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Mental Health Literacy Among University Educators

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Mental Health Literacy Among University Educators

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Abstract

Mental health literacy is a term originally coined the in 1990s that refers to the recognition, prevention, and management of mental illness. Poor mental health literacy can delay or prevent treatment (Godfrey Born et al., 2019; Tay et al., 2018). Higher mental health literacy increases help-seeking behaviors, positive attitudes towards treatments, and improves health outcomes (Jorm, 2012; Rüsch et al., 2011). The current study aimed to explore the mental health literacy of university educators to support student mental health. The study used an electronic survey to collect demographic data, information related to teaching and mental health experience, and responses to the Multiple-Choice Knowledge of Mental Illness Test (MC-KOMIT). The survey was sent to George Fox University faculty. Results were analyzed with SPSS. Results showed that this sample of university educators had higher levels of mental health literacy than a norm group of police officers. Educators in behavioral science fields scored higher on average than faculty in other fields, however, only two of these results were statistically significant. The number of years faculty had been teaching was not related to mental health literacy. This study laid groundwork for future exploration and experimentation of mental health literacy in the context of university educators.

Keywords: mental health literacy, mental health, college students, university educators, college campuses, emerging adults

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Mental Health Literacy Among University Educators

Chapter 1

College campuses play an enormous role in the identification and early treatment of mental illness in young adults. 75% of all lifetime mental illness emerges by the age of 24 years (National Alliance on Mental Illness [NAMI], n.d.). However, the average amount of time between symptom onset and receiving treatment for mental illness is 11 years (NAMI, n.d.). Early intervention and treatment of mental illness can be crucial in improving patient outcomes and altering the trajectory of a developing mental illness (Shonkoff et al., 2009). Yet, in the United States, only about half of those with a mental illness receive treatment and globally two thirds of people who have a known mental disorder do not seek professional help (NAMI, n.d.; World Health Organization [WHO], 2013). Promoting the mental health of young adults is not only beneficial to the individuals themselves but also to their communities by attempting to improve functioning and quality of life for the future generations of adults (World Health Organization [WHO], n.d.).

Mental Health Literacy

Altweck et al. (2015) found that delays in mental health service use can be related to lack of access to treatment, underestimating the need for treatment, and failing to identify mental health problems. A person's ability to correctly identify mental illness can be improved with a concept known as mental health literacy. In 1997, Jorm and colleagues coined the term mental health literacy to refer to "knowledge and beliefs about mental disorders which aid their recognition, management, and prevention" (Jorm et al., 1997, p. 182). Mental health literacy itself can be further broken down into six main components:

> (a) the ability to recognize specific disorders or different types of psychological distress, (b) knowledge and beliefs about risk factors and causes, (c) knowledge and beliefs about self-help interventions, (d) knowledge and beliefs about professional help available, (e) attitudes which facilitate recognition and appropriate help-seeking, and (f) knowledge of how to seek mental health information. (Jorm, 2000, p. 396)

Mental health literacy also involves knowing how to support oneself and others when dealing with mental health (Tay et al., 2018). Jorm proposed that high levels of mental health literacy in the general population would increase the probability of recognition and early treatment of mental disorders. Since Jorm's original article was published in 1997, many studies from all over the world have explored mental health literacy and its component concepts in relation to specific mental disorders in diverse populations.

Low mental health literacy has been found to delay or even prevent treatment (Godfrey Born et al., 2019; Tay et al., 2018). High mental health literacy has been found to improve help-seeking attitudes and those who have positive attitudes to seeking help are less averse to engaging in mental health services such as therapy (Gonzalez et al., 2011; Bonabi et al., 2016). Additionally, high mental health literacy may decrease negative attitudes and stigma towards people with mental illness (Furnham & Swami, 2018).

People with higher levels of mental health literacy are more likely to be able to recognize mental illness and be able to identify appropriate treatment options (Jorm, 2012; Rüsch et al., 2011). They can also help decrease the stigma of mental illness because people with higher mental health literacy are more willing to interact with mentally ill people (Jorm, 2012). Increased levels of mental health literacy have been found to increase help-seeking behaviors, positive attitudes towards treatment, and better health outcomes (Jorm, 2012; Rüsch et al., 2011).

Predictors of Mental Health Literacy

Various predictors of mental health literacy have been identified in the literature including, age, gender, and level of education. In general, younger people tend to have higher levels of mental health literacy than older people and are more likely to correctly identify mental illness (Farrer et al., 2008; Hadjimina & Furnham, 2017). Some have suggested that this difference is because young people primarily get their information about mental illness from educational programs and more educational programs target younger people than older people.

