institution became more open to individuals who never had the opportunity to attend university and these institutions had to adjust to these students. “Most schools soon realized that the mental health professionals needed to not only counsel needy

students but also to advise the faculty and staff of ways to improve the mental health of all students at the school” (Kraft, 2011, p. 477).

From this point forward, mental health issues would be handle throughout universities from the perspective of incorporating all departments, staff and faculty in supporting mental health issues, using evidence-based treatments, and short-term therapy models (Kraft, 2011). By understanding how mental health has developed at the university, one is able to understand how universities have moved from a medical model to a holistic model (Farnsworth, 1957). By looking at this development, the culture surrounding mental health on college campuses is created. These changes explain how institutions respond to individuals with mental health issues.

#### Students with Mental Health Issues Definition

Mental health was defined in Chapter 1 as a “condition that affects a person’s thinking, feeling or mood. Such conditions may affect someone’s ability to relate to others and function each day” (National Alliance on Mental Illness, 2016, p.1). For this study, the definition of mental health is broad to include all aspects that could potentially alter or change someone’s behavior or mood. Since each individual will have a different response to a particular incident, any physical or psychological instance could impact an individual.

The definition was chosen as a way to not exclude any individual who is experiencing a mental health issue. Students may experience a mental health issue any time before or during college and these experiences will impact their time at the institution (Kessler et al., 1995; Kitzrow, 2003; Glass, 2010). It is important for academic advisors to be aware of the fact that they may be encountering students with mental health issues since these students have a tendency to leave the institution for academic as well as personal reasons (Kessler et al., 1995; Gruttadaro & Crudo, 2012; Salzer, 2012).

### Prevalence in Higher Education

Mental health illnesses are frequently diagnosed from 18 to 25 years of age (Cook, 2007; Sharpe et al., 2004; Substance Abuse and Mental Health Services Administration, 2009; Unger, 1992) which is the time many students are pursuing higher education. All institutions should be aware of the fact that the onset for multiple mental health issues occurs during the time when students are achieving a post-secondary education. This fact alone provides support for institutions to invest in services and education of faculty and staff to help these students. These students can come into the institution with a mental health issue or can develop one while pursuing a degree (Kessler et al., 1995; Kitzrow, 2003; Glass, 2010). Since faculty and staff will not know who will end up experiencing mental health issues, it is important for them to be aware of their attitudes toward mental health issues and those experiencing mental health issues (Peerce et al., 2007).

According to Dungy (2010) there are three different types of students who experience mental health issues while in college: 1) students who are previously diagnosed with a mental health issue and receive treatment during their time in college, 2) students who develop a mental health issue during their time in college, and 3) students who are previously diagnosed with a mental health issue and choose not to receive treatment or stop taking medication during their time in college.

Many students are diagnosed with mental health issues before the student attends college. This gives the student the opportunity to understand their diagnosis and prepare them to go into a new environment. These students also have the opportunity to seek out treatment that is appropriate for them since they may already know what works for them and what does not. Improved medications and treatment have allowed these students to attend college (Collins & Mowbray, 2005).

The next group of students is a bit more difficult to figure out since every student who comes to college has the potential to develop a mental health issue (Kessler et al., 1995; Kitzrow, 2003; Glass, 2010). These students may notice they are responding differently to situations compared to before, have a difficult time adjusting to the new environment or not succeeding academically. These are a few factors that may indicate that a student is experiencing a mental health issue. Regarding these students, the student can become aware that they are experiencing a mental health issue or someone at the institution may notice.

The last group of students have an awareness of their mental health issue and choose to not pursue treatment. This can happen due to not wanting others to know they have a mental health issue (Cook, 2007; Fuller et al., 2004; Quinn et al., 2009; Gruttadaro & Crudo, 2012) or believing that they are able to control their mental health issue without treatment (Gallagher, 2007). These students may begin to experience similar issues and concerns as the second group of students. It is important for institutions to be aware of the issues that students may come to college with or develop while in college. This specific issue of students experiencing mental health issues has the potential to impact the institutional culture as well as retention (Vowell, Farren, & McGlone, 1990; Seidman, 1991).

One of the latest challenges CAS has determined for academic advising is the increasing evidence of students attending colleges with mental health issues (CAS & Mitstifer, 2012). This demonstrates the need for colleges to take a look at what practices are in place for working with and supporting students with mental health issues. Colleges and institutions will need to make sure that all aspects, including faculty and staff, meet the competencies set forth by CAS regarding supporting students experiencing mental health issues.

### Student Challenges when facing Mental Health Issues

An early intervention approach is being utilized regarding students being diagnosed with mental health issues compared to previous years (Kitzrow, 2003). More awareness and knowledge are being shared and discussed more openly. Testing is taking place at a younger age in K-12 institutions, which is making parents more aware of their child's changes in behavior and other manifestations. Marano (2004) determined that students are being more effectively diagnosed compared to previous generations. These earlier diagnoses have to do with more knowledge regarding the onset of mental health issues and parents taking a more proactive approach to understanding the change in their child's behavior. By receiving this help at an earlier stage, students are able to have a better understanding of how their mental health issues are experienced and how these experiences will impact their life (Kessler, Olfson, & Berglund, 1998). These early interventions can also prepare students on how they responded to certain situations. By knowing what situations may increase mental health issues, students may be able to remove themselves from situations where these instances are happening (Kessler et al., 1998). This knowledge helps those who are experiencing mental health issues transition to the new college environment.

Students with mental health issues experience all the similar issues compared to those who have transitioned to the university without mental health issues. "Students with mental illnesses face the same barriers as other students, including difficulty paying college tuition, poor preexisting academic skills, and lack of confidence" (Salzer, 2012, p. 3). These transitional experiences may be more difficult for students due to the mental health issues they are experiencing. These mental health issues will also affect their interactions with others and the new environment they have just moved into. Students with mental health issues have to focus on additional issues regarding this transition. These issues include learning to balance their time,

keeping up with appointments to doctors as well as any medications they may be prescribed, stigma associated with having a mental health issue, and lower academic self-confidence (Corrigan, 2004). If students are not able to balance the traditional transition issues with their mental health issues there is a high chance that they will leave the institution (Kessler et al., 1995). This may be due to feeling as if they are unable to handle all of the new experiences and feeling as if their mental health issues may be out of control. At a large university, the environment can be stressful and is often characterized by high stakes academic pressure, minimal academic support compared with high school, potential social isolation during the transition and long term financial debt (Kadison & DiGeronimo, 2004). According to Mowbray et al. (2006) these transitional factors represent the kinds of stresses that can worsen mental health symptoms.

All students experience an adjustment to the university (Compas et al., 1986; Arnett, 2004). These students begin to experience life essentially on their own, away from parents and familiar social support. Students will need to learn to adjust to a new environment based on the skills they have learned up until this point. Students who are experiencing a mental health issue will have the same adjustments that those not experiencing a mental health issue will have plus more. Researchers have noted that the transition to a university for a student with a mental health issue may be a different experience (Kessler et al., 1995; Kitzrow, 2003; Glass, 2010).

### *Academic Experiences of Students with Mental Health Issues*

Academics are the pulse that keeps an institution alive. Without academics an institution would not be classified as an institution (Brubacher & Rudy, 2008). Mental health issues can interfere with the thought processes and critical thinking skills that are needed for self-regulated learning (Collins & Mowbray, 2005). Eisenberg, Golberstein, and Hunt (2009) surveyed 2,798

students regarding their academic records and if those students have or have experienced mental health issues. This study determined that those who indicated they experienced depression, anxiety, or eating disorders had a lower GPA while attending college. This study is important as it demonstrates a link between mental health issues and academic struggles.

An important area to focus on would be the retention of these students since this is what impacts a university at its core. “86% of students with mental illnesses withdraw from college prior to completing their degree compared to a 45% withdrawal rate for the general population” (Kessler et al., 1995, p. 1028). This academic failure tends to be attributed to lack of concentration, time management issues, and not receiving the necessary support. Lack of concentration and difficulty performing can be attributed to students’ mental health issues. If these students are not receiving the correct support and resources they will continue to not do well, which may lead to continued academic issues. “Data from several postsecondary-based studies show the academic consequences: depressed students, whether male or female, and whether they are undergraduates or graduate students, have lower grade point averages (GPAs) and blunted levels of academic persistence and achievement compared with their peers who are not depressed” (Douce & Keeling, 2014, p. 2). Students with mental health issues also discussed issues of not being able to concentrate, not sleeping well, low self-esteem, stigma from peers or faculty, maintaining stamina, motivation issues, and pressure to achieve in college (Mowbray & Megivern, 1999; Megivern et al., 2003; Collins & Mowbray, 2005). As students continue to attend college, they will come to the institution with mental health issues or develop mental health issues while at the institution. Students who have mental health issues may see their academics impacted. The institution will need to provide support for these students so that they have the opportunity to progress toward academic completion.

One study conducted by Hartley (2013) looked at students with mental health issues and a resiliency factor regarding completion of academics. The study looked a sample of 121 students with mental health issues. One important factor this study determined was that resiliency may be a critical factor in students with mental health issues being able to complete credits over time. By identifying a factor that can help students with mental health issues complete credits, this study provides an area of focus for individuals and institutions to focus on.

Koch, Mamiseishvili, and Higgins (2014) conducted a study regarding students with psychiatric disabilities and degree completion. The study focused on persistence, background in college characteristics, participation in academic and social activities, and educational services. The data set was taken from the 2004-2009 Beginning Postsecondary Students Longitudinal Study and included 350 students who identified themselves as having depression or a psychiatric/emotional condition that lasted 6 months or more. The study demonstrated that those with psychiatric disabilities were less likely to utilize accommodations offered by the university. The study did cite a limitation such as background of individuals and in college characteristics as potential variables that may contribute to students not seeking out accommodations. The results of this study provide evidence that students with psychiatric disabilities find it difficult to engage with the university. By not seeking out help from the institution, these individuals are putting themselves at risk for not completing a degree.

Another factor to take into consideration with this population is that some of these students may be utilizing medications that were prescribed by a psychiatrist or a medical doctor (Kitzrow, 2003). Students experiencing mental health issues have an added factor of the impacts of medication usage. The side effects of psychotropic medications have been found to impair students' attention, concentration, and stamina due to headaches, nausea, insomnia, and fatigue

(Weiner & Weiner, 1996). According to the study conducted by Gruttadaro & Crudo (2012), 47% of students disclosed that medications were critical to their success in college. In order to continue in an educational setting, medications are needed. Medications may positively and negatively affect a student and their academics. Students experiencing mental health issues need to monitor how their medication usage is affecting their academics in the new college environment (Gallagher, 2007). These students are stuck in a conundrum where either decision, to continue to take or stop taking medications, will have an impact on their educational experiences at the institution.

When students transition to a college or university, these students are entering a new academic experience. Students who are experiencing a mental health issue have an added layer to their experience in college and with academics specifically (Kessler et al., 1995; Weiner & Weiner, 1997; Mowbray & Megivern, 1999; Megivern et al., 2003; Corrigan, 2004). Students with mental health issues may experience a more difficult time with academics. If this is the case, there is a greater chance that they will not succeed and leave the institution (Gerdes & Mallinckrodt, 1994; Kessler et al., 1995). The above studies provide a glimpse into how students experiencing mental health issues are affected when it comes to academics. This provides background into some of the academic issues students experiencing mental health issues go through while attending college. As a result of providing information on how these students are affected from an academic standpoint, this demonstrates how important the institution is in providing support for these students.

### *Social Experiences of Students with Mental Health Issues*

The majority of students entering college would say that social support is an important aspect in helping with the transition (Hays & Oxley, 1986; Hefner & Eisenberg, 2009). Whether

individuals are transitioning to college with a support group or not, eventually new relationships will have to be formed. Students with mental health issues have an additional burden regarding creating new relationships once they transition to the university. The debate about whether or not to disclose their mental health issue is one of these burdens. By disclosing a mental health issue, the student is opening themselves up for potential social avoidance and stigma (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999; Corrigan & Wassel, 2008; Al-Nagger, 2013). If this is the outcome once a mental health issue is disclosed, the chance for the student to leave the university increases (Gruttadaro & Crudo, 2012).

A study conducted by Hefner and Eisenberg (2009) focused on the relationship between mental health and social support. This study utilized 1378 students who completed a social support module. The study found that students with characteristics differing from most other students, such as minority race or ethnicity, international status, and low socioeconomic status, are at greater risk of social isolation. A case could be made that students with mental health issues are another group of students who have differing characteristics from other students who come into the institution. Since these students are experiencing something different than the majority of the students attending the university, an argument can be made that these students are their own diversity group. According to this study, those who differ from the majority are not able to connect socially compared to others. This makes it difficult for them to engage with the environment and the institution.

A quantitative study by Hays and Oxley (1986) focused on the development of social support networks among college freshman. The study focused on characteristics associated with positive adaption to the new university setting. There were two main aspects of this study: to describe both the structural and functional characteristics of the freshman's social networks as

they evolved over the course of the first term and to identify the relative degree to which the various network characteristics were associated with positive adaptation to the university. It was hypothesized that networks composed of individuals experiencing the same role transition as the freshman would be more conducive to positive adaptation to the university. The study was conducted over a 12-week period with 89 students who lived either in university residence halls or at home with parents. Questionnaires were given out during the fourth, eighth, and twelfth weeks of the fall semester about aspects of university life, including social relationships. According to the study, the number of fellow university students within the freshman's network was the most strongly related variable with college adaptation. Another important note about this study was the relative adaptiveness of particular network characteristics over time. Those who moved into university housing included much more new acquaintances compared to those who commuted. This study demonstrated the importance of social networks while students are transitioning to college. The study also revealed that the more individuals the student interacts with who are going through the same process that student is, the more likely they are able to adapt to the new college environment.

As students continue to attend college, they will come to the institution with mental health issues or develop mental health issues while they are attending the institution (Dungy, 2010). Mental health issues will impact the academic aspects as well as the social aspects of these students. It is important to understand how these students are being impacted while at college since students experiencing mental health issues are having a different experience compared to those who are not experiencing mental health issues (Kessler et al., 1995; Kitzrow, 2003; Glass, 2010). By understanding what these students are experiencing from an academic and social aspect, changes can be made to provide a more supportive campus environment.

### Institutional Challenges when facing Mental Health Issues

Institutional impact occurs in the form of faculty and staff as well as the institution as a whole providing and creating a supportive environment for students with mental health issues (Peerce et al., 2007). When an environment is created for students where they feel welcomed, students will want to remain at the university (Ford & Ford, 2009; Drake, 2013).

Byrd and McKinney (2012) studied the impact of the institution on the individual if support was not adequate. A total of 2,203 students responded to a survey based on health and campus environment. The study found that “perceptions of campus climate and institutional satisfaction were related to overall mental health” (Byrd & McKinney, 2012, p. 191). Based on the study, it was determined that when the institution addressed the needs of the individual and the community, this had the most impact on the individual’s mental health. Students may also not seek out accommodations due to lack of support from institutional administration. By informing the university community about mental illness, people’s beliefs regarding mental illness have the ability to change. Interactions with students who have mental illness issues can also change the stigma surrounding these students.

Students with mental health issues also experience a higher dropout rate compared to those who are not experiencing mental health issues. This has to do with symptoms the student may be experiencing, academic issues, and lack of support from peers and the institution (Weiner & Wiener, 1997; Mowbray & Megivern, 1999; Megivern et al., 2003). With students who are experiencing mental health issues not completing their degree programs, this affects the student personally by potentially making it more difficult for students to get a job but also affects the institution from a retention and completion standpoint. It is the institution’s responsibility to provide opportunities for all students to persist and feel supported in the college environment. “Mental and behavioral health is a critical component of well-being for all students, and having a

campus culture and learning environment that supports healthy minds is a core need deeply centered in the mission of every institution of higher education” (Douce & Keeling, 2014, p. 3).

It is important to understand the impact students experiencing mental health issues has on the university (Stanley & Manthrope, 2002; Kitzrow, 2003). “The entire institution has a role in prevention, providing support, and in offering a range of opportunities to enable students to participate in higher education” (Stanley & Manthrope, 2002, p. 30). The student is impacted by not being able to complete their degree and leaving the institution. This makes it more difficult for the student to continue their education and may impact job opportunities and career goals. The institution is impacted when students do not complete programs, which leads to an issue of retention for the university. Both the student and the institution will be hurt by this relationship not being one of support and understanding.

### Attitudes

Central to this current research is the concept of attitudes. There are many definitions regarding attitude. For the purposes of this study attitude will be defined as “a learned, global evaluation of an object (person, place, or issue) that influences thought and action either positively or negatively” (Perloff, 2003, p. 39).

“Attitudes are acquired over the course of socialization in childhood and adolescence” (Perloff, 2003, p. 40). One can infer from this that attitudes are either formed once an interaction occurs or a behavior is observed regarding that person, place or issue. Attitudes are also an evaluation of something. “Having an attitude means that you have categorized something and made a judgment of its net value or worth” (Perloff, 2003, p. 41). Because a judgment is made, the person who has made a decision about an attitude toward something is no longer able to be

objective about that subject or topic. “Attitudes express passions and hates, attractions and repulsions, likes and dislikes” (Eagly & Chaiken, 1998, p. 269).

Attitudes also influence thoughts and actions. When one comes up with an attitude toward something, it is easier to organize and understand that subject or topic better since it has been judged as either positive or negative and processed accordingly. Attitudes also affect behavior. “In our society, consistency between attitude and behavior is valued” (Perloff, 2003, p. 41). People develop attitudes about subjects or topics they have encountered. Some of these attitudes are so small they are unnoticeable and other attitudes affect a person’s entire way of living.

There are three components that make up an attitude. These are the affective component, behavioral component, and cognitive component (LaPiere, 1934). The affective component involves the person’s emotions toward the object or individual, the behavioral component refers to how the person acts or behaves, and the cognitive component involves the person’s beliefs or thoughts (LaPiere, 1934). It is important to understand how attitudes are formed and what makes up one’s attitude. As a result of being able to understand where attitudes come from, the ability to change one’s attitude can occur.

The two most common attitudes toward individuals who are experiencing mental health issues are empathy and stigma (Batson, Polycarpou, Harmon-Jones, Imhoff, Mitchener, Bednar, Klein, & Highberger 1997; Link et al., 1999; Finlay & Stephen, 2000; Corrigan & Watson, 2002; Vescio, Sechrist & Paolucci, 2003; Vogel, Wade, & Hackler, 2007; Mousa, 2015). Empathy is defined as “the ability to understand the emotional make up of other people and the skill in treating them according to their emotional reactions” (Mousa, 2015, p. 98). Stigma is defined as an indicator or flaw from a personal, physical, or psychological characteristic that is viewed by

society as unacceptable (Blaine, 2000). Empathy, in relation to attitude towards those who are experiencing mental health issues, would be an individual being able to understand and recognize the experiences those who have a mental health issue go through and provide support (Phelan & Basow, 2007). Stigma can be defined as “the perception that an individual who seeks psychological treatment is undesirable or socially unacceptable” (Vogel, Wade, & Haake, 2006, p. 325). Below is a more in-depth look at how empathy and stigma are referred to in the literature regarding mental health issues.