Females have significantly higher mental health literacy than males (Fisher & Goldney, 2003; Cotton et al., 2006; Hadjimina & Furnham, 2017). Those with higher levels of education also tend to have higher levels of mental health literacy (Hadjimina & Furnham, 2017). Additionally, those who are close to someone with a mental illness have higher degrees of mental health literacy themselves (Farrer et al., 2008; Reavley et al., 2013; The Royal Australian & New Zealand College of Psychiatrists, 2010.

Educators as Mental Health Resource

Educators represent a crucial link in the chain when it comes to referring young adults for mental health services. Faculty may interact with students in a variety of contexts including in class, in the dining hall, and in smaller study groups. As they build relationships with their students, faculty can encourage students to receive support from college mental health services if there are mental health concerns. One of the impacts of improved mental health literacy is the ability to recognize symptoms of mental illness in oneself and others as well as being knowledgeable regarding appropriate treatment options (Tay et al., 2018). Additionally, Jorm and Kitchener (2011) noted that the mental health literacy of those who do not currently experience mental illness can promote early intervention for those who do experience mental illness. For

educators to best support the wellbeing of their students, evaluating and increasing the mental health literacy of faculty would be beneficial.

The Current Study

However, although the research surrounding mental health literacy has increased rapidly in many directions since the inception of the term in the late 1990s, one significant gap in the research concerns the mental health literacy of educators. At the present time, one dissertation and two articles have explored the mental health literacy of teacher candidates and pre-service teachers and evaluated the training high school teachers receive regarding mental health. No published research has yet explored the mental health literacy of college or university faculty.

The current study aimed to examine the mental health literacy of college educators. Once there is an understanding of faculty mental health literacy, mental health trainings can be more precisely tailored to further educate this population. Given this background the following hypotheses are proposed.

Hypothesis 1: Faculty will have higher rates of mental health literacy than the norm group of the scale used.

Hypothesis 2: Faculty in the social sciences such as psychology and sociology will have higher mental health literacy than faculty in non-social science fields such as engineering.

Hypothesis 3: Faculty who recently began teaching will have higher rates of mental health literacy than those who have been teaching longer.

Chapter 2

Methods

Participants

Participants were recruited via faculty listserv and community newsletter from George Fox University. Participants represented a variety of different departments and disciplines within the university. Due to the unique limitations of sampling from a small private religious university, recruiting participants from diverse backgrounds was limited. This study was approved by the George Fox University IRB. Informed consent was obtained from all participants.

A total of 79 survey responses were received, however, 26 survey responses were discarded due to being incomplete. A total of 53 survey responses were deemed usable for the study. 58.5% of respondents identified as cisgender females (n = 31) and 41.5% of respondents identified as cisgender males (n = 22) (Table 1). 92.5% of respondents identified as heterosexual (n = 49) (Table 1). 5.7% of respondents identified as asexual (n = 3) (Table 1). 1.9% of respondents was unsure of how to identify their sexuality (n = 1) (Table 1).

Table 1

Demographic Characteristics of University Professor Population

Baseline Characteristics	*n*	%
Gender		
Cisgender male	22	41.5
Cisgender female	31	58.5
Sexuality		
Heterosexual	49	92.5
Asexual	3	5.7
Other	1	1.9
Race/Ethnicity		

Baseline Characteristics	*n*	%
African American	1	1.9
Asian-American	1	1.9
European-American	49	92.5
Biracial/multiracial	1	1.9
Other	1	1.9
Age		
25–34 years old	10	18.9
35–44 years old	9	17.0
45–54 years old	11	20.8
55–64 years old	12	22.6
65+ years old	11	20.8

Regarding racial and ethnic demographics, 92.5% of respondents identified as European-American (*n* = 49); 1.9% identified as African American (*n* = 1); 1.9% identified as Asian-American (*n* = 1); 1.9% identified as biracial or multiracial (*n* = 1) (Table 1); and 1.9% were unsure of their ethnic or racial heritage (*n* = 1) (Table 1). There was a good range of ages represented with 18.9% of respondents aged 25–34 years (*n* = 10), 17% of respondents aged 35–44 years (*n* = 9), 20.8% of respondents aged 45–54 years (*n* = 11), 22.6% of respondents aged 55–64 years (*n* = 12), and 20.8% of respondents were 65 years or older (*n* = 11) (Table 1). The participants in this study identified as primarily European-Americans across the age range.

Finally, the fields of study and department representation varied as well with 11.3% of respondents identified their field of study as being within arts, humanities, or social science which comprised history, politics, English, theatre, art and design, music, communication and cinematic arts, world languages, and cultural studies (*n* = 6). Behavioral health science which comprised social work, nursing, physical therapy, health and human performance, and psychology accounted for 35.8% of respondents (*n* = 19). The Business Department, including business and economics, represented 7.5% of respondents (*n* = 4). Education which comprised of

education and counseling was 24.5% of respondents (n = 13). Engineering represented 9.4% which included mechanical engineering, civil engineering, electrical engineering, computer science, mathematics, applied science, biology, biochemistry, and chemistry (n = 5). Christian studies accounted for 7.5% of respondents which comprised of seminary, ministry, and undergraduate Christian studies (n = 4). Finally, 3.8% of respondents identified more than one field of study (n = 2).

Materials

The Multiple-Choice Knowledge of Mental Illness Test (MC-KOMIT: Compton et al., 2011) is a 33-item multiple choice measure used to assess mental health knowledge. Total scores on the MC-KOMIT range from 0–33. The MC-KOMIT was normed on a sample of police officers before and after they received a weeklong training on recognizing mental illnesses and addiction, verbal de-escalation training, and when to connect community members with mental health programs.

Test-retest reliability is the degree to which scores obtained from participants are consistent over time when the participants' response is not likely to change. The Pearson correlation coefficient for the MC-KOMIT was determined to be good (.79, $P < 0.001$). Construct validity was determined by examining the average participant scores before and after their training. The MC-KOMIT was found to be sensitive to change after an intervention designed to increase mental health literacy (paired samples $t = 4.24$, $df = 67$, $P < 0.001$). Construct validity was also examined by comparing the average scores of police who have experienced mental health treatment with the average scores of their colleagues who did not endorse experiencing mental health treatment. Police officers who endorsed experiencing mental

health treatment scored an average of 22.5 on the MC-KOMIT compared to their colleagues who scored an average of 18.3 ($t = 3.19$, $df = 185$, $P = 0.002$).

Finally, in addition to the MC-KOMIT, participants answered demographic questions including years of teaching, a self-assessment of comfort with mental health resources, and identifying and having conversations with students about mental health.

Procedure

Participants were administered the survey on a web-based survey platform which contained demographic questions, questions related to teaching and supporting student mental health, and the MC-KOMIT.

Chapter 3

Results

Hypothesis 1 Results

Hypothesis 1 predicted university faculty would have higher levels of mental health literacy than the norm group of the MC-KOMIT. Participants scored an average of 25.23 ($SD = 3.51$) on the MC-KOMIT. The participants the MC-KOMIT was normed on scored an average of 18.70 before their mental health training and 20.8 after their training. A one-sample *t*-test was employed to compare the mean MC-KOMIT score of the current sample with those of the normative sample. The current sample had significantly higher scores than the normative sample, $t(52) = 13.53$, $p < .001$, Cohen's $d = 3.51$, a very large effect size. Therefore, the hypothesis was supported.

Hypothesis 2 Results

Hypothesis 2 predicted faculty in behavioral sciences would have higher levels of mental health literacy than their colleagues in other fields. Multiple *t*-tests were run with the total MC-

KOMIT score as the dependent variable and each broad field of study as the independent variable. Participants who taught across multiple university enterprises (n = 2) were excluded from the analysis. A Bonferroni correction (.05/5 tests = .01) was used to reduce Type 1 error inflation.

A comparison of MC-KOMIT scores for behavioral science faculty and those from other disciplines is shown in Table 2. Behavioral science faulty scored higher than faculty in all other disciplines and their scores were significantly higher than faculty in business and education. It should also be noted that the effect sizes for all comparisons were very large, which might indicate that with larger sample sizes it is likely that all the comparisons would have demonstrated statistical significance. Therefore, this hypothesis is supported.