### *Empathy*

Empathy has the ability to connect individuals based on the understanding of a person’s feelings (Rogers, 1967). As a result of being able to understand and sympathize with what others are going through, individuals are able to provide support to those having a difficult time. When interacting with individuals who are experiencing mental health issues, empathy can bridge the gap between those with mental health issues and those who are not experiencing mental health issues (Mousa, 2015). Empathy falls in the same category as benevolence. Benevolence is “a paternalistic, sympathetic view, based on humanistic and religious principles” (Taylor & Dear, 1981, p. 226). This attitude addresses the belief that society should be sympathetic and kind to those who are experiencing mental illness (Thornton & Wahl, 1996). Empathy and benevolence are important attitudes to have toward those who are experiencing mental health issues. As a result of expressing these attitudes towards those who are experiencing a mental health issue, those individuals will feel more supported (Batson et al., 1997; Mousa, 2015). When an individual develops empathy for an individual who is part of a stigmatized group, these attitudes are able to be felt toward the entire stigmatized group (Batson et al., 1997). As a result of

experiencing empathy, those who have been previously stigmatized have the opportunity to be supported.

A study conducted by Mousa (2015) examined the change in empathy toward patients who have mental illness among students earning a nursing degree before and after an educational psychiatric experience. The study included 204 students from Egypt who were enrolled in a psychiatric and mental health nursing course. The study looked at the concept of empathy from two perspectives: basic empathy and trained empathy. Basic empathy was defined as a human trait that cannot be taught but that individuals already to express towards others. Trained empathy individuals could learn through professional practice (Alligood, 1992; Kunyk & Olson, 2001; Felt, 2011; Ouzouni & Nakakis, 2012). Students were in enrolled in a course titled “psychiatric nursing and mental health” that is both theoretical and clinical. Students were surveyed before the course and after based on their previous experience with mental health and their empathy level toward mental health. Based on the results, the study was able to determine that educational experience made a positive contribution in developing and increasing levels of empathy in students. An important note regarding this study is the idea that “developmental empathy is dependent on the students’ increased awareness of themselves” (Mousa, 2015, p. 104).

This study determined that those who went through an educational experience with people who have mental health issues were able to develop empathy. This is an important finding as it suggests that those who are open to learning about and from those who have mental health issues are able to develop empathy. Once empathy is developed, the relationship with the individual with mental health issues can be deepened since a level of understanding can be achieved (Rogers, 1967). An important note about this study is the fact that the students who

were able to develop deeper levels of empathy had a better understanding of their emotional state. It can be concluded that it is important for those working with individuals who have mental health issues to be aware of their own emotional state as this will affect the development of empathy.

Empathy has the ability to impact personal factors such as tolerance. Granello and Granello (2000) conducted a study on college students and their tolerance towards those who had a mental health issue. The study looked at 99 undergraduate students who completed the *Community Attitudes toward the Mentally Ill questionnaire* (CAMI) and a definitions questionnaire surrounding mental health issues. This study determined that when students understood mental health in a broad sense, these students experienced more tolerance toward those with mental health issues. It can be concluded, based on this study, that education surrounding mental health issues can provide tolerance towards this population (Granello & Granello, 2000).

### *Stigma*

Stigma has the ability to influence how individuals interact with students with mental health issues and the environment (Corrigan, 2004). “Negative connotations and false ideas that become connected to mental health identity may be more harm compared to the disease itself” (Corrigan & Watson, 2002, p. 18). Stigma can be separated into two forms: Public stigma and self-stigma.

Public stigma can be defined as “the perception held by others (society) that an individual is socially unacceptable” (Corrigan, 2004, p. 619). Public stigma has the ability to create a more hostile environment for the stigmatized population, in this case students with mental health issues. The public typically gathers these negative viewpoints from stories they may have heard,

portrayals in the media, or through personal interactions. Typically these viewpoints grow from a lack of understanding and education regarding the issues these individuals experience. These public perceptions create environments where individuals who experience mental health issues are not able to participate in activities and engage with others.

Self-stigma can be defined as “the perception an individual has that he or she is socially unacceptable. This impacts self-esteem and self-worth and prevents one from seeking psychological treatment” (Vogel et al., 2006, pg. 325). Students who experience mental health issues may also experience a degree of self-stigma. Self-stigma can be interpreted from the many messages these individuals experience throughout their lifetime. These messages, whether direct or indirect, play a role in how these individuals view themselves. “Social rejection, interpersonal disruption, and fractured identity can be created due to stigma from society” (Feldman & Crandall, 2007, p.140).

People tend to stereotype individuals who are diagnosed with a severe mental illness as those who are unpredictable and possibly dangerous (Overton & Medina, 2008). By having this viewpoint of mental illness, a false idea about those who suffer may be created. This dynamic results in stigma leading to discrimination, which, in turn, causes disadvantage and restricts opportunities. More students will not want to let others know they have a mental health illness, which prevents them from seeking access to resources on campus (Fuller et al., 2004; Cook, 2007; Quinn et al., 2009; Gruttadaro & Crudo, 2012). Also, students with mental health issues may feel ashamed to let others know what they are experiencing, which may hinder their engaging in creating new relationships or engagement with campus organizations. These experiences may also lead students to leave the institution if they do not feel that the institution is a supportive environment (Kessler et al., 1995; Gruttadaro & Crudo, 2012; Salzer, 2012). These

resources could be beneficial to these students and if a positive interaction is had, these students could potentially stay at the institution (Heisserer & Parette, 2002; Myers, 2004; Cleary, Walter, & Jackson, 2011; Byrd & McKinney, 2012).

Cleary et al. (2011) provided information based on various studies that determined that those students who have a mental health concern may experience feelings of fear and shame for accessing mental health services provided by the institutions. Shame and the stigma that comes from having mental health issues prevent students from disclosing to others about their issues and experiences (Link, Cullen, Frank, & Wozniak, 1987). If these experiences are withheld, an environment of fear and shame will continue to exist for those with mental health issues. As a consequence of perceiving the environment as one that is unaccepting of those with mental health issues, these students may believe the institution cannot be trusted and the campus environment is no longer safe (Kessler et al., 1995; Gruttadaro & Crudo, 2012; Salzer, 2012).

A study conducted by Salzer (2012) examined campus experiences and relationships of college students with mental illnesses compared to general student norms. The study looked at whether the experiences may be associated with graduation and what extent engagement is associated with perceived stigma and discrimination. There were 449 participants in this study that stated they experienced mental health issues at over 300 colleges and universities. It is important to note that during this study the majority of respondents were females who were white. The study also took into consideration those who had left the institution and those who remained. The researcher found that college students with mental illnesses had different campus experiences and relationships compared to normed students. The study found that 86% of students with mental illnesses ended up withdrawing from college compared to 45% of general students. The students who left the institution were less satisfied with their college experiences

compared to those individuals who remained. The study also found that stigma and discrimination were factors that affected the campus experiences of students with mental illnesses. This study further supports campus engagement theories and how those who felt supported by the institution and environment remained and completed.

Becker et al. (2002) studied what institutions can do to help students with mental illness achieve their educational goals. In this study, 315 faculty responded to the survey regarding perceptions about mental illness and 1901 students responded to the survey regarding similar issues as the faculty survey. The results of the study indicate that there is a potential for stigmatization or social distancing for students and faculty as demonstrated by the amount that agreed that those who had mental illnesses should not be allowed to attend classes. Faculty and other students who are not experiencing these issues demonstrate signs of treating these individuals differently based on preconceived notions. As a result of this treatment, these students may not feel welcome and will not want to engage with the institution. As a consequence of not being able to engage in the new environment, these students are not able to adapt and transition and may leave the institution. According to the study, “The key to improving the university environment for students with disabilities lies in developing the will, dedicating the resources, finding the most effective way of educating faculty and students, and using resources to develop supported education services that effectively support students with mental illnesses” (Becker et al., 2002, p. 360). This study is an example of public stigma and supports the notion that students who do not experience support will increase their chances of leaving the institution.

When it comes to attitudes, specifically stigma, students experiencing mental health issues tend to experience this intentionally or unintentionally from other students and the

institution. It is important for the institution to look into the campus culture surrounding mental health issues (Peerce, et al., 2007). A look into how those who are working with students directly should be made a priority. If students who are experiencing mental health issues encounter a faculty member or staff member who harbors negative attitudes toward mental health issues, the student will more than likely not engage with the institution. This response creates a situation where the student is not reaching out for resources and support (Peerce, et al., 2007; Gruttadaro & Crudo, 2012). This in turn has the potential to affect the student to the point of them leaving the institution.

As a brief summary on attitudes and stigma it could be stated that it is important for academic advisors to be aware of their attitudes towards students experiencing mental health issues. If an academic advisor harbors negative attitudes towards these students, building a relationship with these students may become impossible. If an academic advisor experiences positive attitudes towards these students, the positive reaction demonstrated when a student discloses their mental health issue will further deepen their relationship (Peerce, et al., 2007).

### Summary

Mental health issues occur in everyday life. All individuals regardless of race, ethnicity, and location have the potential to develop and experience a mental health issue. It is important for higher education to understand the issues students with mental health issues may experience while earning a degree, how the institution is impacted by these students leaving the institution, and how attitudes of those working with these students have an impact on their experiences. As a result of providing this background knowledge regarding the experience of students with mental health issues and what they encounter, institutions are able to understand where changes can be made to effectively engage these students.

## Theoretical Framework

This study utilized the theoretical framework of Relational-Cultural Theory (RCT). This theory was developed by Jean Baker Miller, a psychiatrist, who proposed a new way to interpret human development in the 1970s. Jean Baker Miller and other psychologists (Judith Jordan, Irene Stiver, and Janet Surrey) started meeting informally to reexamine developmental psychology and how it was being utilized in the clinical setting (Jordan et al., 1991). These individuals were able to discuss the importance relationships had for their clients and how lack of relationships impacted their clients' lives. This led to the reexamination of how humans developed based around the formation of relationships (Jordan et al., 1991). The Relational-Cultural Theory was formulated as a way to explain the importance of connections and relationships (Jordan, 2010). Relationships between women were looked at specifically when developing this theory but other gender relationships and cultures were taken into consideration in the formation of this theory (Jordan, 2010). Because of this, the Relational-Cultural Theory has roots in feminist and multicultural counseling (Frey, 2013). The Relational-Cultural Theory is utilized by mental health professionals and other counseling fields because of the foundation of the theory heavily relying on relationship development.

The main premise of the Relational-Cultural Theory (RCT) is the idea that human beings grow through and toward connections with others and if they are unable to have positive connections, disconnections will develop instead (Jordan, 2010; Jordan & Hartling, 2002). Through positive connections with others, individuals will continue to create relationships. When negative connections are experienced, the individual will shun other relationships and if they do seek out relationships these relationships are not authentic and genuine (Jordan, 2010). These positive relationships are used as healing mechanisms and indicators for psychotherapy, mental health, and wellness (Jordan et al., 1991). By being able to create meaningful and mutual

connections with others, the individual will grow and develop a sense of self (Miller & Stiver, 1997). Due to the individual feeling like they are being accepted for aspects they may have deemed as unlovable, a greater acceptance of one's self occurs.

One of the core tenets of RCT is the Central Relational Paradox (CRP). The CRP states that all humans have a natural drive toward relationships and in these relationships we are looking for acceptance (Jordan et al., 1991). If there are aspects about ourselves that we do not think others will like or view as unacceptable, we will hide these pieces from those we would like to make connections with. This creates relationships and connections that are not real and not as validating as they might be if we were true with those individuals (Jordan et al., 1991). These connections or disconnections can occur with anyone, including family. Anyone that an individual would like to develop a mutual relationship with has the potential to experience aspects of the Central Relational Paradox (Jordan, 2010). This tenet also recognizes that these disconnections are inevitable in relationships with others and it is a matter of how an individual responds to these interactions in the relationships. Through exploring and working on these disconnections, deeper relationships can be developed and created.

According to Jordan (2010) there are additional core components of RCT. These components are:

- a) people grow through and toward relationships throughout the life span; b) movement toward mutuality rather than separation characterizes mature functioning; c) relationship differentiation and elaboration characterize growth; d) mutual empathy and mutual empowerment are at the core of growth-fostering relationships; e) authenticity is necessary for real engagement and full participation in growth-fostering relationship; f) in growth-fostering relationships, all people contribute and grow or benefit. Development is

not a one-way street; and g) one of the goals of development from a relational perspective is the development of increased relational competence and capacities over the life span (p. 24).

These core tenets can be applied to the relationship that is developed between the academic advisor and student.

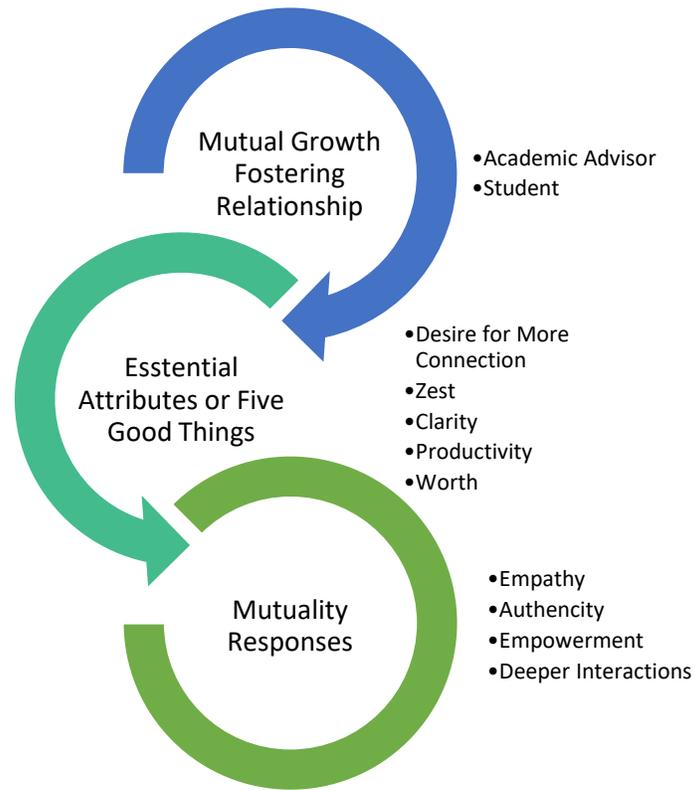
The academic advisor is able to contribute to the development and growth of students throughout their time in college (Hughey, 2011; Kuh, 2008). By creating a collaborative relationship, as described in several academic advising definitions (O'Banion, 1972; Crookston, 1972; Wilson, Enders, & Miller, 1982; American College Testing Program, 1984; Crockett, 1987; Creamer & Creamer, 1994; Chickering, 1994; Frost, 1994, Kuhn, 2008), the academic advisor and student create a partnership based on mutuality and respect. The academic advisor is the expert in development and institutional make-up and the student is the expert on themselves. These individuals are able to develop a relationship that provides support and growth. In order for a relationship to develop, both individuals need to have an authentic relationship with each other. "For advisors to be effective in establishing and maintaining a nonjudgmental relationship for the purpose of meeting the needs of students, they must be able to set an environment for advisees to feel comfortable to share their stories, ask their questions, and engage in self-discovery. It is within this environment that the advisor is able to communicate using the interpersonal skills of advanced reflecting, probing questions, challenging and confronting, and implementing appropriate intervention skills to address change" (Hughey, 2011, p. 24). Both the academic advisor and the student must contribute during the advising interaction in order for a relationship to be built. "Like all social relationships, academic advising involves both participants' expectations and behaviors" (Rawlins & Rawlins, 2005, p. 12). By developing a

collaborative relationship, the academic advisor and student are able to take the skills used in building this relationship and apply these skills to other relationships.

One main goal of RCT is to create and maintain Mutual Growth Fostering Relationships in which both parties feel that they are respected and matter (Jordan et al., 1991). According to Miller (1976), when both parties feel that a growth-fostering relationship is mutual the five essential attributes or the “Five Good Things” define their interaction: 1) a desire to move into more relationships which refers to one growing and developing where they want to continue creating new relationships to continue to grow; 2) a sense of zest which refers to a connection with other individuals where both parties experience an increase energy; 3) increased knowledge of oneself (clarity) which refers to one growing and developing as an individual and creating the ability to be more authentic; 4) a desire to take action (productivity) which refers to when the individual wants to put in practice what they have learned from other relationships; and 5) overall increased sense of worth (worth) which refers to the individual growing and opening up more due to becoming more authentic with others (Jordan et al., 1991; Miller & Stiver, 1997; Jordan, 2010).

Once the Five Good Things occurs, four responses are developed: 1) mutual engagement and empathy which is defined as being committed and involved in the relationship at hand and having the ability to impact and be impacted by the other individual; 2) authenticity which is defined as being able to express one’s feelings and experiences in an open and honest manner; 3) empowerment which is defined as the personal strength that develops from the relationship; and 4) express, receive, and process differences and conflicts (Miller & Stiver, 1997; Liang et al., 2006; Jordan, 2010). When all of these responses occur, a Mutual Growth Fostering Relationship develops.

## Relational Cultural Theory



*Note:* Relational Cultural Theory. Jordan, 2010; Jordan et al., 1991; Miller, 1976; & Miller & Stiver, 1997. Illustration Copyright 2018 by Danielle. N. Aming

*Figure 1.* Relational Cultural Theory

RCT was chosen for this study due to the main focus on creating mutually growth-fostering interactions between individuals. As discussed previously, academic advisors experience more job satisfaction when a student-centered approach is utilized in their interactions with students. Building relationships is also one of the main functions academic advisors experience in their jobs (O'Banion, 1972; Crookston, 1972; Wilson, Enders, & Miller, 1982; American College Testing Program, 1984; Crockett, 1987; Creamer & Creamer, 1994; Chickering, 1994; Frost, 1994, & Kuhn, 2008). Academic advisors have the opportunity to create relationships with students from the time they enter the institution up until the time they leave.

According to Yarbrough (2002), “the brief exchanges between advisor and advisee may have the greatest impact on the student’s sense of self-efficacy in completing his or her degree requirements” (p. 63). Academic advisors provide guidance and the opportunity for students to explore their desires and concerns academically and personally. By giving these students the space to explore their concerns and academic progress, academic advisors are allowing students to develop their sense of self (O’Banion, 1972; Chickering, 1994; PBS Teleconference, 1999; & Ramos, 1999). Academic advisors are also developing professionally and personally by working with and creating relationships with students. One of the core competencies in the academic advising field is relational (NACADA, 2006). This theory was also chosen due it’s utilization in other helping fields such as counseling and supervision (Walsh, Gillespie, Greer, & Eanes, 2003). Due to similar practices being utilized in counseling and academic advising, this theory was deemed applicable for this study.

Students do better when they are engaged in a positive relationship with a member of the institution (Harper & Wilson, 2010; Kuh, 2011; Pearson, 2012). Through a relationship with an academic advisor, students are more likely to thrive in the higher education environment. When a relationship that is mutually beneficial to the student and the academic advisor occurs, both individuals have the opportunity to grow and develop (Crockett, 1987; PBS Teleconference, 1999).

Students experiencing mental health issues may not want to reveal these issues for fear that they will be rejected or be stigmatized (Fuller et al., 2004; Cook, 2007; Quinn et al., 2009; Gruttadaro & Crudo, 2012). If the student has expressed that they are experiencing mental health issues and a staff, faculty or administrator responds in a negative way, this may also stop the student from engaging with other institutional staff members (Becker et al., 2002; Benton &

Benton, 2006). Therefore, it is important that academic advisors are aware of their responses to students who experience mental health issues and RCT provides a conceptual frame to explore both positive and negative interactions in the academic advisor–student relationship, from the perspective of the academic advisor only.