Table 2

Comparison of MC-KOMIT for Behavior Science Faculty and Those from Other Disciplines

Group	*N*	*M*	*SD*	*t*	df	Sig (1-tailed)	Effect size
Behavioral Science	19	27.53	3.32				
Arts & Humanities	6	24.50	2.67	2.02	23	.03 (ns)	3.11 (L)
Business	4	22.25	5.91	2.52	21	.01	3.80 (L)
Education	13	23.62	2.87	3.48	31	<.001	3.11 (L)
Engineering	5	25.20	1.48	1.51	22	.07 (ns)	3.07 (L)
Christian Studies	4	23.50	1.73	2.26	22	.02 (ns)	3.11 (L)

Hypothesis 3 Results

Hypothesis 3 predicted faculty who recently began teaching would have higher rates of mental health literacy than those who have been teaching longer. The average number of years participants had been teaching (n = 53) was 17.15 years (SD = 12.57). A simple regression analysis was run to predict MC-KOMIT scores based on years teaching. Years of teaching was not a statistically significant predictor of MC-KOMIT scores (R^2 = .01, F(1, 51) = .66, p = .42). Hypothesis 3 was not supported.

Additional Analyses

A correlation coefficient was run for age and total scores on the MC-KOMIT (see Table 3). The correlation between age, an interval variable, and MC-KOMIT scores was r = .18, p = .23. These results indicated that the age of participants was not significantly related to their total score on the MC-KOMIT.

Table 3

Age and Total MC-KOMIT Score Analysis

Age (years)	*M*	*SD*
25-34	25.10	3.51
35-44	25.22	3.23
45-54	23.00	4.60
55-64	26.33	2.01
65+	26.36	3.26

Additionally, an ANOVA for gender and total scores on the MC-KOMIT was analyzed. The average score on the MC-KOMIT for cisgender males (n = 22) was 24.95 (SD = 2.85). The average score on the MC-KOMIT for cisgender females (n = 31) was 25.42 (SD = 3.95). These means were not statistically significantly different, F(1, 51) = .22, p = .64, η^2 = .004.

Chapter 4

Discussion

In his work on mental health literacy, Jorm (1997) theorized that by improving the mental health literacy of the population we would also increase the odds of recognizing and treating conditions early on. Within the context of university, students are experiencing increasing rates of mental illness and often not receiving treatment for their conditions (Oswalt et al., 2020). All university staff, including faculty, represent key figures in the efforts to support student mental health. The purpose of this study was to examine the mental health literacy of university educators with the assumption that higher rates of mental health literacy will result in improved awareness of student mental health.

Contributions to Current Research

Hypothesis 1 of this study predicted that university faculty would have higher levels of mental health literacy than the norm group of the MC-KOMIT. The hypothesis was supported by all participant groups scoring higher on average in this study on the MC-KOMIT than the measure's norming group. On average, participants in all groups scored higher than the highest scoring participants from the norm group. This finding aligns with the literature of mental health literacy which has identified years of education as one of the factors related to higher levels of mental health literacy (Hadjimina & Furnham, 2017). It is important to note that the study sample and the norm group comprised very different populations, that being university educators and police officers respectively. University educators likely have higher levels of mental health literacy due to continuing education requirements or institution provided training in addition to their advanced degrees.

Hypothesis 2 of this study stated that university faculty in behavioral science fields would have higher levels of mental health literacy than their colleagues in other fields due to mental health being more integrated in behavioral science fields. This hypothesis was supported. Participants from the behavioral science group scored higher on average than any other group in this study. Behavioral science faculty did have a higher statistically significant score on the MC-KOMIT than their colleagues in the fields of business and education. However, the scores of behavioral science participants were not statistically significantly higher than their colleagues in the arts, engineering, or Christian studies fields. There are several possible reasons this may have occurred.

According to a 2016 study, university students in the arts and humanities had an increased likelihood of mental health problems compared to other fields (Lipson et al., 2016). The reason for this is not known but other researchers have suggested that perhaps emotion, subjectivity, and intuition are associated with higher levels of emotional dysregulation compared to fields that prioritize logic and objectivity (Ludwig, 1998). Emotions and mental health have a significant place in the creation, appreciation, and understanding of art. The literature on mental health literacy has identified personal experience with mental health to be related to having a higher level of mental health literacy (Reavley et al., 2013). The higher rates of mental illness among those in the arts and humanities as identified in Lipson et al.'s research may make those within such fields better able to recognize mental health conditions when they arise, which align with the findings of this study.

There is scant research on engineering and mental health. Lipson et al.'s 2016 study identified engineering students as some of the least likely to seek out mental health services. However, in this study engineering faculty were found to have the second highest score of

mental health literacy. This is likely due to individual differences in the sample and unique experiences of the participants in the current study. These differences may be attributed to greater personal awareness or mental health education of the respondents that happened to participate in this study. Furthermore, it may be that those that are more interested in the topic of this study were the ones that were more likely to participate.

As part of this study, professors from the divinity school were surveyed and captured in the Christian Studies group in this research. Clergy and faith leaders are some of the first people turned to when someone is having a crisis (Neighbors et al., 1998). Clergy and faith leaders can play a significant role in supporting the wellbeing of their congregants by making referrals to mental health professionals and supporting engagement with mental health services (Cole, 2010). Pastors and ministry staff may be called upon to act as a lay counselor to their congregation such as when a community member passes away and parishioners struggle with grief. Pastors and ministers may have more exposure to mental health by virtue of their work with the community which may contribute to them having higher levels of mental health literacy as found in this study.

Number of Years Teaching

Hypothesis 3 of this study stated that faculty who recently began teaching would have higher mental health literacy than those who have been teaching for longer. The hypothesis was not supported as the results were not statistically significant. The assumption underlying this hypothesis was that faculty who recently began teaching would have been trained more recently than faculty who have been in academia for more years and had more mental health training. However, this was predicated on faculty who have been teaching for years not also continuing to work in their chosen field, which was not clearly defined by the parameters of this study. The

study did not account or control for people who were both teaching on the university level and continuing to work in their field of study.

Age

In the literature on mental health literacy, age is one of the factors linked to higher levels of mental health literacy. Those who are younger have higher levels of mental health literacy than those who are older (Hadjimina & Furnham, 2017). However, in this study when participant age was compared to total scores on the MC-KOMIT, no statistically significant relationship was found. In this sample younger faculty did not score significantly higher than older faculty. In addition to age, years of education is a significant predictor of mental health literacy. Given the findings of this study, years of education may be more highly correlated with one's level of mental health literacy than one's age in a sample of university professors.

Gender

Gender has also been identified in the mental health literacy research as being a predictor of mental health literacy. Those who identify as female tend to have higher levels of mental health literacy than those who identify as male (Hadjimina & Furnham, 2017). In this study, there was no significant difference found between cisgender males and cisgender females. Perhaps in this case as well, level of education was more strongly correlated to one's mental health literacy than one's gender in this population.

Implications

This study found that university educators have significantly higher mental health literacy than a norm group of police officers who received some mental health training. Faculty represent another layer of support for university students when it comes to identifying and supporting student mental health. All faculty will likely benefit from training on mental health literacy. One

of the significant findings from this study was that faculty in the behavioral sciences had higher mental health literacy than faculty in business or education. This suggests that faculty in business and education may benefit more from broad and general training on mental health literacy while those in the arts, engineering, and Christian studies fields may benefit more from tailored mental health literacy training to fill specific gaps in knowledge.

Limitations

The current study is not without its limitations. Perhaps the most glaring limitation of this study is sample size. Although 79 survey responses were collected, only 53 were complete and usable. Those 53 respondents were then split into groups based on their field of study. The result of this was participants distributed unequally into six groups. Several groups had as few as four participants which were then compared against a group of 19 participants. The groups that were the largest corresponded to the departments that had some of the larger departments in the institution. The unequal distribution of participants in groups may have prevented significant results from being detected. Sampling from multiple universities may help avoid this problem in the future.

Additionally, there may also have been a self-selection bias in this study. Participants who were already more interested in mental health may have been more likely to participate in the study and thus could skew the data. This bias may be decreased by increasing sample size. Collaborating with universities to have the study's surveys embedded into yearly data collection may also help reduce this bias.

Diversity was also limited in this sample. 92.5% of the population identified as White or European-American. This is largely due to the university sampled being a predominantly White institution. 100% of participants identified as cisgender, though there was a good sampling of

cisgender females and cisgender males represented. However, according to the U.S. Department of Education (2020), 75% of university faculty identified as White, 12% identified as Asian or Pacific Islander, 6% identified as Black, 6% identified as Hispanic, and 1% identified as American Indian/Alaska Native or two or more races. The diversity in this sample did not align the national trends in postsecondary education (χ goodness of fit (4) = 29.85, $p < .0001$). In the future, sampling from multiple universities may help expand demographics and allow for more generalizability.

Another limitation of this study was the instruments used. Although the concept of mental health literacy has been around in the late 1990s, there are very few psychometrically sound measures with which to evaluate it. Most research on mental health literacy utilizes non-standardized vignettes. Although every effort was made to choose the most psychometrically robust measure possible, there may be another measure better suited to the needs of this study.