### Summary

As students continue to pursue higher education, there will be students who are experiencing mental health issues (Gruttadaro & Crudo, 2012). Whether or not these students come to institutions with mental health issues or develop a mental health issue while in college, the institution has a responsibility to provide an environment for students to achieve their educational pursuits. “College personnel have the responsibility of giving students the best educational environment possible, which should include the availability of outstanding academic advising and a genuine caring attitude toward the student—inseparable partners in higher education” (Ford & Ford, 2009, p. 62). The academic advisor is one individual that will interact with the student on behalf of the institution. The role of the academic advisor is to build a relationship with the student so that the student can persist at the institution (O’Banion, 1972; Crookston, 1972; Wilson, Enders, & Miller, 1982; American College Testing Program, 1984; Crockett, 1987; Creamer & Creamer, 1994; Chickering, 1994; Frost, 1994, & Kuhn, 2008). If this relationship is unable to be built, both the academic advisor and the student will suffer. One aspect that may impact the relationship between the academic advisor and the student is if the student is experiencing mental health issues (Brockelman et al., 2006). How the academic advisor responds to these students will determine if a relationship with this population of students can be created.

## CHAPTER 3 METHODOLOGY

### Introduction

As discussed in the previous two chapters, students with mental health issues have become a population of students that need institutional focus. Due to academic advisors being an intricate part of the student experience, it is important for academic advisors to be aware of their attitudes toward students with mental health issues. Negative or positive beliefs may have the potential to play a role in how students with mental health issues perceive the institution and its personnel. Depending on what the academic advisor's attitudes are regarding mental health issues, this may impact the ability of the academic advisor to build a relationship with the student, especially those who may be experiencing mental health issues. This study attempted to determine whether there is a relationship between mental health attitudes and academic advisors' characteristics. This study also attempted to determine if there is a relationship between the Five Good Things that make up a relationship and attitudes toward those experiencing mental health issues.

### Research Questions

The following questions were used to direct this study:

1. What is the relationship between academic advisors' characteristics and their attitudes toward mental health issues as measured by the *Community Attitudes toward the Mentally Ill Questionnaire*?
2. What is the relationship between academic advisors' characteristics and the "Five Good Things" as measured by the *Mutual Psychological Development Questionnaire*?

3. What is the relationship between academic advisors' attitudes toward mental health issues as measured by the *Community Attitudes toward the Mentally Ill Questionnaire* and the mutuality of a Growth Fostering Relationships as measured by the *Mutual Psychological Development Questionnaire*?

### Population and Sample

The desired population for this study was academic advisors employed at a major, public, four-year institutions in the Southeast United States of America. Institutions were chosen based on being public, four-year institutions and having an Academic Advising Council. Academic Advising Councils provide a central location for academic advisors to receive updates about the institution, policy changes, and the opportunity to engage in professional development. Based on these criteria, five institutions in the Southeast United States of America were chosen and 482 academic advisors were contacted for this study.

### Study Variables

In this research study, the independent variables were the academic advisors' characteristics which are defined as age, ethnicity, educational level, gender, race, years in advising, professional training for mental health issues, and personal experience with mental health issues and the dependent variables were the *Community Attitudes toward Mental Illness* (CAMI) and the *Mutual Psychological Development Questionnaire* (MPDQ). Academic advisors' characteristics were examined to determine if these variables impact variance in the criterion variables. The CAMI looked at attitudes toward mental health issues in form of four categories: authoritarianism, social restrictiveness, benevolence, and community mental health

ideology. The MPDQ measured if empathy, engagement, authenticity, empowerment, zest, and diversity are occurring in the form of mutuality.

### Research Design

A quantitative research study was conducted to measure academic advisors' attitudes toward students who are experiencing mental health issues and how their responses toward mental health issues may impact their relationship with the student. Creswell (2014) states that quantitative methods should be used when looking for numeric descriptions of different populations. The findings of quantitative studies are more generalizable making them easier to explain specific phenomena.

This study utilized different statistical methods to analyze each research question as follows:

1. RQ1: Correlation for ordinal (educational level) and ratio (age and years in advising) data. Multiple Regression for categorical (ethnicity, gender, age, professional training with mental health issues, and personal experience with mental health issues) data – An analysis regarding academic advisors' characteristics and their attitudes toward mental health issues will be conducted. There are four subscales that make up the attitudes towards those experiencing mental health issues: authoritarianism, social restrictiveness, benevolence, and community mental health ideology. A correlation was used to determine if a relationship exists between the two groups in terms of outcomes (Creswell, 2014). A multiple regression was used to predict the value of a variable based on two or more variables (Creswell, 2014).
2. RQ2: Correlation for ordinal (educational level) and ratio (age and years in advising) data. Multiple Regression for categorical (ethnicity, gender, age, professional training

with mental health issues, and personal experience with mental health issues) data – determine if a relationship exists between academic advisors’ characteristics and the “Five Good Things” also known as mutuality. These Five Good Things are measured using the *Mutual Psychological Development Questionnaire* which determines if mutuality exists in a romantic relationship or friendship. Mutuality is defined as 1) empathy; 2) zest; 3) engagement; 4) authenticity; 5) empowerment; and 6) diversity. A correlation was used to determine if a relationship exists between the two groups in terms of outcomes (Creswell, 2014). A multiple regression was used to predict the value of a variable based on two or more variables (Creswell, 2014).

3. RQ3: Correlation – determine if a relationship exists between academic advisors’ attitudes toward mental health issues as measured by the *Community Attitudes Toward the Mentally Ill Questionnaire* and the mutuality of a Growth Fostering Relationships as measured by the *Mutual Psychological Development Questionnaire*. A correlation was used to determine if a relationship exists between the two groups in terms of outcomes (Creswell, 2014).

Table 3

*Research question statistical analysis*

	Theoretical Framework	Instrument	Statistical Test
RQ1	N/A	Characteristics/ CAMI	Correlation and Multiple Regression
RQ2	RCT	Characteristics/MPDQ	Correlation and Multiple Regression
RQ3	RCT	CAMI/MPDQ	Correlation

### Instrumentation

The survey instrument contained a total of 75 items and questions based on demographic information, plus the *Community Attitudes toward the Mentally Ill* (CAMI) questionnaire (Taylor & Dear, 1981) and the *Mutual Psychological Development Questionnaire* (MPDQ) (Genero, et al. 1992). The CAMI and MPDQ are located in Appendix C. The CAMI was chosen for the purposes of gathering information based on individual's viewpoints of those experiencing mental health issues in the community. The MPDQ was chosen for the purposes of gathering information on the Five Good Things and how these Five Good Things impact the mutuality of a relationship with an individual. The MPDQ was also created as an instrument to utilize from the Relational-Cultural Theory perspective.

The *Community Attitudes toward the Mentally Ill* (CAMI) questionnaire was developed in order to assess stigma and attitudes towards adults with mental illness (Taylor & Dear, 1981). The questionnaire was developed from two instruments: the *Opinions about Mental Illness* (OMI) scale (Cohen & Struening, 1962) and the *Community Mental Health Ideology* (CMHI) scale (Baker & Schulberg, 1967). The CAMI is a 40-item self-report survey that uses a 5-point Likert scale (5 = "strongly agree" to 1 = "strongly disagree"). Each subscale is comprised of 10 questions, 5 scored positively and 5 scored negatively. Scores are reversed on negatively scored items and then the total score for each subscale is calculated. "The scores for each subscale ranges from 10 to 50" (Thorton & Wahl, 1996, p. 23). A mean score is calculated for each of the four subscales. Due to certain subscales (authoritarianism and social restrictiveness) endorsing contradictory beliefs compared to other subscales (benevolence and community mental health ideology, it does not benefit the researcher to create one overall composite score (Taylor & Dear, 1981).

The questionnaire is comprised of four subscales: authoritarianism, social restrictiveness, benevolence, and community mental health ideology. According to Thorton and Wahl (1996), the subscales are defined as:

Authoritarian measures responses towards those needing hospitalization for a mental health illness and the difference between those with mental health issues and those without; Social Restrictiveness measures the responses involving the dangerousness of people with mental health illness, the need to maintain social distance, and lack of responsibility on the part of the mental ill; Benevolence measures responses involving the responsibility of society to those experiencing mental illness, the need for sympathy and a willingness to become personally involved; and Community Mental Health Ideology measures responses involving the therapeutic value of the community. (p.22)

Each subscale provides an understanding of an individual's attitudes surrounding mental health issues. The subscales for the CAMI have the ability to correlate with one another in both positive and negative ways.

An example of authoritarianism on the instrument would be *As soon as a person shows signs of mental disturbance, he or she should be hospitalized* and reversed scored would be *Less emphasis should be placed on protecting the public from the mentally ill*. Higher scores on the authoritarianism subscale endorse more negative attitudes toward individuals with mental health issues (Taylor & Dear, 1981).

An example of social restrictiveness on the instrument would be *I would not want to live next door to someone who has been mentally ill* and a reversed scored example would be *Mental patients should be encouraged to assume the responsibilities of normal life*. Higher scores on the

social restrictiveness subscale endorse negative attitudes toward individuals with mental health issues similar to authoritarianism (Taylor & Dear, 1981).

An example of benevolence on this instrument would be *The mentally ill have for too long been the subject of ridicule* and a reversed scored example would be *Increased spending on mental health services is a waste of tax dollars*. Higher scores on this subscale endorse a more positive view of mental illness (Taylor & Dear, 1981).

An example of the last subscale, community mental health ideology, would be *Locating mental health services in residential neighborhoods does not endanger local residents* and a reversed score example would be *Locating mental health facilities in a residential area downgrades the neighborhoods*. Similar to benevolence, a high score on the community mental health ideology endorses positive attitudes about mental illness (Taylor & Dear, 1981).

The *Mutual Psychological Development Questionnaire* (MPDQ) was developed to assess perceived mutuality in close adult relationships (Genero et al., 1992). The MPDQ instrument is comprised of 22 scale items with ratings on 6-point scale (1 = “never” to 6 = “all the time”). Each of the six dimensions has two positively worded and two negatively worded phrases in the instrument. The individual assesses the relationship from their own perspective as well as the other individual’s perceived perspective, making 22 required total item ratings. The survey is comprised of six conceptual dimensions of mutuality: empathy, engagement, authenticity, zest, diversity, and empowerment (Miller, 1986). According to Miller (1988) the dimensions are defined as the following:

Empathy measures the ability to connect with one another; Engagement measures shared attentiveness, interest, and responsiveness; Authenticity measures the process of understanding each other’s experiences; Zest measures the energy releasing components

of the relationship; Diversity measures the ability to express and work through different feelings; and Empowerment measures the capacity for action. (p.30)

The total ratings are summed together and then divided by the number of items rated to arrive at a mean mutuality score – a higher score indicates a higher level of mutuality is achieved in that relationship (Genero et al., 1992).

For the purpose of the study, the instructions asked the participants to consider a relationship they have with a student instead of a romantic relationship or relationship with a friend. The verbiage change only affected the instructions and not the actual questions. The following verbiage was changed to reflect the relationship the study sought to determine:

- In this section, I would like to explore certain aspects of your relationship with your student. Using the scale below, please tell me your best estimate of how often you and your student experience each of the following:
- When we talk about things that matter to my student, I am likely to
- When we talk about things that matter to me, my student is likely to
- Pick up on my student's feelings

By replacing the word choice in the instructions and questions, this has the potential to change the outcome from how the instrument was originally created.

It is also important to note the broadness of how mental health was utilized in this study. The definition given to participants' to keep in mind while answering questions was the following: "Condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and function each day" (National Alliance on Mental Illness, 2016, p. 1). By utilizing a broad definition, the participants' may have varied examples that came to mind when answering these questions.

Other variables in this study such as personal experience with mental health issues and professional training with mental health issues were not defined in this study. Due to there not being a definition for either variable in this study, participants' were able to define and answer if they felt that had any personal experience with mental health issues and if they had received any professional training for mental health issues.

A brief pilot of this study was conducted with other colleagues in higher education that engage with students. The pilot was conducted in order to obtain feedback on the length, time taken, and clarity of the two questionnaires for this study. According to the participants, the study took five minutes to complete. The survey was adapted based on the feedback received from the participants (e.g. format questions differently in Qualtrics, restructure how the questions look, etc.).

### Reliability and Validity

The authors of the CAMI tested the instrument in regards to the reliability:

Three of the four scales have high reliability: community mental health ideology ( $\alpha = .88$ ), social restrictiveness ( $\alpha = .80$ ) and benevolence ( $\alpha = .76$ ). The coefficient for authoritarianism ( $\alpha = .68$ ), though lower, is still satisfactory. (Taylor & Dear, 1981, p. 236)

To determine reliability, Taylor and Dear (1981) performed a factor analysis and examined the correlations among the factors. "The Cronbach's Alpha coefficient for this 40-item scale was .90 with all items having item-total correlation coefficients ranging from .04 to .66" (Taylor & Dear, 1981, p. 234).

The authors of the MPDQ created the instrument from the perspective of a romantic relationship or a friend. For the purpose of this study, the reliability and validity was used based

on the friend relationship. This baseline was chosen due to aspects of the academic advising relationship being similar to those of a friendship. “Academic advising relationships can incorporate aspects of both types of friendship in emerging and edifying ways” (Rawlins & Rawlins, 2005, p. 10). “The reliability for friend was ( $r = .96$ ) and the Alpha coefficient was .89 for friend, suggesting a high degree of internal consistency among the items” (Genero et al., 1992, p. 40). For purposes of establishing the validity of the MPDQ, the authors also collected measures of “adequacy of social support, relationship satisfaction, cohesion, and depression” (Genero et al., 1992, p.41):

The validity for friend mutuality scores ( $n = 323$ ) correlated with measures of social support ( $r = .24, p < .001$ ), relationship satisfaction ( $r = .60, p < .001$ ), cohesion ( $r = .42, p < .0001$ ), and depression ( $r = .21, p < .001$ )” (Genero et al., 1992, p. 43). “These results were replicated for Form B (.26, .61, .43, and -.19, respectively). (Genero et al., 1992, p. 43)

### Data Collection Plan and Analysis

Prior to contacting academic advisors, approval from the Institutional Review Board (IRB) was obtained. Once obtained, academic advisors at five public, four-year institutions were contacted through their university email addresses. The email contained the link to the research instrument and explained the purpose of the study.

In order to increase participation, Dillman, Smyth, and Christian (2014) identifies several methods to follow. These methods are: providing survey information to the participants, providing contact information should a participant require any assistance, and thanking the participant for their participation. These suggestions were included in the survey. Dillman et al. (2014) also identified establishing trust to increase responses, this was done by obtaining

authorization to use the *Community Attitudes toward Mentally Ill Questionnaire* and the *Mutual Psychological Development Questionnaire*.

Dillman et al. (2014) recommend a timeframe for Internet survey distribution and completion; this study utilized a one-month completion period. Participants received an email notifying them of their selection in the study, provided background information about the study, and a link to the study itself. Two follow up emails were sent as reminders seven and 14 days after the initial contact. A final reminder email was sent one week prior to the closing of the survey. According to Dillman et al. (2014) additional contacts after the initial email interaction can increase response rates.

This study achieved a minimum of a 35% response rate from academic advisors. According to Fincham (2008), nonresponse bias is a deadly blow to the reliability and validity of survey findings. In this instance, if a survey response achieves 35% the nonresponse bias is 65%. Regarding this study's sample, a response of 169 academic advisors is needed.

### Limitations

The sample for this study was limited to academic advisors at five institutions. These five institutions are not representative of all academic advisors throughout higher education. Academic advisors were determined based on the majority of their job consisting of being in an academic advising role. Academic advisors may also not have wanted to participate due to revealing unfavorable responses to the questions asked. Since the survey instrument is one based on self-reporting, it was not possible to ensure accuracy and authenticity of the respondents.

The way in which this study has utilized the Mutual Psychological Developmental Questionnaire was the first time this instrument was used to test this type of relationship.

Previously, this instrument was utilized to determine romantic relationships between individuals (Gennero et al., 1994), relationships between college students (Sanftner, Ryan, & Pierce, 2009), and the relationship between supervisor and supervisee from the supervisee's point of view (Walsh et al., 2003). Due to the way this instrument was utilized in this instrument, the outcomes of this study should be interpreted cautiously.

Another limitation was the broadness of definitions utilized in the study specifically in regards to mental health, personal experience, and professional training. The definition of mental health was extremely broad leaving the interpretation of relationships and how questions should be answered up to the participants. The variables of personal experience and professional training were not defined also leaving the interpretation up to the participants. Due to this, the significance of these findings may not be as impactful since the researcher is unable quantify how the participants responded to the questions.

### Originality Score

The major professor of this researcher requires the submission of dissertations to iThenticate to test for originality. The results were discussed with the members of the dissertation committee on the date of the defense.

### Summary

This dissertation recommended a quantitative study guided by the Relational-Cultural Theory framework. This theoretical framework was chosen to focus on the relationship-building aspect that academic advisors and students experience. The research questions, population and sample, variables, and study design were all described and explained in this chapter. This chapter also outlined the instruments being used, the plan for data collection, and limitations.



## CHAPTER 4 DATA ANALYSIS AND FINDINGS

### Introduction

The purpose of this study was to identify academic advisors' attitudes toward students who are experiencing mental health issues. The study focused the importance of creating mutual growth fostering relationships with advisees. This study further examined whether academic advisors' characteristics such as age, ethnicity, educational level, gender, race, years in advising, professional training for mental health issues, and personal experience with mental health issues affect these attitudes. The attitudes toward mental health issues were measured by the *Community Attitudes toward the Mentally Ill* instrument. The importance of a mutual growth fostering relationship was measured by *Mutual Psychological Development Questionnaire* that has roots in the Relational Cultural Theory.

The *Community Attitudes toward the Mentally Ill* instrument utilized 40 questions. These questions represented four subscales: authoritarianism, social restrictiveness, benevolence, and community mental health ideology. Two subscales endorsed positive attitudes toward mental illness and the other two endorsed negative or punitive attitudes toward mental illness. Each subscale contained 10 questions with five requiring reverse scoring. A 5-point Likert scale was utilized ranging from Strongly Agree – 5, Agree – 4, Neutral -3, Disagree – 2, and Strongly Disagree – 1. The inverse applied to the reverse scoring: Strongly Agree – 1, Agree – 2, Neutral - 3, Disagree – 4, and Strongly Disagree – 5. Each subscale produced a totaled score and a mean score. The total score ranged from 10 to 50. A higher score on the negative subscales (authoritarianism and social restrictiveness) represented a more negative attitude toward mental health and a higher score on the positive subscales (benevolence and community mental health ideology) represented a more positive attitude toward mental health.

In order to measure if mutuality exists in a relationship, academic advisors were presented with 22 questions from the *Mutual Psychological Development Questionnaire*. There were six concepts that made up the concept of mutuality: empathy, engagement, authenticity, empowerment, zest, and diversity. The items were measured on a 6-point Likert scale that ranged from Never – 1, Rarely – 2, Occasionally – 3, More Often Than Not – 4, Most of the Time – 5, and All of the Time – 6. The items were totaled and then divided by the number of items scored to calculate a mean mutuality score. The higher the score, the higher mutuality is valued in the specific relationship – in this case, relationships between the academic advisor and a student.