Future Research

To date, no other study examines the mental health literacy of university educators. Future research may want to examine in more detail how the predictors of age, education, economic class, and gender identification bear out in a population of university faculty. Additionally, future researchers may want to sample from a wider range of universities including public, private, religious, and non-religious to see if similar findings occur. Future researchers may also want to examine how much change occurs in university educators before and after participating in a mental health literacy training or workshop.

Based on the findings of this study, it may be beneficial for a psychometrically sound measure of mental health literacy specific to university faculty be created. Many participants in this study scored near the top of the available scale. A measure specific to university faculty may

be able to give a more detailed and nuanced understanding of their level of mental health literacy, which can further inform continuing education opportunities regarding mental health.

Summary

The current study sought to evaluate the mental health literacy of university educators. Results showed that university educators have greater mental health literacy than the group of police officers the MC-KOMIT was normed on. However, when faculty mental health literacy was compared based on field they were in, there were only two significant differences found, between behavioral science and business and education. Additionally, this research found that age and gender were not significant predictors of mental health literacy in this sample. Further, how long someone has been teaching did not impact mental health literacy.

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Appendix A

Invitation to Participate

Greetings!

I am conducting surveys as part of a research study to evaluate educators understanding of mental health literacy. Mental health literacy involves the ability to recognize and seek help for mental health disorders. Your participation in this study will help researchers gain a greater understanding of the public's understanding of mental health disorders.

The survey will take approximately ten minutes to complete via the Internet. You will be asked to report demographic data such as your field of study. Your information will be kept confidential. Your participation will further the understanding of mental health literacy within psychology.

If you would like to participate, please fill out this survey (link). If you have any questions, do not hesitate to reach out to me at kewing16@georgefox.edu.

Thank you for your time,

Danni Ewing

Appendix B

Informed Consent

Introduction

You are being asked to participate in a research project. The purpose of this project is to explore mental health literacy (the ability to recognize mental illness and understanding of potential treatment) among educators. Please answer each question. The survey only needs to be completed once and should only require 10 minutes of your time.

Risks and Benefits

There are no physical or psychological risks associated with completing the survey. This study will help psychologists better understand the differences in knowledge about mental health and illness between different generations.

Confidentiality

You will be asked for relevant demographic information such as your field of study, years spent teaching, etc. Your responses will be kept confidential.

Questions or Comments

If you have questions about this study or any of the procedures, you may contact the primary researcher Danni Ewing, M.A. at kewing16@georgefox.edu or Amber Nelson, PsyD. at nelsona@georgefox.edu.

Appendix C

Demographic Questions

1. What is your age?

    Under 25

    25-34

    35-44

    45-54

    55-64

    65+

2. Are you of Spanish or Latino origin?

    Yes

    No

3. What would best describe you?

    African American

    Asian American

    Native American/Alaskan Native

    European American

    Biracial/Multiracial

    Other (please specify)

4. Which gender do you identify most with?

    Cisgender Male

    Cisgender Female

    Transgender Male

Transgender Female

Nonbinary

Other (please specify)

5. How would you describe your sexuality?

Asexual

Bisexual

Heterosexual

Homosexual

Pansexual

Other (please specify)

Appendix D

Teaching Questions

6. What is your field of study?

7. When did you graduate with an advanced degree in your field? (Year)

8. How many years have you been teaching? Please respond with a number.

9. Have you ever spoken with students about the mental health resources that are available on campus?

Yes

No

10. Have you ever referred students or encouraged students to refer themselves to mental health or support services?

Yes

No

11. How many times have you referred students to mental health in the past 24 months?

0 times

1 time

2-3 times

4-6 times

7-10 times

More than 10 times

12. How confident do you feel in referring students to mental health? (Not very confident to very confident)

Extremely confident

Very confident

Somewhat confident

Not so confident

Not at all confident

13. How confident do you feel in having conversations with students about mental health?

Extremely confident

Very confident

Somewhat confident

Not so confident

Not at all confident

14. How confident do you feel in helping someone with a mental health problem?

Extremely confident

Very confident

Somewhat confident

Not so confident

Not at all confident

15. Have you ever spoken with a colleague about mental health?

Yes

No

16. Have you ever personally experienced a mental health condition?

Yes

No

17. Have you ever known someone who has experienced a mental health condition?

Yes

No

Appendix E

Multiple-Choice Knowledge of Mental Illnesses Test (MC-KOMIT)

E5a. Some people with obsessive–compulsive disorder may benefit from which of the following?