In this chapter, the research methodology used to conduct the study is defined. This includes response rate, demographic data of the participants, missing data, and the results of the statistical tests conducted to answer the three research questions. All data were analyzed using SPSS version 24.0 at the  $\alpha = .05$  level of significance. A more in-depth discussion surrounding these results can be found in Chapter 5.

#### Review of Methodology and Response Rate

The study's survey instrument consisted of three parts: a demographic portion, the *Community Attitudes toward the Mentally Ill* instrument, and the *Mutual Psychological Development Questionnaire*. The survey consisted of 75 total items. Due to the length of the instrument, a pilot test was sent to five professional staff who were not included in the sample population. The reason for this pilot test was to determine how long it would take professional staff to complete the survey. It was determined that the survey took 5-10 minutes, which was included in the email communication.

The survey instrument was distributed through email to the selected population of 482 academic advisors at five targeted institutions. Dillman et al.'s (2014) recommended procedures

for email distribution outlined in Chapter 3 were followed. The selected institutions were chosen due to the existence of an Academic Advising Council. These councils provide a standard way for academic advisors to receive information about university changes and professional development.

The researcher emailed the first contact letter (Appendix A) to the participants on May 7, 2018. Six of the original emails were bounced and not delivered. The researcher did not attempt to obtain correct email addresses for these six academic advisors, therefore, they did not receive any additional contact. All other emails to academic advisors were delivered successfully. The second contact email (Appendix A) was sent seven days later on May 14, 2018 to all participants who had not completed the survey. The third contact (Appendix A) was sent on May 21, 2018 to all participants who had not completed the survey. The fourth and final contact (Appendix A) was sent on May 28, 2018 to all participants who had not completed the survey. The survey was closed at midnight on June 4, 2018.

The minimum response rate agreed upon during the defense of the study's proposal was 35%. Out of 482 individuals contacted, 183 responded. This represents a response rate of 38%. There were 50 participants who did not answer all questions in regards to the *Community Attitudes toward the Mentally Ill* instrument or the *Mutual Psychological Development Questionnaire*. Those respondents were removed from all data analysis.

### *Missing Data*

According to Schafer and Graham (2002), missing data is an inevitable part of conducting research and it is important to acknowledge missing data. Schafer and Graham (2002) discussed three concepts for missing data: missing at random (MAR), data missing completely at random (MCAR), and data missing not at random (MNAR). MAR data refers to

items not being understood by the respondent so they are unable to answer these questions. MCAR data refers to items not having any relationship to why they are missing. The researcher in this instance is unable to conclude as to why these items were missing since a pattern cannot be established. MNAR data refers to items that are related to other variables in the study.

During this study, 19 respondents missed one or two questions throughout the entire survey. These individuals likely fall under the MAR concept based on the fact that all other questions were completed. Besides these missing questions, the survey was completed in its entirety. This leads the researcher to believe that the questions that were skipped may have been due to lacking the scope of what the question was asking, not having that experience before, or not being comfortable answering those specific questions.

The other 31 individuals fell into one of two categories: only completed the demographic portion or completed only one of the instruments – either the *Community Attitudes toward the Mentally Ill* or the *Mutual Psychological Development Questionnaire*. These individuals would fall under MCAR because not completing the survey may have had nothing to do with any variables. MNAR may likely be present but since the missing data from this group was evenly distributed it is less likely that these individuals fell into the MCAR component. Missing data in this study can be categorized as mostly MCAR; data missing completely at random. Since the data were considered MCAR, deletion of data was acceptable (Schafer & Graham, 2002).

#### *Additional Question*

This study defines mental health as a “condition that affects a person’s thinking, feeling or mood”. Such conditions may affect someone’s ability to relate to others and function each day. The following question was asked to participants regarding the definition of mental health issues: “Based on the above definition have you ever encountered a student experiencing a

mental health issue?" All participants with the exception of one responded yes (99.2%). The one participant did not respond to this question nor any of the demographic questions (0.8%).

### Demographics

The researcher included demographic questions in the survey to accurately describe the population and also as an independent variable for this study.

*Table 4*  
*Study population by gender, age, ethnicity, race, educational level and years in advising*

Characteristic	<i>f</i>	%
<b>Gender</b>		
Male	35	26.3
Female	97	72.9
<b>Age</b>		
23-26	14	10.7
27-30	23	17.4
31-34	23	17.4
35-38	16	12.2
39-42	9	6.9
43-46	14	10.6
47-50	10	7.6
50-56	8	6.1
57-61	4	3.2
62-67	6	4.6
<b>Hispanic or Latino</b>		
Yes	20	15.0
No	112	84.2
<b>Educational Level</b>		
Bachelor's Degree	19	14.3
Master's Degree	100	75.2
Doctoral Degree	13	9.8
<b>Race</b>		
American Indian or Alaska Native	1	0.8
Asian	6	6.0
Black or African American	16	12.0
Native American or Pacific Islander	1	0.8
White	98	73.7

Characteristic	<i>f</i>	%
Prefer Not to Say	3	2.3
American Indian or Alaska Native/White	1	0.8
Asian/White	2	1.5
Years in Advising		
0-1.5	15	11.3
2-3.5	26	19.6
4-5.5	21	15.8
6-8	25	19.7
9-11.5	13	9.8
12-15	9	6.9
16-19	13	9.9
20-24	7	5.4
Professional Training		
Yes	69	51.9
No	63	47.3
Personal Experience		
Yes	132	99.2
No	0	0

The majority of participants were White (73.7%), Non-Hispanic (84.2%), and female (72.9%). The average age of participants was 37.65 years old. The overwhelming majority of participants held a Master's Degree (75.2%). The average years in advising for all participants was 7.4 years. A large majority of participants have had a personal experience with mental health issues (95.5%). The demographic characteristics for age, gender, ethnicity, race, educational level, years in advising, professional training with mental health issues, and personal experience with mental health issues are presented in Table 4.

A majority of the participants were female (72.9%) compared to male (26.3%), with one participant (0.8%) choosing not to respond to this question. A summary of the gender distribution can be found in Table 4.

The average age for participants was 37.65 years. Ages ranged from 23 to 67 years in this study. Not all years between the range were represented: 53, 54, 55, 59, 64, 65, and 67. Six participants (4.5%) chose to not respond to this question. Participants had the option to type in age for this study. A summary of the age distribution can be found in Table 4.

Regarding ethnicity, an overwhelming majority of participants responded that they were Non-Hispanic (84.2%) compared to Hispanic (15%), with one participant (0.8%) who chose not to respond to this question. A summary of the ethnicity distribution can be found in Table 4.

A majority number of participants reported having a Master's degree (75.2%) compared to a Bachelor's Degree (14.3%) or a Doctoral Degree (9.8%), with one participant (0.8%) who chose not to respond to this question. A summary of the educational level and ethnicity distribution can be found in Table 4.

The majority of participants responded that they were White (73.7%) compared to American Indian or Alaska Native (0.8%), Asian (6%), Black or African American (12%), Native American or Pacific Islander (0.8%), Prefer Not to Say (2.3%), American Indian or Alaska Native/White (0.8%), and Asian/White (1.5%). Three participants (2.3%) chose not to respond to this question. A summary of the race distribution between participants can be found in Table 4.

The average years in the academic advising field was 7.4 years. Years in advising ranged from 0 to 24. Not all years were reported in this study: 22. One participant (0.8%) chose not to respond to this question. Participants had the option to type in the years in advising for this study. A summary of the years in advising distribution between participants can be found in Table 4.

There was almost an even split regarding participants who have had professional training with mental health issues (51.9%) compared to those who do not have professional training with mental health issues (47.3%). One participant (0.8%) chose not to respond to this question. A summary of the years in advising distribution between participants can be found in Table 4.

An overwhelming majority of participants indicated that they had a personal experience with mental health issues (99.2%). One participant (0.8%) chose not to respond to this question. A summary of the years in advising distribution between participants can be found in Table 4.

### Analysis of Research Questions

The following subheadings include an analysis of the results as they pertain to the *Community Attitudes toward the Mentally Ill* instrument and the *Mutual Psychological Development Questionnaire* instruments.

#### *Community Attitudes toward the Mentally Ill*

##### Authoritarianism

To measure authoritarianism, participants were asked to indicate to what level they strongly agreed with an item or strongly disagreed with an item. There were 10 items throughout the survey to represent authoritarianism. Higher scores on this subscale indicated negative attitudes toward the mentally ill.

*Table 5*  
*Authoritarianism*

Factor	n	Items	Items Reversed Scored	Cronbach Alpha	Mean	Variance	Std. Deviation
Authoritarianism	133	a, i, q, y, gg	e, m, u, cc, kk	0.691	20.29	20.87	4.57

The reliability of this study met acceptable criteria with a Chronbach's Alpha score of 0.691. The mean score measured for participants was 20.29 demonstrating a low score on this subscale. This indicates a more positive attitude toward the mentally ill from these participants. The variance score measured for participants was 20.87. The standard deviation score measured for participants was 4.57. This indicates that most of the numbers were close to the average. The results of tests frequency are represented in Table 5 and Figure 2.

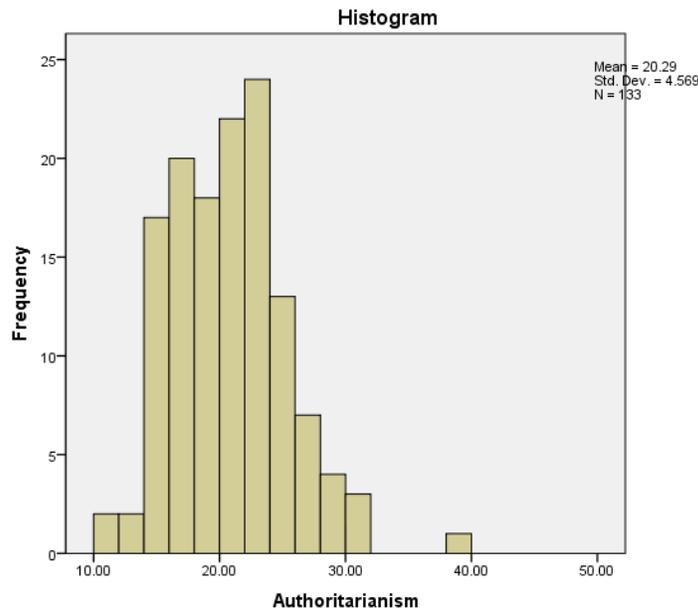


Figure 2. Authoritarianism Responses

The following statements represent the pro- response that participants answered for the subscale of authoritarianism: *As soon as a person shows signs of mental health disturbance, he/she should be hospitalized, There is something about the mentally ill that makes it easy to tell them from normal people, Mental patients need the same kind of control and discipline as a*

*young child, The best way to handle the mentally ill is to keep them behind locked doors, and One of the main causes of mental illness is a lack of self-discipline and will power.*

*The following statements represent the anti- response that participants answered for the subscale of authoritarianism: Mental illness is an illness like any other, Less emphasis should be placed on protecting the public from the mentally ill, The mentally ill should not be treated as outcasts of society, Mental hospitals are an outdated means of treating the mentally ill, and Virtually anyone can become mentally ill.*

Based on the participants surveyed, for the statement, *There is something about the mentally ill that makes it easy to tell them from normal people*, zero participants chose “Strongly Agree”. For the following statements: *As soon as a person shows signs of mental health disturbance, he/she should be hospitalized, The mentally ill should not be treated as outcasts, The best way to handle the mentally ill is to keep them behind locked doors, One of the main causes of mental illness is a lack of self-discipline and will power, and Virtually anyone can become mentally ill*, the participants’ answers were skewed either toward the positive end or negative end. For the other statements: *Mental illness is an illness like any other, Less emphasis should be placed on protecting the public from the mentally ill, Mental patients need the same kind of control and discipline as a young child, and Mental hospitals are an outdated means of treating the mentally ill*, the participants’ were more evenly distributed between the options. The results of the participants’ answers are represented in Appendix D.

### Social Restrictiveness

To measure social restrictiveness, participants were asked to indicate to what level they strongly agreed with an item or strongly disagreed with an item. There were 10 items throughout

the survey to represent social restrictiveness. Higher scores on this subscale indicated negative attitudes toward the mentally ill.

*Table 6*  
*Social Restrictiveness*

Factor	n	Items	Items Reversed Scored	Cronbach Alpha	Mean	Variance	Std. Deviation
Social Restrictiveness	133	c, k, s, aa, ii	g, o, w, ee, mm	0.757	20.59	21.94	4.68

The reliability of this study met acceptable criteria with a Chronbach’s Alpha score of 0.757. The mean score measured for participants was 20.59, demonstrating a low score on this subscale. This indicates a more positive attitude toward the mentally ill. The variance was 21.94. The standard deviation was 4.68. This indicates that most of the numbers were close to the average. The results of tests frequency are represented in Table 6 and Figure 3.

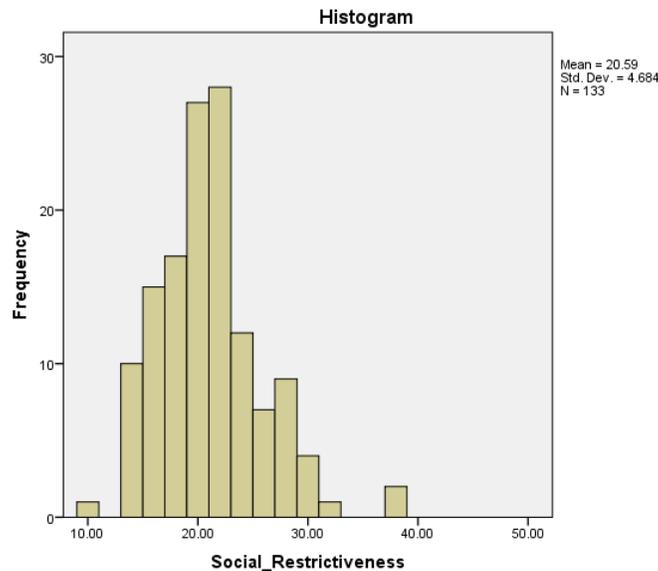


Figure 3. *Social Restrictiveness Responses*

The following statements demonstrate the pro- response that participants answered for the subscale of social restrictiveness: *The mentally ill should be isolated from the rest of the community, A person would be foolish to marry someone who has suffered from mental illness, even though he or she seems fully recovered, I would not want to live next door to someone who has been mentally ill, Anyone with a history of mental problems should be excluded from taking public office, and The mentally ill should not be given any responsibility.*

The following statements demonstrate anti- response that participants answered for the subscale of social restrictiveness: *The mentally ill are far less of a danger than most people suppose, No one has the right to exclude the mentally ill from their neighbourhood, Mental patients should be encouraged to assume the responsibilities of normal life, The mentally ill should not be denied their individual rights, and Most people who were once patients in a mental hospital can be trusted as babysitters.*

*Based on the participants surveyed, for this statement, The mentally ill should be isolated from the rest of the community, zero participants chose “Strongly Agree” or “Agree”. For the following statements: A person would be foolish to marry someone who has suffered from mental illness, even though he or she seems fully recovered, No one has the right to exclude the mentally ill from their neighbourhood, I would not want to live next door to someone who has been mentally ill, Mental patients should be encouraged to assume the responsibilities of normal life, Anyone with a history of mental problems should be excluded from taking public office, The mentally ill should not be denied their individual rights, and The mentally ill should not be given any responsibility, the participants’ answers were skewed either toward the positive end or negative end. The following statement: Most people who were once patients in a mental hospital*

can be trusted as babysitters, participants' answers were skewed toward the middle. *The following statement:* The mentally ill are far less of a danger than most people suppose, participants' answers were evenly distributed. The results of the participants' answers are represented in Appendix E.

Benevolence

To measure benevolence, participants were asked to indicate to what level they strongly agreed with an item or strongly disagreed with an item. There were 10 items throughout the survey to represent benevolence. Higher scores on this subscale indicated positive attitudes toward the mentally ill.

*Table 7  
Benevolence*

Factor	n	Items	Items Reversed Scored	Cronbach Alpha	Mean	Variance	Std. Deviation
Benevolence	133	b, j, r, z, hh	f, n, v, dd, ll	0.863	42.31	29.34	5.42

The reliability of this study met acceptable criteria with a Chronbach's Alpha score of 0.863. The mean score measured for participants was 42.31 demonstrating a high score on this subscale. This indicates a more positive attitude toward the mentally ill from these participants. The variance score measured for participants was 29.34. The standard deviation score measured for participants was 5.42. This indicates that most of the numbers were close to the average. The results of tests frequency are represented in Table 7 and Figure 4.

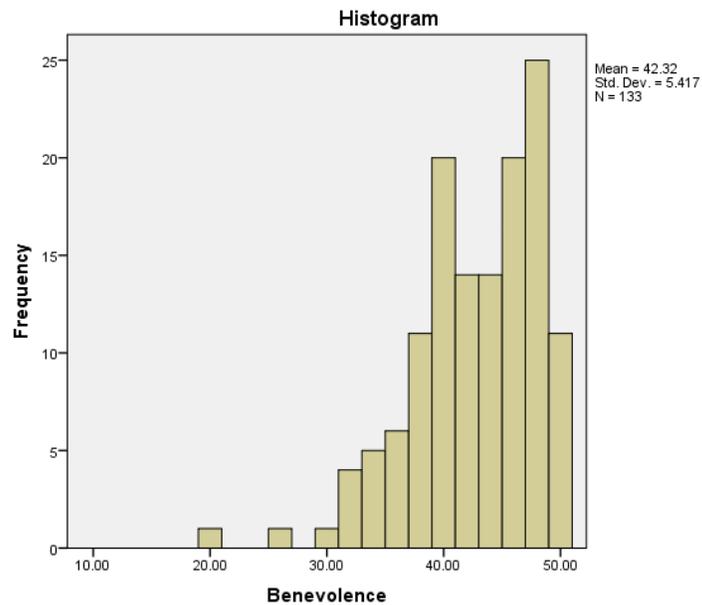


Figure 4. Benevolence Responses

The following statements demonstrate pro response- that participants answered for the subscale of benevolence: *More tax money should be spent on the care and treatment of the mentally ill, The mentally ill have for too long been the subject of ridicule, We need to adopt a far more tolerant attitude toward the mentally ill, Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for, and We have the responsibility to provide the best possible care for the mentally ill.*

The following statements demonstrate the anti- response that participants answered for the subscale of benevolence: *The mentally ill are a burden on society, Increased spending on mental health services is a waste of tax dollars, There are sufficient existing services for the mentally ill, The mentally ill do not deserve our sympathy, and It is best to avoid anyone who has mental problems.*

Based on the participants surveyed, for the statement, *Our mental hospitals seem more like prisons where the mentally ill can be cared for*, zero participants chose “Strongly Disagree”. For the following statements: *More tax money should be spent on the care and treatment of the mentally ill, The mentally ill are a burden on society, The mentally ill have for too long been the subject of ridicule, Increased spending on mental health services is a waste of tax dollars, We need to adopt a far more tolerant attitude toward the mentally ill in our society, There are sufficient existing services for the mentally ill, The mentally ill do not deserve our sympathy, We have the responsibility to provide the best possible care for the mentally ill, and It is best to avoid anyone who has mental problems*, the participants’ answers all skewed toward the positive end or negative end. The results of the participants’ answers are represented in Appendix F.

Community Mental Health Ideology

To measure community mental health ideology, participants were asked to indicate to what level they strongly agreed with an item or strongly disagreed with an item. There were 10 items throughout the survey to represent community mental health ideology. Higher scores on this subscale indicated positive attitudes toward the mentally ill.

*Table 8  
Community Mental Health Ideology*

Factor	n	Items	Items Reversed Scored	Cronbach Alpha	Mean	Variance	Std. Deviation
Community Mental Health Ideology	133	d, l, t, bb, jj	h, p, x, ff, nn	0.871	37.09	32.05	5.66

The reliability of this study met acceptable criteria with a Chronbach’s Alpha score of 0.871. The mean score measured for participants was 37.09, demonstrating an above average

score on this subscale. This indicates a more positive attitude toward the mentally ill from the participants. The variance score measured for participants was 32.05. The standard deviation score measured for participants was 5.66. This indicates that most of the numbers were close to the average. The results of tests frequency are represented in Table 8 and Figure 5.

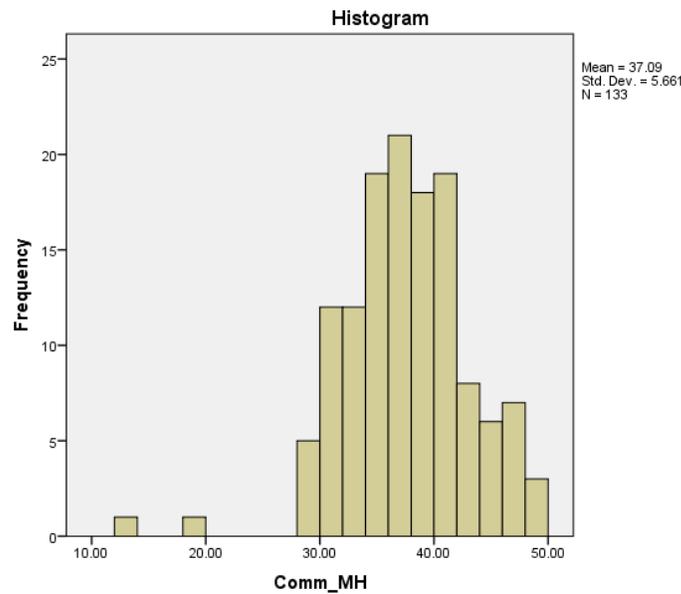


Figure 5. Community Mental Health Ideology Responses

The following statements demonstrate the pro- response that participants answered for the subscale of community mental health ideology: *The best therapy for many mental patients is to be part of a normal community, As far as possible mental health services should be provided through community-based facilities, Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community, Locating mental health services in residential neighbourhoods does not endanger local residents, and Residents*

*have nothing to fear from people coming into their neighbourhood to obtain mental health services.*

The following statements demonstrate the anti- response that participants answered for the subscale of community mental health ideology: *Locating mental health facilities in a residential area downgrades the neighbourhood, Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great, Local residents have good reason to resist the location of mental health services in their neighbourhood, Mental health facilities should be kept out of residential neighbourhoods, and It is frightening to think of people with mental problems living in residential neighbourhoods.*

Based on the participants surveyed, for this statement, *The best therapy for many mental patients is to be part of a normal community*, zero participants chose “Strongly Disagree”. For the following statements: *As far as possible mental health services should be provided through community-based facilities, Local residents have good reason to resist the location of mental health services in their neighbourhoods, and It is frightening to think of people with mental problems living in residential neighbourhoods*, the participants’ answers skewed toward the positive end or negative end. For the following statements: *Locating mental health facilities in a residential area downgrades the neighbourhood, Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great, Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community, Locating mental health services in residential neighbourhoods does not endanger local residents, Mental health facilities should be kept out of residential neighbourhoods, and Residents have nothing to fear from people coming into their*

neighbourhood to obtain mental health services, the participants' answers were distributed toward the middle. The results of the participants' answers are represented in Appendix G.

*Mutual Psychological Development Questionnaire*

Mutuality

To measure mutuality, participants were asked to indicate what level of interaction they experienced with students and how they perceived students felt about a relationship with them. These levels were measured from 'never' to 'all the time' for each item. There were 11 items rating the relationship from the participants' viewpoint and 11 items rating the perceived relationship the student had with the participant. Empathy, engagement, authenticity, empowerment, zest, and diversity contribute to the definition of mutuality defined in this study. Higher scores on this test indicate a mutuality or a growth fostering relationship.

*Table 9  
Mutuality*

Factor	<i>n</i>	Items	Cronbach Alpha	Mean	Variance	Std. Deviation
Responses about Students	133	1-11		3.50	0.066	0.258
Responses about Advisors	133	1-11		3.32	0.138	0.371
Mutuality	133	1-11; 1-11	0.661	3.41	0.077	0.278

The reliability of this study met acceptable criteria with a Chronbach's Alpha score of 0.661. The mean score measured for participants was 3.41 demonstrating an above average score on this subscale. This indicates a degree of perceived mutuality. The variance score measured for participants was 0.077. The standard deviation score measured for participants was 0.278. This indicates that most of the numbers were close to the average. The results of tests frequency are represented in Table 9 and Figure 6.

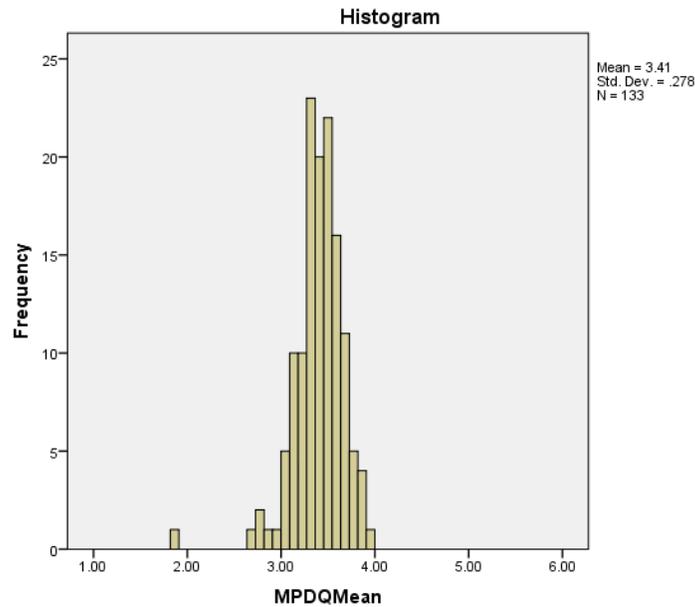


Figure 6. Mutuality Responses

The participants responded to statements based on how they respond when interacting with a student: *When we talk about things that matter to my student, I am likely to*. Eleven statements were asked regarding how participants responded to what they are likely to do when interacting with a student: *Be receptive, Get impatient, Try to understand, Get bored, Feel moved, Avoid being honest, Be open-minded, Get discouraged, Get involved, Have difficulty listening, and Feel energized by our conversation*.

The participants also responded to statements based on how they perceived students would respond when interacting with them: *When we talk about things that matter to me, my student is likely to*. Eleven statements were asked regarding how the participants perceived students responded to them during an academic advising appointment: *Pick up on my feelings, Feel like we're not getting anywhere, Show an interest, Get frustrated, Share similar*

*experiences, Keep feelings inside, Respect my point of view, Change the subject, See the humor in things, Feel down, and Express an opinion clearly.*

The participants had no responses for the following statements and items: *Be receptive* “Never” and “Rarely”, *Get impatient* “More Often Than Not” “Most of the Time” and “All the Time”, *Try to understand* “Never” “Rarely” and “Occasionally”, *Get bored* “Most of the Time” and “All of the Time”, *Feel moved* “Never”, *Avoid being honest* “More Often Than Not” “Most of the Time” “All the Time”, *Be open-minded* “Never” “Rarely” “Occasionally”, *Get discouraged* “Most of the Time” and “All the Time”, *Have difficulty listening* “More Often Than Not” “Most of the Time” and “All the Time”, *Feel energized by our conversation* “Never”, *Feel like we are not getting anywhere* “More Often Than Not” “Most of the Time” and “All the Time”, *Get frustrated* “More Often Than Not” and “All the Time”, *Keep feelings inside* “More Often Than Not” “Most of the Time” and “All the Time”, *Respect my point of view* “Rarely”, *Change the subject* “More Often Than Not” and “Most of the Time”, and *Feel down* “All the Time”.

For the following statements: *Get Involved, Pick up on my feelings, Share similar experiences, See the humor in things, and Express an opinion clearly*, the participants’ answers were distributed between all available options. The results of the participants’ answers are represented in Appendix H.

### *Research Question 1*

The first research question explored was “What is the relationship between academic advisors’ characteristics and their attitudes toward mental health issues as measured by the *Community Attitudes toward the Mentally Ill Questionnaire*?” To respond to this question, the participants’ characteristics of age, ethnicity, educational level, gender, race, and years in

advising were analyzed with the subscales of the *Community Attitudes toward the Mentally Ill* instrument. A correlation analysis was utilized to determine if a relationship existed between age, educational level, years in advising, and the subscales. A multiple regression analysis was utilized to determine if a relationship existed between ethnicity, gender, race, professional training for mental health issues, personal experience with mental health issues, and the subscales.

*Table 10*  
*Correlation – Age, Educational Level, and Years in Advising*

Factor	Characteristic	<i>n</i>	Pearson Correlation	Sig (2 tailed)
Authoritarianism	Age	127	.131	.143
	Educational Level	132	.099	.260
	Years in Advising	132	.050	.570
Social Restrictiveness	Age	127	.118	.188
	Educational Level	132	.013	.887
	Years in Advising	132	.053	.545
Benevolence	Age	127	-.150	.093
	Educational Level	132	-.043	.626
	Years in Advising	132	-.034	.698
Community Mental Health Ideology	Age	127	-.208	.019
	Educational Level	132	.035	.693
	Years in Advising	132	-.111	.207

A Pearson correlation was calculated to determine the relationship between age and authoritarianism. There was not a statistically significant correlation between age and authoritarianism ( $r = .120, n = 127, p = .179$ ). A Pearson correlation was run to determine the relationship between educational level and authoritarianism. There was not a statistically significant correlation between educational level and authoritarianism ( $r = .100, n = 132, p = .253$ ). A Pearson correlation was run to determine the relationship between years in advising and

authoritarianism. There was not a statistically significant correlation between years in advising and authoritarianism ( $r = .052, n = 132, p = .556$ ). A description of the results can be found in Table 10.

A Pearson correlation was run to determine the relationship between age and social restrictiveness. There was not a statistically significant correlation between age and social restrictiveness ( $r = .120, n = 127, p = .178$ ). A Pearson correlation was run to determine the relationship between educational level and social restrictiveness. There was no correlation between educational level and social restrictiveness, which means there was no statistical significance ( $r = .014, n = 132, p = .869$ ). A Pearson correlation was run to determine the relationship between years in advising and social restrictiveness. There was no correlation between years in advising and social restrictiveness, which means there was no statistical significance ( $r = .083, n = 132, p = .345$ ). A description of the results can be found in Table 10.

A Pearson correlation was run to determine the relationship between age and benevolence. There was not a statistically significant correlation between age and benevolence ( $r = -.149, n = 127, p = .094$ ). A Pearson correlation was run to determine the relationship between educational level and benevolence. There was no correlation between educational level, which means there was no statistical significance ( $r = -.045, n = 132, p = .606$ ). A Pearson correlation was run to determine the relationship between years in advising and benevolence. There was no correlation between years in advising and benevolence, which means there was no statistical significance ( $r = -.034, n = 132, p = .695$ ). A description of the results can be found in Table 10.

A Pearson correlation was run to determine the relationship between age and community mental health ideology. There was a negative correlation between age and community mental health ideology, which means there was statistical significance ( $r = -.224, n = 127, p = .011$ ). A

Pearson correlation was run to determine the relationship between educational level and community mental health ideology. There was no correlation between educational level and community mental health ideology, which means there was no statistical significance ( $r = .037, n = 132, p = .675$ ). A Pearson correlation was run to determine the relationship between years in advising and community mental health ideology. There was no correlation between years in advising and community mental health ideology, which means there was no statistical significance ( $r = -.122, n = 132, p = .165$ ). A description of the results can be found in Table 10.

*Table 11*  
*Multiple Regression – Gender, Ethnicity, and Race*

Factor	Characteristic	<i>n</i>	Pearson Correlation	$\beta$	Sig (2 tailed)
Authoritarianism	Regression	129	2.40		.071
	Gender	129		-.171	.064
	Ethnicity	129		.050	.060
	Race	129		-.080	.030
Social Restrictiveness	Regression	129	1.39		.249
	Gender	129		-.056	.533
	Ethnicity	129		.006	.960
	Race	129		-.073	.045
Benevolence	Regression	129	.550		.694
	Gender	129		.060	.594
	Ethnicity	129		-.097	.493
	Race	129		.045	.322
Community Mental Health Ideology	Regression	129	.302		.824
	Gender	129		-.006	.963
	Ethnicity	129		-.100	.514
	Race	129		.031	.533

A multiple regression was carried out to determine if race, ethnicity, and gender could significantly predict participants' authoritarianism. The results of the regression indicated that the regression explained 5.4% of the variance and that the regression was not a predictor of

participants' authoritarianism,  $F(3, 126) = 2.40, p = .071$ . Gender ( $\beta = -.171, p = .064$ ) and ethnicity ( $\beta = .050, p = .060$ ) did not contribute to the regression; however, race did contribute to the interaction effect of the regression ( $\beta = -.080, p < .05$ ). A description of the results can be found in Table 11.

A multiple regression was carried out to determine if race, ethnicity, and gender could significantly predict participants' social restrictiveness. The results of the regression indicated that the regression explained 3.2% of the variance and that the regression was not a predictor of participants' social restrictiveness  $F(3, 126) = 1.39, p = .249$ . Gender ( $\beta = -.056, p = .533$ ) and ethnicity ( $\beta = .006, p = .960$ ) did not contribute to the regression; however, race did contribute to the interaction effect of the regression ( $\beta = -.073, p < .05$ ). A description of the results can be found in Table 11.

A multiple regression was carried out to determine if race, ethnicity, and gender could significantly predict participants' benevolence. The results of the regression indicated that the regression explained 1.3% of the variance and that the regression was not a predictor of participants' benevolence  $F(3, 126) = .550, p = .649$ . Gender ( $\beta = .060, p = .549$ ), ethnicity ( $\beta = -.097, p = .493$ ), and race ( $\beta = .045, p = .322$ ), did not contribute to the regression. A description of the results can be found in Table 11.

A multiple regression was carried out to determine if race, ethnicity, and gender could significantly predict participants' community mental health ideology. The results of the regression indicated that the regression explained 0.7% of the variance and that the regression was not a predictor of participants' community mental health ideology  $F(3, 126) = .302, p = .824$ . Gender ( $\beta = -.006, p = .963$ ), ethnicity ( $\beta = -.100, p = .514$ ), and race ( $\beta = .031, p = .533$ ), did not contribute to the regression. A description of the results can be found in Table 11.

Table 12  
Multiple Regression – Professional Training and Personal Experience

Factor	Characteristic	N	Pearson Correlation	$\beta$	Sig (2 tailed)
Authoritarianism	Regression	131	1.26		.288
	Professional Training	131		.126	.115
	Personal Experience	131		-.012	.956
Social Restrictiveness	Regression	131	2.46		.249
	Professional Training	131		.169	.030
	Personal Experience	131		.038	.852
Benevolence	Regression	131	.687		.505
	Professional Training	131		-.113	.244
	Personal Experience	131		.004	.988
Community Mental Health Ideology	Regression	131	.851		.430
	Professional Training	131		-.134	.197
	Personal Experience	131		.051	.850

A multiple regression was carried out to determine if professional training and personal experience could significantly predict participants' authoritarianism. The results of the regression indicated that the regression explained 1.9% of the variance and that the regression was not a predictor of participants' authoritarianism  $F(2, 129) = 1.26, p = .29$ . Professional training ( $\beta = .126, p = .115$ ) and personal experience ( $\beta = -.012, p = .956$ ) did not contribute to the regression. A description of the results can be found in Table 12.

A multiple regression was carried out to determine if professional training and personal experience could significantly predict participants' social restrictiveness. The results of the regression indicated that the regression explained 3.7% of the variance and that the regression was not a predictor of participants' social restrictiveness  $F(2, 129) = 2.46, p = .090$ . Personal experience ( $\beta = .038, p = .852$ ) did not contribute to the regression; however, professional

training did contribute to the interaction effect of the regression ( $\beta = .169$ ,  $p < .05$ ). A description of the results can be found in Table 12.

A multiple regression was carried out to determine if professional training and personal experience could significantly predict participants' benevolence. The results of the regression indicated that the regression explained 1.1% of the variance and that the regression was not a predictor of participants' benevolence  $F(2, 129) = .687$ ,  $p = .505$ . Professional training ( $\beta = -.113$ ,  $p = .244$ ) and personal experience ( $\beta = .004$ ,  $p = .988$ ) did not contribute to the regression. A description of the results can be found in Table 12.

A multiple regression was carried out to determine if professional training and personal experience could significantly predict participants' community mental health ideology. The results of the regression indicated that the regression explained 1.3% of the variance and that the regression was not a predictor of participants' community mental health ideology  $F(2, 129) = .851$ ,  $p = .430$ . Professional training ( $\beta = -.134$ ,  $p = .197$ ) and personal experience ( $\beta = .051$ ,  $p = .850$ ) did not contribute to the regression. A description of the results can be found in Table 12.

### *Research Question 2*

The second research question explored was "What is the relationship between academic advisors' characteristics and the "Five Good Things" as measured by the *Mutual Psychological Development Questionnaire*?" To respond to this question, the academic advisors' characteristics of age, ethnicity, educational level, gender, race, and years in advising were analyzed against the mutuality outcome from the *Mutual Psychological Development Questionnaire*. A correlation was utilized to determine if a relationship existed between age and mutuality, educational level and mutuality, and years in advising and mutuality. A multiple regression was utilized to determine if a relationship existed between ethnicity and mutuality, gender and mutuality, race

and mutuality, professional training for mental health issues and mutuality, and personal experience with mental health issues and mutuality.

*Table 13  
Correlation – Age, Educational Level, and Years in Advising*

Factor	Characteristic	<i>n</i>	Pearson Correlation	Sig (2 tailed)
Mutuality	Age	127	.108	.226
	Educational Level	132	.056	.526
	Years in Advising	132	.006	.946

A Pearson correlation was run to determine the relationship between age and mutuality. There was no correlation between age and mutuality, which means there was no statistical significance ( $r = .108, n = 127, p = .226$ ). A Pearson correlation was run to determine the relationship between educational level and mutuality. There was no correlation between education level and mutuality, which means there was no statistical significance ( $r = .056, n = 132, p = .526$ ). A Pearson correlation was run to determine the relationship between years in advising and mutuality. There was no correlation between years in advising and mutuality, which means there was no statistical significance ( $r = .006, n = 132, p = .946$ ). A description of the results can be found in Table 13.

*Table 14  
Multiple Regression – Gender, Ethnicity, and Race*

Factor	Characteristic	<i>n</i>	Pearson Correlation	$\beta$	Sig (2 tailed)
Mutuality	Regression	129	.188		.904
	Gender	129		-.043	.456
	Ethnicity	129		.000	.997
	Race	129		-.005	.824

A multiple regression was carried out to determine if race, ethnicity, and gender could significantly predict participants' mutuality. The results of the regression indicated that the regression explained 0.4% of the variance and that the regression was not a predictor of participants' mutuality  $F(3, 126) = .188, p = .904$ . Gender ( $\beta = -.043, p = .456$ ), ethnicity ( $\beta = .000, p = .997$ ), and race ( $\beta = -.005, p = .824$ ), did not contribute to the regression. A description of the results can be found in Table 14.

*Table 15*  
*Multiple Regression – Professional Training and Personal Experience*

Factor	Characteristic	N	Pearson Correlation	$\beta$	Sig (2 tailed)
Mutuality	Regression	131	8.121		.000
	Professional Training	131		-.045	.332
	Personal Experience	131		-.467	.000

A multiple regression was carried out to determine if professional training and personal experience could significantly predict participants' mutuality. The results of the regression indicated that the regression explained 11.2% of the variance and that the regression was statistically significant  $F(2, 129) = 8.121, p < .05$ . Professional training ( $\beta = -.045, p = .332$ ) did not contribute to the regression but personal experience ( $\beta = -.467, p < .05$ ) significantly contributed to the interaction effect of the regression. A description of the results can be found in Table 15.

### *Research Question 3*

The third research question explored was “What is the relationship between academic advisors' attitudes toward mental health issues as measured by the *Community Attitudes toward the Mentally Ill* Questionnaire and the mutuality of a Growth Fostering Relationships as measured by the *Mutual Psychological Development Questionnaire*?” To respond to this

question, the four subscales from the *Community Attitudes toward the Mentally Ill* Questionnaire were analyzed against and the mutuality score from the *Mutual Psychological Development Questionnaire*. A correlation was utilized to determine if a relationship existed between authoritarianism and mutuality, benevolence and mutuality, social restrictiveness and mutuality, and community mental health ideology and mutuality.

*Table 16*  
*Correlation – Authoritarianism, Social Restrictiveness, Benevolence, and Community Mental Health Ideology*

Factor	Characteristic	<i>n</i>	Pearson Correlation	Sig (2 tailed)
CAMI and MPDQ	Authoritarianism	133	.071	.420
	Social Restrictiveness	133	.012	.892
	Benevolence	133	.025	.777
	Community Mental Health Ideology	133	-.036	.684

A Pearson correlation was run to determine the relationship between authoritarianism and mutuality. There was not a statistically significant correlation between authoritarianism and mutuality ( $r = .065, n = 133, p = .459$ ).

A Pearson correlation was run to determine the relationship between benevolence and mutuality. There was not a statistically significant correlation between benevolence and mutuality ( $r = .026, n = 133, p = .768$ ).

A Pearson correlation was run to determine the relationship between social restrictiveness and mutuality. There was not a statistically significant correlation between social restrictiveness and mutuality ( $r = .008, n = 133, p = .930$ ).

A Pearson correlation was run to determine the relationship between community mental health ideology and mutuality. There was not a statistically significant correlation between community mental health ideology and mutuality ( $r = -.027, n = 133, p = .756$ ). A description of the results can be found in Table 16.

### Summary

This chapter detailed the research methodology and demographic data for the participants including response rates along with the results of the statistical tests conducted on participants' authoritarianism, benevolence, social restrictiveness, community mental health ideology, and perceived mutuality. To evaluate the general attitudes of academic advisors' towards mental health and their perceived mutuality regarding relationships with students, the responses were analyzed generally and also accounted for several demographic variables correlations and multiple regressions. To evaluate the relationship between age, educational level, and years in advising and the four subscales, correlations were calculated. To evaluate the relationship between ethnicity, gender, race, professional training for mental health issues and personal training for mental health issues and the four subscales, a multiple regression was calculated. To evaluate the relationship between age, educational level, and years in advising and mutuality, correlations were calculated. To evaluate the relationship between ethnicity, gender, race, professional training for mental health issues and personal training with mental health issues and mutuality, a multiple regression was calculated. To evaluate the relationship the four subscales

and mutuality a correlation was calculated. The discussion, recommendations, and conclusions based on these analyses are provided in Chapter 5.

## CHAPTER 5 DISCUSSION, RECOMMENDATIONS, & CONCLUSIONS

### Introduction

The purpose of this study was to add to the literature surrounding academic advisors' attitudes toward students experiencing mental health issues. Previous studies have been conducted regarding attitudes toward students with mental health issues that are expressed by faculty and staff (Fuller et al., 2004; Brockelman et al., 2006; Quinn et al., 2009; Salzer, 2012) few have focused on academic advisors. More so, research has not yet been conducted on the relationship between the student and the academic advisor. The research completed in this study will hopefully contribute to more successful methods for academic advisors working with students experiencing mental health issues.

This chapter discusses the results of the data analysis and findings of the research questions. The results of this study will be extrapolated to its implications for practice and policy, as well as the limitations and delimitations of the study. While the findings provided limited statistical significance, opportunities generated for future research will be discussed. This chapter closes with concluding remarks.

### Discussion

The subheadings that follow include a discussion regarding the Relational Cultural Theory (Miller, 1976) and how it impacted the study and findings. Also discussed were the outcomes of this study and how this supported or did not support the literature currently in the field. This section also examined the results from Chapter 4 and how each research question was impacted.

### *Relational Cultural Theory*

The incorporation of the Relational Cultural Theory (Miller, 1976) provided the framework to explore the relationship between academic advisors and how they interact with their students. This theory focuses on the importance of creating relationships with another individual. Within the theory, personal growth occurs by creating positive relationships and working through negative interactions (Miller, 1976; Jordan, 2010). This theory also posits that in order for mutuality to be accomplished between two individuals, five essential attributes or the “Five Good Things” must be present. Those attributes are: 1) develop new relationships; 2) zest; 3) clarity; 4) productivity; and 5) sense of worth (Jordan et al., 1991; Miller & Stiver, 1997; Jordan, 2010).

In order to determine if mutuality existed between two individuals, *the Mutual Psychological Development Questionnaire* (Genero et al., 1992) was developed. The instrument asks participants to answer questions based on how they view a friend or romantic partner. It then asks the participant questions based on how they believe their friend or romantic partner views them. For this study, the relationship between an academic advisor and an advisee represented a friendship. This was due in part to the relationship that develops between an academic advisor and student having similar traits as that of a friendship.

Relational Cultural Theory has not previously been utilized when examining attitudes toward those experiencing mental health issues. This theory has been utilized in the counseling field, specifically when discussing how to build a relationship between a counselor and a client or a supervisor and a supervisee (Walsh et al., 2003). This theory was selected due to counseling and academic advising having similar attributes in the form of developing goals and discussing previous experiences and how that may impact the individual currently (Kuhn et al., 2006).

The Relational Cultural Theory provided the researcher the opportunity to consider the relationships that are developed between academic advisor and student. Since one of the main responsibilities of an academic advisor is to develop a relationship with a student (Bloom et al., 2008), this framework was deemed appropriate for the study. The reliability of the instrument used will be discussed further.

### *Literature Review*

The literature review focused on the role of the academic advisor, the impact of mental health on students, the ability of attitudes to influence viewpoints on mental health. The results of the study supported portions of literature, but was in contrast with other findings.

One result that supported the literature was that students are attending the institution with mental health issues. Virtually all advisors indicated that they had encountered a student with mental health issues. This result supports the research that a large number of students either enter college with a mental health issue or develop one while in attendance (Kessler et al., 1995; Kitzrow, 2003; Glass, 2010). It is important to note that this outcome was based on the definition utilized by this study. This study defined mental health in the following manner: “Condition that affects a person’s thinking, feeling or mood. Such conditions may affect someone’s ability to relate to others and function each day” (National Alliance on Mental Illness, 2016, p. 1). Due to a broad definition being utilized to define mental health in this study, this particular outcome should be interpreted cautiously. Even though this question was not included in any of the statistical analyses, it was important to measure how many academic advisors encounter students who are experiencing mental health issues. This information also begins to address the gap in the literature concerning academic advisors and the students they encounter in their advising sessions.

The results also showed that academic advisors generally perceive their relationships with students as mutual. Mutuality for this study was defined as the “Ability to grow toward an individual with an emphasis on developing empathy, engagement, authenticity, empowerment, zest, and diversity” (Jordan, 2010, p. 50). By indicating an above average score on mutuality in the perceived student-advisor relationship, this demonstrates academic advisors place importance on learning and growing along with their students (Winston & Sandor, 1984; Kelley & Lynch, 1991; Love & Tinto, 1995; Schnell, 1998; Shapiro & Levine, 1999; Gallagher & Allen, 2000; Zhao & Kuh, 2004). Several of the previous definitions for academic advising include creating or building a relationship (O’Banion, 1972; Crookston, 1972; Wilson, Enders, & Miller, 1982; American College Testing Program, 1984; Crockett, 1987; Creamer & Creamer, 1994; Chickering, 1994; Frost, 1994, Kuhn, 2008). This result supports the literature regarding the importance of fostering a mutual relationship between students and academic advisors.

The main result that was in contrast with the literature was the impact of attitudes towards mental health on a relationship. The literature suggests that a positive or negative attitude towards mental health impacts the ability to form relationships with those who are experiencing mental health issues (Corrigan, 2004; Mousa, 2015). This was not the case for this study. This study determined that attitudes toward mental health issues defined by the *Community Attitudes toward the Mentally Ill* instrument did not impact the relationships between academic advisors and the student. This was determined by the interaction between the results from the *Community Attitudes toward the Mentally Ill* instrument and the *Mutual Psychological Development Questionnaire*. As discussed in Chapter 3, this is the first time the Mutual Psychological Development Questionnaire was utilized to determine the perceived relationship

between the academic advisor and the students that are served. It would be important to reexamine other ways to determine the relationship between academic advisors and students. Another gap that still exists in the literature is how the attitudes of academic advisors impact the collegiate experience of students experiencing mental health issues. The relationship between the academic advisor and student is one type of interaction these individuals will experience. The academic advisor may have the opportunity to be an advisee's mentor or professor, and could engage the student in other ways (Kuhn et al., 2006). This particular study examined the perceived mutuality of the academic advisor's relationship with the student. There remains a gap in the literature concerning how attitudes towards students experiencing mental health issues affects their collegiate experience.

#### *Research Question 1*

The first research question explored was "What is the relationship between academic advisors' characteristics and their attitudes toward mental health issues as measured by the *Community Attitudes toward the Mentally Ill* Questionnaire?" This relationship was examined through four subscales that demonstrated an individual's attitude toward the mentally ill: authoritarianism, social restrictiveness, benevolence, and community mental health ideology. Several academic advisor characteristics such as age, ethnicity, educational level, gender, race, years in advising, professional training for mental health issues, and personal experience with mental health issues were also considered. The results demonstrated that certain characteristics (age, race, and professional training) have the potential to impact the relationship with several subscales.

The following discussion explores the statistical findings for each subscale and the impacts of the academic advisors' characteristics.

### Authoritarianism

Authoritarianism represents the concept that mentally ill individuals must be cared for by others and treated as subservient (Taylor & Dear, 1981). The higher an individual scored on this scale the more likely they are to hold these attitudes toward the mentally ill. The mean for the participants in this study was 20.29 which denotes a trend toward disagreeing with the concept. There were no statistically significant correlations between authoritarianism and age, educational level, and years in advising. Additionally, a multiple regression revealed there was no predictive relationship between authoritarianism and professional training on mental health issues or personal experience with mental health issues. A multiple regression also revealed there was also no predictive relationship between authoritarianism and gender, ethnicity, and race; however, race did contribute to the interaction effect of the regression. This indicated that race had the potential to play a role in the interaction with the variables of gender and ethnicity and authoritarianism if the interaction was statistically significant. The sample size being too small to definitively indicate what the impact of race in this regression would have been.

### Social Restrictiveness

Social restrictiveness refers to the attitude that people with a mental illness should not have certain roles in society, such as holding a public office (Taylor & Dear, 1981). The mean for the participants in this study was 20.59 which denotes a trend toward disagreeing with the attitude. There were no statistically significant correlations between social restrictiveness and age, educational level, and years in advising. Additionally, a multiple regression revealed there was no predictive relationship between social restrictiveness and professional training on mental health issues or personal experience with mental health issues; however, professional training did contribute to the interaction effect of the regression. This indicated that professional training had

the potential to play a role in the interaction with the variables of personal experience with mental health training and professional training and social restrictiveness if the interaction was statistically significant. A multiple regression also revealed there was no predictive relationship between social restrictiveness and gender and ethnicity; however, race did contribute to the interaction effect of the regression. This indicated that race had the potential to play a role in the interaction with the variables of gender and ethnicity and social restrictiveness if the interaction was statistically significant.

This also indicated that race played a role in the interaction with the variables of gender and ethnicity and social restrictiveness, however, the sample size was too small to definitively indicate the impact of race in this regression. This also applied to professional training. There was an indication that professional training impacted the interaction between personal experience and social restrictiveness; however, the sample size was too small to definitively indicate the impact of professional training in this regression.

### Benevolence

Benevolence refers to a more sympathetic view of those experiencing mental illness typically from a religious and humanistic perspective (Taylor & Dear, 1981). There were no statistically significant relationships between benevolence and any of the academic advisors' characteristics. The mean for participants on this subscale was 42.31 indicating that participants were shown to have a more sympathetic viewpoint of those who are mentally ill. This may be due to participants choosing answers that are considered more socially acceptable or may have to do with the overwhelming majority of participants indicating that they have had personal experiences with mental health issues. According to Addison and Thorpe (2004) "those with

personal knowledge of someone with a mental illness are more likely to be positive in their attitudes” (p. 233).

### Community Mental Health Ideology

Community mental health ideology refers to the notion that mental health treatment should be more readily available to those in the community, not in psychiatric hospitals (Taylor & Dear, 1981). The mean for participants on this subscale was 37.09 indicating that participants had more non-committal viewpoints regarding this subscale. There were no statistically significant correlations between community mental health ideology and educational level, and years in advising. There was a statistically significant correlation between community mental health ideology and age. Additionally, a multiple regression revealed there was no predictive relationship between community mental health ideology and professional training on mental health issues or personal experience with mental health issues. A multiple regression also revealed there was also no predictive relationship between community mental health ideology and gender, ethnicity, and race.

There was a slightly statistically significant negative correlation between age and community mental health ideology, indicating that as age increases, positive attitudes towards community mental health decreases. This finding is similar to those that have indicated age impacts attitudes toward mental health issues (Martin, Pescosolido, & Tuch, 2000; Kazantzis, Wakefield, Deane, Ronan, & Johnson, 2009).

### *Research Question 2*

The second research question explored was “What is the relationship between academic advisors’ characteristics and the “Five Good Things” as measured by the *Mutual Psychological Development Questionnaire*?” The relationship was examined through perceived mutuality of

relationships and several academic advisor characteristics such as age, ethnicity, educational level, gender, race, years in advising, professional training for mental health issues, and personal experience with mental health issues. The results demonstrated that personal experience has an impact on perceived mutuality of the relationship between an academic advisor and a student. Some respondents may have had more than one experience with students who have had mental health issues. These experiences may have impacted how the respondents answered these questions.

### Mutuality

Mutuality was defined by the presence of six characteristics: empathy, engagement, authenticity, empowerment, zest, and diversity. The higher the mean score, the more likely the participant viewed their relationship as having mutual benefits. The mean for participants was 3.41 out of a 6-point Likert scale. This indicates that the participants were above average regarding if their relationship with students had a level of mutuality. There were no statistically significant correlations between mutuality and age, educational level, and years in advising. A multiple regression also revealed there was also no predictive relationship between mutuality and gender, ethnicity, and race. There was statistical significance when a multiple regression was also conducted for professional training for mental health issues and personal experience with mental health issues and mutuality. In this regression, personal experience was a statistically significant predictor of mutuality whereas professional training was not. Personal experience had a negative impact on the regression. This indicated that as participants' personal experience with mental health increased their mutuality in the relationship with the student decreased. This finding does not support other findings that demonstrate personal experience with mental health

issues leads to more empathy and a willingness to have relationships with these individuals (Rogers, 1967; Read & Harre, 2001; Mousa, 2015).

### *Research Question 3*

The third research question explored was “What is the relationship between academic advisors’ attitudes toward mental health issues as measured by the *Community Attitudes toward the Mentally Ill* Questionnaire and the mutuality of Growth Fostering Relationships as measured by the *Mutual Psychological Development Questionnaire*?” The researcher sought to answer if mental health attitudes (based on the four subscales from the CAMI) impact the perceived mutuality between academic advisors and students. There was no statistical significance found for this interaction. This implies that attitudes toward mental health issues defined by the CAMI do not impact the perceived mutuality between academic advisors and students.

#### Community Attitudes toward the Mentally Ill

The *Community Attitudes toward the Mentally Ill* provided a frame of reference to measure the attitudes of those regarding mental health issues and the impacts this has on the community. Although this instrument was created during the 1970s, several articles (Cotton, 2004; Cashwell & Smith, 2011) and dissertations (Lowder, 2007; Browne, 2010; Locke, 2010) have successfully utilized it in recent times, demonstrating the importance and impact the instrument still holds today. Reliability was achieved for all subscales ranging from .69 to .87 which was similar to the original reliabilities (.69 to .88).

#### Mutual Psychological Development Questionnaire

The *Mutual Psychological Development Questionnaire* provided a frame of reference to measure academic advisors’ perceived mutuality regarding relationships with students. This is the first time this instrument has been utilized with this scope. Previously, this instrument has

been utilized to measure friendships of college students (Sanftner, Ryan, & Pierce, 2009) and mentoring relationships between supervisor and supervisee (Walsh et al., 2003).

This questionnaire is rooted in the Relational Cultural Theory, which focuses on developing a mutual growth fostering relationship. While the theory is appropriate to apply to academic advisors and the relationships they build with students, the instrument itself may not have been an appropriate fit. Based on the questions being asked and how they were being framed (*Pick up on my feelings, Respect my point of view*), it may have been difficult for academic advisors to answer questions.

### *Summary of Statistics*

The majority of the statistical methods used in this study did not produce statistically significant findings. This may be due to the limited sample size and response rate received for this study. It is important to note the 50 participants removed from this study. As mentioned previously, due to incomplete responses, these participants were eliminated from the final dataset. This impacted the amount of viable data available for the researcher to utilize within the study.

Additionally, a social desirability bias test should have been included regarding both instruments. Those in a helping profession may lean more towards choosing a socially acceptable response as opposed to one that represents their actual beliefs. Krumpal (2011) found that survey participants who are employed in helping professions are more likely to answer surveys with socially acceptable answers and not accurately reflect their actual beliefs.

It is also important to note that for this study certain characteristics were not defined by the researcher. Variables such as personal experience with mental health issues and professional training received for mental health were not defined in this study. These variables were left up to

the participant to define and determine if they had any personal experience with mental health issues and if they had received any professional training for mental health. This leaves a wide interpretation of how individuals will answer each question. Due to the wide interpretation of each participant's experience, these outcomes should be interpreted cautiously.

### Implications and Recommendations

The following section discusses implications and recommendations for administrators and how this study's findings can impact the university community. Additionally, the section addresses further education and training academic advisors on mental health issues and how this may impact their relationships with students.

#### *Guidance for Administrators*

The results of the study show that attitudes toward mental health issues do not impact the perceived mutuality of relationship built between academic advisors and students. While this may be the overarching takeaway from this study, it is important to acknowledge factors that have the potential to impact attitudes toward mental illness.

Regarding administration, it is important to acknowledge that professional training, impacted the predictive regression regarding negative attitudes towards those with mental illness. By providing professional training for mental health issues, administrators have the ability to change advisors' viewpoints regarding those who have mental health issues.

Previous studies have demonstrated that providing professional training has changed how individuals view mental health and those who are experiencing mental health issues (Addison & Thorpe, 2004). By incorporating training for academic advisors and other professional staff, it may be possible to change how mental health issues are viewed throughout the university.

### *Guidance for Academic Advisors*

The results of this study provided helpful information for academic advisors. According to several academic advising frameworks, academic advisors should grow and develop like the students they advise (Crockett, 1987; Bloom et al., 2008). The participants in this study indicated that their mutuality in these relationships was above average. Academic advisors may not view their role as one that develops and grows as they interact with students. They may view this more from gaining professional development and attending conferences compared to daily interactions with students. It is important that academic advisors view working with students as a way of developing and growing as a professional (Bloom et al., 2008).

Personal experience with mental health issues impacted the perceived mutuality an academic advisor had with a student. This finding demonstrated that it is important for individuals to be aware of their personal experience with mental health issues as this has the potential to impact a relationship negatively. Academic advisors must be aware of what their experiences with mental health issues are so that these experiences do not impact the ability to build a relationship with a student. It is also important for academic advisors to receive training on working with students experiencing mental health issues. Training has the ability to impact the perception one has regarding individuals who are experiencing mental health issues and has the ability to allow individuals to become more empathetic toward this population (Alligood, 1992; Kunyk & Olson, 2001; Felt, 2011; Ouzouni & Nakakis, 2012).

### *Guidance for the Profession*

The profession of academic advising has created standards and competencies to guide advisors throughout their daily interactions with students. Since students with mental health issues will continue to attend institutions, and academic advisors will encounter these students,

(Drake, 2013; Peerce et al., 2007), the profession needs to provide more concrete standards and competencies on how to prepare professionals for working with these students. Even though there is no defined or enforced requirements for academic advisors to continue education, in order for academic advisors to become masters of their profession, professional development is needed (Grites, Miller, & Voller, 2016). These professional development opportunities can be provided in a plethora of avenues such as workshops throughout the year and individualized or specialized training (Habley, 2004).

The competencies could be based on the core competencies NACADA has established with a focus on mental health training. These competencies are informational, relational, and conceptual. By creating a training program based around the core competencies NACADA has established, the profession can continue to further develop these previously developed competencies. By adding a new layer to these competencies, the profession will demonstrate growth and adaption to new issues that impact academic advisors. Because of the correlation with students experiencing mental health issues and the likelihood that academic advisors will encounter these students, academic advisors need to be better prepared and developing training around these competencies can help with this preparation.

The profession will also need to begin to adapt advising frameworks to accommodate mental health as a diversity issue. By incorporating this topic along with other diversity areas, the discussion of mental health issues has the ability to become more common place within academic advising (Magolda & Magolda, 2011). This, in turn, will better prepare academic advisors for their relationship with students who suffer from mental health issues.

### Limitations

The limitations of this research study include the following:

1. Due to the self-reporting nature of the survey instrument, it was not possible to ensure authenticity of the respondents.
2. There have been no previous studies using Relational Cultural Theory to examine attitudes towards students experiencing mental health issues.
3. The first time the Mutual Psychological Development Questionnaire was utilized in this format.
4. Academic advisors may have been inclined to choose the answer that they consider to be more socially acceptable as opposed to reflecting how they actually view individuals with mental health.
5. Academic advisors may not have answered the questions regarding perceived mutuality based on their relationship with a student who is experiencing mental health issues.
6. Academic advisors who are part of an Academic Advising Council may have had more professional development or interactions with students with mental health issues.

### Delimitations

The delimitations of this research study include the following:

1. This study was limited to institutions that all had an Academic Advising Council. Advisors who participate in an Academic Advising Council may receive additional training for working with students who have mental health issues.
2. Surveying only five institutions does not provide the ability to extrapolate the results beyond institutions that have an Academic Advising Council.
3. The study used a single theoretical framework.

4. The study combined two instruments which included closed-ended Likert scale items as opposed to open-ended questions.

### Recommendations for Future Research

Based on the limitations and delimitations of this study, the researcher makes several recommendations. Some of the most statistically significant findings were based on attitudes toward mental health issues and certain population variables, specifically race and age. It would be prudent to increase the sample size to determine specifically how race and age impact attitudes toward mental health issues. Professional training was also shown to be important regarding impacts on attitudes toward mental health issues. For a profession that focuses on professional development (NACADA, 2007), it would be important to include those institutions that have professional development for mental health issues.

Future research should also focus on quantifying certain variables such as personal experience with mental health issues and professional training in mental health. These two variables were left open to interpretation by the participant. Due to this there is the potential for a wide range of how each person defined personal experience and professional training. Personal experience could have been anything from a family member or close friend to their own experiences and these experiences could have produced a positive or negative experience. Professional training could have ranged from obtaining a degree in the field of mental health counseling to taking a class on mental health warning signs to reading a paper on mental health issues. By quantifying these variables in the future, more research can be determined to see how impactful these experiences are on the relationship between an individual and someone experiencing mental health issues.

This study also examined the importance of a mutual growth fostering relationship between an academic advisor and student. The instrument was not formed with consideration for this population and it may be beneficial to create an altered instrument for helping professions. There are academic advising frameworks that support the importance of growing with the student (Crockett, 1987; Bloom et al., 2008). This supports the idea of developing an instrument that captures these aspects for professionals. This study also focused on the benefits received by both individuals in a relationship of mutuality. A future focus could be on other aspects in which that the academic advisor and student may engage, such as mentoring, instructing, university engagement, and other roles (Kuhn et al., 2006). Another focus in reference to developing an instrument could be on the closeness between the student and the academic advisor or how much empathy the academic advisor has for a student experiencing mental health issues.

The theoretical framework for this study focused on the mutuality in relationships. Even though this concept aligns with many academic advising frameworks, this limited the instruments available for use in this study. Future studies should explore other frameworks that focus on relationships such as the Mentoring Model Theory (Johnson, 1999). By focusing on relationships instead of the mutuality of a relationship, the impact of attitudes toward mental health issues may be significantly different. Another focus of this study was on how attitudes potentially impact a relationship. Attitude theories such as the Affective Cognitive Consistency Theory (Rosenberg, 1956) or Cognitive Dissonance Theory (Festinger, 1957) may also be an additional framework to utilize for this study. Future studies can utilize these frameworks to study mental health attitudes and how these attitudes impact the relationship between academic advisor and student.

Due to the smaller sample size, inferences can be made based on statistical significance, but it is difficult to determine the true impact. Also, by considering differences between variables as opposed to the relationships between variables, there would be greater options for statistical analysis. The statistical tests for relationships focus mostly on correlations and regressions, while the statistical tests for differences include t-tests, analysis of variance, and other statistical measures that may provide a different perspective.

An additional perspective to take into consideration for future research studies would be the students' own perceptions of mental health issues they are experiencing. Based on the literature students have a difficult time disclosing that they are experiencing a mental health issue out of fear of how individuals may respond (Fuller et al., 2004; Cook, 2007; Quinn et al., 2009; Gruttadaro & Crudo, 2012). This may be due to the public stigma they are experiencing from others or their own self stigma. It would be important to learn in the future how a students' self-stigma impacts the relationship with an academic advisor from the student's perspective. This perspective was not looked at in this study and may be a variable to pursue in future research.

Along with students' own perceptions of mental health issues and how this may impact the relationship with the academic advisor is the importance of looking at how students view the academic advisor and that relationship. According to a study by Smith & Allen (2006) students viewed the following advising functions important to students: information, integration of various parts of the curriculum with academic, career and life goals, individualization, shared responsibility, and referral. The student populations that sought these functions were students who required more financial assistance, African American, Asian, and other multicultural students, as well as new students. Future research regarding this study would be to determine if these factors were also important to students experiencing mental health issues.

Finally, this study was about academic advisors' attitudes toward students experiencing mental health issues. Due to this study being a quantitative study, there was no opportunity to determine what types of professional training or what types of personal experiences with mental health issues each advisor had. By utilizing a qualitative study or mixed methods study, this will provide a richer picture of the individual academic advisor and their individual relationships with students.

### Conclusions

The topic of mental health issues among students is a topic that is evolving and impacting institutions. Throughout multiple higher education conferences, topics regarding mental health have become more prominent. With news outlets and the media bringing attention to students attending colleges with mental health issues, institutions are expected to formulate a response on how they are helping these students. One important aspect is to determine how individuals helping students, such as academic advisors, respond to those who have mental health issues. The attitude an academic advisor has regarding mental health issues, has the ability to impact the formulation of a relationship. Since colleges are being asked to respond and provide a safe environment for students with mental health issues, professional staff interacting with these students will need to be included in these plans.

The purpose of this study was to determine if there is a relationship between academic advisors' characteristics and their attitudes toward mental health issues. A focus on attitudes specifically was chosen since depending on if the attitude is positive or negative, this will have the ability to impact how an individual relates to someone else (Corrigan & Penn, 1999; Penny et al., 2000; Wahl et al., 2002; Cotton, 2004; Watson et al., 2004; Song, Chang, Shih, Lin, & Yang, 2005). This study also considered the relationship an academic advisor builds with a student.

Based on academic advising frameworks such as Appreciative Advising and Development Advising, building a positive relationship with a student not only impacts the student, but also provides the opportunity for the academic advisor to grow as a professional (Bloom et al., 2008). To determine if mutuality was achieved from the academic advisor's point of view, the following aspects were tested: empathy, engagement, authenticity, empowerment, zest, and diversity (Genero et al., 1992). These aspects represent mutuality, according to the Relational Cultural Theory (Miller 1986; Jordan, 2000).

The results revealed that attitudes toward mental health issues do not impact the perceived mutuality between the academic advisors and the student. The study found that race, age, and professional training impact attitudes toward the mentally ill. Personal experience with mental health issues also impacted the perceived mutuality between academic advisors and students.

Recommendations included professional training for academic advisors and professional staff on mental health issues. By providing training to those who interact with students, the university is fostering a campus-friendly environment for those who have mental health issues.

This study adds to the literature surrounding attitudes toward students experiencing mental health issues but also begins the conversation surrounding this new topic. Would the same outcome occur with a larger sample size? If an instrument to test mutuality was created for professionals instead of friends or romantic partners, would academic advisors answer differently? If a new instrument to define mutuality was created, would personal experience with mental health issues have an impact on this relationship? With a larger sample size, how does race impact the relationship with attitudes toward mental health issues?

Students experiencing mental health issues will continue to seek higher education. Academic advisors must be provided with the tools to effectively build mutuality with those students. The onus is on institutions to create an environment where these students feel welcomed and a part of the campus community.

APPENDIX A  
EMAIL COMMUNICATION PLAN

### Initial Communication

Dear <Participant>,

My name is Danielle Aming and I am a Doctoral Candidate in the Higher Education and Policy Studies program. I am writing to ask for your help with my research regarding academic advisors attitudes towards working with students experiencing mental health issues.

You are part of a selection of academic advisors at this institution that have been chosen to complete a brief questionnaire about your attitudes towards working with students experiencing mental health issues. A goal of this survey is to better understand academic advisors attitudes towards students with mental health issues.

The questionnaire is around 75 questions but should only take 5-10 minutes to complete. To begin the survey, simply click on this link: <Insert Link>

This survey is confidential. Your participation is voluntary, and if you come to any question you prefer not to answer please skip it and go on to the next. Should you have any questions or comments please contact me at dnaming@[REDACTED]edu.

I greatly appreciate your help with this study,  
Danielle Aming

### Follow-Up Communication #1

Hello <Participant>,

Last week, I sent an e-mail to you asking for your participation in in a survey regarding academic advisors attitudes towards working with students experiencing mental health issues. I hope that providing you with a link to the survey website makes it easy for you to respond. To complete the survey, simply click on this link: <Insert Link>

The information gathered in this survey will be particularly important in helping administrations better adjust policy and prepare appropriately when it comes to working with students experiencing mental health issues. Your response is voluntary and should only take approximately 5-10 minutes. I appreciate your considering my request.

Thank you for your help,

Danielle Aming

## Follow-Up Communication #2

Hi <Participant>,

You have been selected as part of a study regarding academic advisors attitudes toward students experiencing mental health issues. Your participation in this research will help inform administrations on how to appropriately and effectively provide a supportive environment for students experiencing mental health issues.

The survey should take approximately 5-10 minutes to complete and can be found here:

<Insert Link>

Should you have any questions, please do not hesitate to contact me at [dnaming@\[REDACTED\].edu](mailto:dnaming@[REDACTED].edu)

Thank you,

Danielle Aming

## Final Communication

Hi <Participant>,

I am writing to follow up on the message I sent last week asking you to participate in the survey regarding academic advisors attitudes towards working with students experiencing mental health issues. This assessment of the impacts the experience of students who have mental health issues at the university, and this is the last reminder I will be sending about the study.

The URL is included below to provide an easy link to the survey website:

<Insert link>

I also wanted to let you know that if you are interested in seeing a summary of results, I hope to defend my dissertation in the fall of 2018. Please feel free to contact me with any questions you may have regarding this research at [dnaming@\[REDACTED\].edu](mailto:dnaming@[REDACTED].edu).

In the meantime, good luck with the remainder of the semester.

Danielle Aming

APPENDIX B  
SURVEY: ATTITUDES TOWARD MENTAL HEALTH AND  
RELATIONSHIPS

## **Socio-Demographic Characteristics**

What is your gender?

- Male
- Female
- Other

Are you of Hispanic, Latino, or of Spanish Origin?

- Yes
- No

How would you identify yourself?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native American or Pacific Islander
- White
- Prefer Not to Say

What is your age?

What is the highest degree or level of school you have completed? *If currently enrolled, highest degree received.*

Bachelor's Degree

Master's Degree

Doctoral Degree

What is your degree in?

What Professional Organizations do you belong to?

What is your current job title?

Based on your current job responsibilities, is the majority (50% or more) of your job related to academic advising?

Yes

No

What are your total years as an Academic Advisor?

Mental Illness or Mental Health is defined as: "A condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and function each day".

Based on the above definition, have you ever encountered a student experiencing a mental health issue?

Yes

No

Based on the above definition, have you ever received professional training toward working with students experiencing mental health issues?

Yes

No

Based on the above definition, have you ever had a personal experience with someone who experienced a mental health issue?

Yes

No

### Community Attitudes Toward the Mentally Ill Questionnaire

The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please indicate the response which most accurately describes your reaction to each statement. It's your first reaction which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
As soon as a person shows signs of mental disturbance, he or she should be hospitalized.	<input type="radio"/>				
More tax money should be spent on the care and treatment of the mentally ill.	<input type="radio"/>				
The mentally ill should be isolated from the rest of the community.	<input type="radio"/>				
The best therapy for many mental patients is to be part of a normal community.	<input type="radio"/>				
Mental illness is an illness like any other.	<input type="radio"/>				
The mentally ill are a burden on society.	<input type="radio"/>				

The mentally ill are far less of a danger than most people suppose.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Locating mental health facilities in a residential area downgrades the neighborhood.	<input type="radio"/>				
There is something about the mentally ill that makes it easy to tell them from normal people.	<input type="radio"/>				
The mentally ill have for too long been the subject of ridicule.	<input type="radio"/>				
A person would be foolish to marry someone who has suffered from mental illness, even though he or she seems fully recovered.	<input type="radio"/>				
As far as possible mental health services should be provided through community-based facilities.	<input type="radio"/>				
Less emphasis should be placed on protecting the public from the mentally ill.	<input type="radio"/>				
Increased spending on mental health services is a waste of tax dollars.	<input type="radio"/>				
No one has the right to exclude the mentally ill from their neighborhood.	<input type="radio"/>				
Having mental patients living within residential neighborhoods might be good therapy, but the risks to residents are too great.	<input type="radio"/>				
Mental patients need the same kind of control and discipline as a young child.	<input type="radio"/>				

We need to adopt a far more tolerant attitude toward the mentally ill in our society.

I would not want to live next door to someone who has been mentally ill.

Residents should accept the location of mental health facilities in their neighborhood to serve the needs of the local community.

The mentally ill should not be treated as outcasts of society.

There are sufficient existing services for the mentally ill.

Mental patients should be encouraged to assume the responsibilities of normal life.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Local residents have good reason to resist the location of mental health services in their neighborhood.	<input type="radio"/>				
The best way to handle the mentally ill is to keep them behind locked doors.	<input type="radio"/>				
Our mental health hospitals seem more like prisons than like places where the mentally ill can be cared for.	<input type="radio"/>				
Anyone with a history of mental problems should be excluded from taking public office.	<input type="radio"/>				
Locating mental health services in residential neighborhoods does not endanger local residents.	<input type="radio"/>				

Mental hospitals are an outdated means of treating the mentally ill.	<input type="radio"/>				
The mentally ill do not deserve our sympathy.	<input type="radio"/>				
The mentally ill should not be denied their individual rights.	<input type="radio"/>				
Mental health facilities should be kept out of residential neighborhoods.	<input type="radio"/>				
One of the main causes of mental illness is a lack of self-discipline and will power.	<input type="radio"/>				
We have the responsibility to provide the best possible care for the mentally ill.	<input type="radio"/>				
The mentally ill should not be given any responsibility.	<input type="radio"/>				
Residents have nothing to fear from people coming into their neighborhoods to obtain mental health services.	<input type="radio"/>				
Virtually anyone can become mentally ill.	<input type="radio"/>				
It is best to avoid anyone who has mental problems.	<input type="radio"/>				
Most people who were once patients in a mental hospital can be trusted as babysitters.	<input type="radio"/>				
It is frightening to think of people with mental problems living in residential neighborhoods.	<input type="radio"/>				

## Mutual Psychological Development Questionnaire

The following statements will explore certain aspects of your relationships with students you have worked with as an academic advisor. Using the scale below, please indicate your best estimate of how often you and your students experience each of the following:

When we talk about things that matter to my students, I am likely to:

	Never	Rarely	Occasionally	More Often Than Not	Most of the Time	All of the Time
Be Receptive	<input type="radio"/>					
Get Impatient	<input type="radio"/>					
Try to Understand	<input type="radio"/>					
Get Bored	<input type="radio"/>					
Feel Moved	<input type="radio"/>					
Avoid Being Honest	<input type="radio"/>					
Be Open-Minded	<input type="radio"/>					
Get Discouraged	<input type="radio"/>					
Get Involved	<input type="radio"/>					
Have Difficulty Listening	<input type="radio"/>					
Feel Energized By Our Conversations	<input type="radio"/>					

When we talk about things that matter to me, my students are likely to:

	Never	Rarely	Occasionally	More Often Than Not	Most of the Time	All of the Time
Pick Up On My Feelings	<input type="radio"/>					
Feel Like We're Not Getting Anywhere	<input type="radio"/>					
Show An Interest	<input type="radio"/>					
Get Frustrated	<input type="radio"/>					
Share Similar Experiences	<input type="radio"/>					
Keep Feelings Inside	<input type="radio"/>					

<https://ucf.ca1.qualtrics.com/ControlPanel/Ajax.php?action=GetSurveyPrintPreview>

6/7

8/11/2018

Qualtrics Survey Software

	Never	Rarely	Occasionally	More Often Than Not	Most of the Time	All of the Time
Respect My Point of View	<input type="radio"/>					
Change the Subject	<input type="radio"/>					
See the Humor in Things	<input type="radio"/>					
Feel Down	<input type="radio"/>					
Express an Opinion Clearly	<input type="radio"/>					

APPENDIX C  
INSTRUMENTS: COMMUNITY ATTITUDES TOWARD THE MENTALLY  
ILL AND MUTUAL PSYCHOLOGICAL DEVELOPMENT QUESTIONNAIRE

The following statements express various opinions about mental illness and the mentally ill. The mentally ill refers to people needing treatment for mental disorders but who are capable of independent living outside a hospital. Please circle the response which most accurately describes your reaction to each statement. It's your first reaction which is important. Don't be concerned if some statements seem similar to ones you have previously answered. Please be sure to answer all statements.

a. As soon as a person shows signs of mental disturbance, he should be hospitalized.

SA A N D SD

b. More tax money should be spent on the care and treatment of the mentally ill.

SA A N D SD

c. The mentally ill should be isolated from the rest of the community.

SA A N D SD

d. The best therapy for many mental patients is to be part of a normal community.

SA A N D SD

e. Mental illness is an illness like any other.

SA A N D SD

f. The mentally ill are a burden on society.

SA A N D SD

g. The mentally ill are far less of a danger than most people suppose.

SA A N D SD

h. Locating mental health facilities in a residential area downgrades the neighbourhood.

SA A N D SD

i. There is something about the mentally ill that makes it easy to tell them from normal people.

SA A N D SD

j. The mentally ill have for too long been the subject of ridicule.

SA A N D SD

k. A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.

SA A N D SD

l. As far as possible mental health services should be provided through community-based facilities.

SA A N D SD

m. Less emphasis should be placed on protecting the public from the mentally ill.

SA A N D SD

n. Increased spending on mental health services is a waste of tax dollars.

SA A N D SD

o. No one has the right to exclude the mentally ill from their neighbourhood.

SA A N D SD

p. Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.

SA A N D SD

q. Mental patients need the same kind of control and discipline as a young child.

SA A N D SD

r. We need to adopt a far more tolerant attitude toward the mentally ill in our society.

SA A N D SD

s. I would not want to live next door to someone who has been mentally ill.

SA A N D SD

t. Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.

SA A N D SD

u. The mentally ill should not be treated as outcasts of society.

SA A N D SD

v. There are sufficient existing services for the mentally ill.

SA A N D SD

w. Mental patients should be encouraged to assume the responsibilities of normal life.

SA A N D SD

x. Local residents have good reason to resist the location of mental health services in their neighbourhood.

SA A N D SD

y. The best way to handle the mentally ill is to keep them behind locked doors.

SA A N D SD

z. Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.

SA A N D SD

SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree

SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree

aa. Anyone with a history of mental problems should be excluded from taking public office.

SA A N D SD

bb. Locating mental health services in residential neighbourhoods does not endanger local residents.

SA A N D SD

cc. Mental hospitals are an outdated means of treating the mentally ill.

SA A N D SD

dd. The mentally ill do not deserve our sympathy.

SA A N D SD

ee. The mentally ill should not be denied their individual rights.

SA A N D SD

ff. Mental health facilities should be kept out of residential neighbourhoods.

SA A N D SD

gg. One of the main causes of mental illness is a lack of self-discipline and will power.

SA A N D SD

hh. We have the responsibility to provide the best possible care for the mentally ill.

SA A N D SD

ii. The mentally ill should not be given any responsibility.

SA A N D SD

jj. Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.

SA A N D SD

kk. Virtually anyone can become mentally ill.

SA A N D SD

ll. It is best to avoid anyone who has mental problems.

SA A N D SD

mm. Most women who were once patients in a mental hospital can be trusted as baby sitters.

SA A N D SD

nn. It is frightening to think of people with mental problems living in residential neighbourhoods.

SA A N D SD

SA=Strongly Agree A=Agree N=Neutral D=Disagree SD=Strongly Disagree

## COMMUNITY ATTITUDES TOWARDS THE MENTALLY ILL

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Department of Geography, McMaster University, Hamilton, Ontario, Canada

### Community Attitudes Toward The Mentally Ill

Key to Items	Scoring				
	SA	A	N	D	SD
<b>Authoritarianism</b>					
Pro: a, i, q, y, gg	5	4	3	2	1
Anti: e, m, u, cc, kk	1	2	3	4	5
<b>Benevolence</b>					
Pro: b, j, r, z, hh	5	4	3	2	1
Anti: f, n, v, dd, ll	1	2	3	4	5
<b>Social Restrictiveness</b>					
Pro: c, k, s, aa, ii	5	4	3	2	1
Anti: g, o, w, ee, mm	1	2	3	4	5
<b>Community Mental Health Ideology</b>					
Pro: d, l, t, bb, jj	5	4	3	2	1
Anti: h, p, x, ff, nn	1	2	3	4	5

# MUTUAL PSYCHOLOGICAL DEVELOPMENT QUESTIONNAIRE (MPDQ)

*N. P. Genero, J. B. Miller, & J. Surrey*

*Instructions:* We would like you to tell us about your relationship with your spouse or partner. By partner, we mean a person with whom you live or with whom you have a steady relationship.

If married, how many years? \_\_\_\_\_

What is your spouse's age? \_\_\_\_\_

If not married, how long have you known your partner? \_\_\_\_\_

What is your partner's age? \_\_\_\_\_

Are you currently living with your partner? (Please circle)                      Yes      No

## FORM A

### FORM A

In this section, we would like to explore certain aspects of your relationship with your spouse or partner. Using the scale below, please tell us your best estimate of how often you and your spouse/partner experience each of the following:

Never	Rarely	Occasionally	More Often Than Not	Most of the Time	All the Time
1	2	3	4	5	6

When we talk about things that matter to my spouse/partner, I am likely to . . .

	Never	Rarely	Occasionally	More Often Than Not	Most of the Time	All the Time
1. Be receptive	1	2	3	4	5	6
2. Get impatient	1	2	3	4	5	6
3. Try to understand	1	2	3	4	5	6
4. Get bored	1	2	3	4	5	6
5. Feel moved	1	2	3	4	5	6
6. Avoid being honest	1	2	3	4	5	6
7. Be open-minded	1	2	3	4	5	6

8. Get discouraged	1	2	3	4	5	6
9. Get involved	1	2	3	4	5	6
10. Have difficulty listening	1	2	3	4	5	6

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Mutual Psychological Development Questionnaire

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11. Feel energized by our conversation      1      2      3      4      5      6

When we talk about things that matter to me, my spouse/partner is likely to . . .

	Never	Rarely	Occasionally	More Often Than Not	Most of the Time	All the Time
12. Pick up on my feelings	1	2	3	4	5	6
13. Feel like we're not getting anywhere	1	2	3	4	5	6
14. Show an interest	1	2	3	4	5	6
15. Get frustrated	1	2	3	4	5	6
16. Share similar experiences	1	2	3	4	5	6
17. Keep feelings inside	1	2	3	4	5	6
18. Respect my point of view	1	2	3	4	5	6
19. Change the subject	1	2	3	4	5	6
20. See the humor in things	1	2	3	4	5	6
21. Feel down	1	2	3	4	5	6
22. Express an opinion clearly	1	2	3	4	5	6

APPENDIX D  
AUTHORITARIANISM RESPONSES

Authoritarianism

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
As soon as a person shows signs of mental health disturbance, he/she should be hospitalized.	1 (0.8%)	3 (2.3%)	15 (11.3%)	70 (52.6%)	44 (33.1%)
Mental Illness is an illness like any other.	31 (33.8%)	62 (46.6%)	13 (9.8%)	22 (16.5%)	5 (3.8%)
There is something about the mentally ill that makes it easy to tell them from normal people.	0 (0%)	8 (6.0%)	13 (9.8%)	67 (50.4%)	45 (33.8%)
Less emphasis should be placed on protecting the public from the mentally ill.	10 (7.5%)	41 (30.8%)	56 (42.1%)	23 (17.3%)	3 (2.3%)
Mental patients need the same kind of control and discipline as a young child.	19 (14.3%)	52 (39.1%)	49 (36.8%)	12 (9.0%)	1 (0.8%)
The mentally ill should not be treated as outcasts of society.	67 (50.4%)	53 (39.8%)	5 (3.8%)	2 (1.5%)	6 (4.5%)
The best way to handle the mentally ill is to keep them behind locked doors.	3 (2.3%)	1 (0.8%)	2 (1.5%)	34 (25.6%)	93 (69.9%)
Mental hospitals are an outdated means of treating the mentally ill.	15 (11.3%)	40 (30.1%)	53 (39.8%)	23 (17.3%)	2 (1.5%)
One of the main causes of mental illness is a lack of self-discipline and will power.	3 (2.3%)	1 (0.8%)	14 (10.5%)	36 (27.1%)	79 (59.4%)
Virtually anyone can become mentally ill.	62 (46.6%)	55 (41.4%)	13 (9.8%)	1 (0.8%)	2 (1.5%)

APPENDIX E  
SOCIAL RESTRICTIVENESS RESPONSES

Social Restrictiveness

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The mentally ill should be isolated from the rest of the community.	0 (0%)	0 (0%)	5 (3.8%)	48 (36.1%)	80 (60.2%)
The mentally ill are far less of a danger than most people suppose.	10 (7.5%)	68 (51.1%)	39 (29.3%)	13 (9.8%)	3 (2.3%)
A person would be foolish to marry someone who has suffered from mental illness, even though he or she seems fully recovered.	1 (0.8%)	3 (2.3%)	13 (9.8%)	49 (36.8%)	67 (50.4%)
No one has the right to exclude the mentally ill from their neighbourhood.	43 (32.3%)	65 (48.9%)	17 (12.8%)	5 (3.8%)	3 (2.3%)
I would not want to live next door to someone who has been mentally ill.	4 (3.0%)	5 (3.8%)	27 (20.3%)	63 (47.4%)	34 (25.6%)
Mental patients should be encouraged to assume the responsibilities of normal life.	24 (18%)	67 (50.4%)	36 (27.1%)	4 (3%)	2 (1.5%)
Anyone with a history of mental problems should be excluded from taking public office.	3 (2.3%)	7 (5.3%)	30 (22.6%)	73 (54.9%)	20 (15%)
The mentally ill should not be denied their individual rights.	52 (39.1%)	58 (43.6%)	11 (8.3%)	4 (3%)	8 (6%)
The mentally ill should not be given any responsibility.	1 (0.8%)	1 (0.8%)	9 (6.8%)	66 (49.6%)	56 (42.1%)
Most people who were once patients in a mental hospital can be trusted as babysitters.	4 (46.6%)	31 (23.3%)	75 (56.4%)	21 (15.8%)	2 (1.5%)

APPENDIX F  
BENEVOLENCE RESPONSES

Benevolence

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
More tax money should be spent on the care and treatment of the mentally ill.	53 (39.8%)	61 (45.9%)	14 (10.5%)	4 (3.0%)	1 (0.8%)
The mentally ill are a burden on society.	1 (0.8%)	5 (3.8%)	10 (7.5%)	60 (45.1%)	57 (42.9%)
The mentally ill have for too long been the subject of ridicule.	59 (44.4%)	56 (42.1%)	15 (11.3%)	2 (1.5%)	1 (0.8%)
Increased spending on mental health services is a waste of tax dollars.	1 (0.8%)	1 (0.8%)	9 (6.8%)	49 (36.8%)	73 (54.9%)
We need to adopt a far more tolerant attitude toward the mentally ill in our society.	54 (40.6%)	55 (41.4%)	19 (14.3%)	4 (3%)	1 (0.8%)
There are sufficient existing services for the mentally ill.	3 (2.3%)	4 (3%)	15 (11.3%)	59 (44.4%)	52 (39.1%)
Our mental hospitals seem more like prisons than like places where the mentally ill can be cared for.	21 (15.8%)	52 (39.1%)	50 (37.6%)	10 (7.5%)	0 (0%)
The mentally ill do not deserve our sympathy.	1 (0.8%)	1 (0.8%)	10 (7.5%)	45 (33.8%)	76 (57.1%)
We have the responsibility to provide the best possible care for the mentally ill.	65 (48.9%)	55 (41.4%)	11 (8.3%)	1 (0.8%)	1 (0.8%)
It is best to avoid anyone who has mental problems.	2 (1.5%)	2 (1.5%)	5 (3.8%)	59 (44.4%)	65 (48.9%)

APPENDIX G  
COMMUNITY MENTAL HEALTH IDEOLOGY RESPONSES

### Community Mental Health Ideology

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The best therapy for many mental patients is to be part of a normal community.	19 (14.3%)	60 (45.1%)	50 (37.6%)	4 (3.0%)	0 (0%)
Locating mental health facilities in a residential area downgrades the neighbourhood.	1 (0.8%)	10 (7.5%)	36 (27.1%)	66 (49.6%)	20 (15%)
As far as possible mental health services should be provided through community-based facilities.	21 (15.8%)	69 (51.9%)	4 (25.6%)	8 (6%)	1 (0.8%)
Having mental patients living within residential neighbourhoods might be good therapy, but the risks to residents are too great.	2 (1.5%)	5 (3.8%)	40 (30.1%)	60 (45.1%)	6 (19.5%)
Residents should accept the location of mental health facilities in their neighbourhood to serve the needs of the local community.	20 (15%)	62 (46.6%)	42 (31.6%)	6 (4.5%)	3 (2.3%)
Local residents have good reason to resist the location of mental health services in their neighbourhood.	2 (1.5%)	9 (6.8%)	38 (28.6%)	66 (49.6%)	18 (13.5%)
Locating mental health services in residential neighbourhoods does not endanger local residents.	16 (12%)	66 (49.6%)	40 (30.1%)	8 (6.8%)	2 (1.5%)
Mental health facilities should be kept out of residential neighbourhoods.	2 (1.5%)	3 (2.3%)	49 (36.8%)	57 (42.9%)	22 (16.5%)
Residents have nothing to fear from people coming into their neighbourhood to obtain mental health services.	14 (10.5%)	54 (40.6%)	49 (36.8%)	12 (9%)	4 (3%)
It is frightening to think of people with mental health problems living in residential neighbourhoods.	2 (1.5%)	1 (0.8%)	23 (17.3%)	78 (58.6%)	29 (21.8%)

APPENDIX H  
MUTUALITY RESPONSES

Mutuality

Statement: <i>When we talk about things that matter to my student, I am likely to ...</i>	Never	Rarely	Occasionally	More Often Than Not	Most of the Time	All the Time
Be receptive.	0 (0%)	0 (0%)	1 (0.8%)	5 (3.8%)	56 (42.1%)	71 (53.4%)
Get impatient.	15 (11.3%)	83 (62.4%)	35 (26.3%)	0 (0%)	0 (0%)	0 (0%)
Try to understand.	0 (0%)	0 (0%)	0 (0%)	7 (5.3%)	36 (27.1%)	90 (67.7%)
Get bored.	41 (30.8%)	76 (57.1%)	14 (10.5%)	2 (1.5%)	0 (0%)	0 (0%)
Feel moved.	0 (0%)	3 (2.3%)	51 (38.3%)	40 (30.1%)	33 (24.8%)	6 (4.5%)
Avoid being honest.	70 (52.6%)	50 (37.6%)	13 (9.8%)	0 (0%)	0 (0%)	0 (0%)
Be open-minded.	0 (0%)	0 (0%)	0 (0%)	7 (5.3%)	50 (37.6%)	76 (57.1%)
Get discouraged.	26 (19.5%)	60 (45.1%)	46 (34.6%)	1 (0.8%)	0 (0%)	0 (0%)
Get involved.	1 (0.8%)	5 (3.8%)	30 (22.6%)	35 (26.3%)	47 (35.3%)	15 (11.3%)
Have difficulty listening.	54 (40.6%)	68 (51.1%)	11 (8.3%)	0 (0%)	0 (0%)	0 (0%)
Feel energized by our conversation.	0 (0%)	3 (2.3%)	20 (15%)	52 (39.1%)	48 (36.1%)	10 (7.5%)
Statement: <i>When we talk about things that matter to my student, I am likely to ...</i>	Never	Rarely	Occasionally	More Often Than Not	Most of the Time	All the Time

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Pick up on my feelings.	3 (2.3%)	6 (4.5%)	26 (19.5%)	37 (27.8%)	51 (38.3%)	10 (7.5%)
Feel like we're not getting anywhere.	17 (12.8%)	81 (60.9%)	35 (26.3%)	0 (0%)	0 (0%)	0 (0%)
Show an interest.	1 (0.8%)	1 (0.8%)	26 (19.5%)	50 (37.6%)	49 (36.8%)	6 (4.5%)
Get frustrated.	27 (20.3%)	66 (49.6%)	39 (29.3%)	0 (0%)	1 (0.8%)	0 (0%)
Share similar experiences.	2 (1.5%)	2 (1.5%)	33 (24.8%)	51 (38.3%)	41 (30.8%)	4 (3.0%)
Keep feelings inside.	70 (52.6%)	50 (37.6%)	13 (9.8%)	0 (0%)	0 (0%)	0 (0%)
Respect my point of view.	1 (0.8%)	0 (0%)	7 (5.3%)	48 (36.1%)	66 (49.6%)	11 (8.3%)
Change the subject.	13 (9.8%)	83 (62.4%)	36 (27.1%)	0 (0%)	0 (0%)	1 (0.8%)
See the humor in things.	1 (0.8%)	5 (3.8%)	30 (22.6%)	55 (41.4%)	41 (30.8%)	1 (0.8%)
Feel down.	26 (19.5%)	70 (52.6%)	34 (25.6%)	1 (0.8%)	2 (1.5%)	0 (0%)
Express an opinion clearly.	1 (0.8%)	2 (1.5%)	20 (15%)	56 (42.1%)	44 (33.1%)	10 (7.5%)

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APPENDIX I  
IRB HUMAN SUBJECTS PERMISSION LETTER



University of Central Florida Institutional Review Board

Office of Research & Commercialization

12201 Research Parkway, Suite 501

Orlando, Florida 32826-3246

Telephone: 407-823-2901 or 407-882-2276 [www.research.ucf.edu/compliance/irb.html](http://www.research.ucf.edu/compliance/irb.html)

### **Determination of Exempt Human Research**

**From: UCF Institutional Review Board #1  
FWA00000351, IRB00001138**

**To: Danielle Aming**

**Date: May 04, 2018**

Dear Researcher:

On 05/04/2018, the IRB reviewed the following activity as human participant research that is exempt from regulation:

Type of Exempt Determination  
Review:  
Project Title: Academic Advisors Attitudes Towards Students  
Experiencing Mental Health Issues.  
Investigator: Danielle Aming  
IRB Number: SBE-18-13991  
Funding  
Agency:  
Grant Title:  
Research ID: N/A

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made and there are questions about whether these changes affect the exempt status of the human research, please contact the

IRB. When you have completed your research, please submit a Study Closure request in iRIS so that IRB records will be accurate.

In the conduct of this research, you are responsible to follow the requirements of the [Investigator Manual](#).

This letter is signed by:

A handwritten signature in black ink, appearing to read "Gillian Morien". The signature is fluid and cursive, with a long horizontal stroke at the end.

Signature applied by Gillian Morien on 05/04/2018 04:43:00 PM

EDT Designated Reviewer

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