A. Developing new hobbies
B. Dietary counseling
C. Legal restraining orders
D. Limiting social contacts
E. Support groups

J5b. A 76-year-old man has mild memory problems, difficulty maintaining his house, and some confusion about what month it is. Which of the following resources may be most beneficial to him?

A. Assisted living facility
B. Nursing home
C. Outpatient psychotherapy
D. Physical exercise counseling
E. Rehabilitation hospital

A1b. A 19-year-old begins to hear voices and act paranoid several months after graduating from high school. Which of the following is the most likely cause of these problems?

A. Excessive worries about other peoples' intentions
B. Genetic tendency toward developing an illness
C. Increasing use of alcohol during adolescence
D. Not enough support from parents

E. Stress of graduating from high school

J5a. Which of the following community services is especially important for people with dementia and their families?

A. Detoxification programs for those with alcohol abuse

B. Hygiene programs for those with grooming problems

C. Memory retrieval programs for those with memory loss

D. Re-orientation programs for those who are disoriented

E. Safe return programs for those who become lost

D5b. A man is evaluated by a psychiatrist, who tells him that psychotherapy is much more important for his problems than any medications. Which of the following disorders is he most likely being seen for?

A. Bipolar disorder

B. Dependent personality disorder

C. Dyslexia

D. Heroin withdrawal

E. Paranoid schizophrenia

B3a. People who have had an episode of major depression are at most risk for which of the following?

A. Becoming addicted to anti-depressant medicines

B. Being diagnosed with migraines

C. Developing schizophrenia

D. Experiencing flashbacks about their depression

E. Having another episode of depression

D5a. Psychotherapy may be the most beneficial resource for which of the following conditions?

A. Alcohol withdrawal

B. Cognitive disorders

C. Developmental disorders

D. Learning disorders

E. Personality disorders

F2a. Which of the following is a feature of all developmental disabilities?

A. Difficulties walking

B. Impairment in daily functioning

C. Inability to communicate verbally

D. Mental retardation

E. Unusual body appearance

H4a. Which of the following is most true of psychiatric medicines for children?

A. They are helpful for all psychiatric disorders

B. They are often crushed and mixed in food

C. They improve some types of symptoms

D. They require a signature from both parents

E. They should only be used after puberty

D1b. A woman sees a therapist weekly to work on her maladaptive patterns of behavior which have repeatedly interfered with relationships and work. When stressed out, she becomes very impulsive, feels empty, thinks of suicide, and makes multiple cuts on her forearms. Which of the following most likely contributed to her problems?

A. A brain infection in childhood

B. Abusive or neglecting parents

C. Influence of bad friends in adulthood

D. Lack of everyday rest and relaxation

E. Not enough vitamins and minerals in her diet

E2a. Which of the following is a common symptom of obsessive– compulsive disorder?

A. Fear of social situations

B. Intrusive thoughts or impulses

C. Ongoing concern about having a panic attack

D. Overeating and weight gain

E. Thinking that others are watching or following

F3b. A woman brings her 16-year-old son to a psychologist for an evaluation of failing grades. In order for the psychologist to ensure that this young man does not have mental retardation, which of the following questions is he likely to ask?

A. Did any of his family members have learning problems?

B. Do his classmates make fun of him?

C. Does he also have unusual beliefs?

D. When did his learning difficulties first begin?

E. Which class does he currently like the least?

I1b. A35-year-old womanhasbeencourt-ordered toseeapsychologist forproblems stemming from her alcoholand cocaine use. Whichof the following is the psychologist likely to be working to change?

A. Avoidance

B. Denial

C. Pessimism

D. Violence

E. Withdrawal

D2b. A woman who has borderline personality disorder frequently becomes suicidal due to an ongoing fear. Which of the following is she most likely subconsciously afraid of?

A. Abandonment

B. Being followed

C. Contamination

D. Gaining weight

E. Growing old

E3a. People who have posttraumatic stress disorder are at highest risk for also having which of the following?

A. Alcohol abuse

B. Bipolar disorder

C. Early-onset dementia

D. Mental retardation

E. E. Schizophrenia

F4b. A 13-year-old girl with severe mental retardation has been followed by a child psychiatrist for ten years. She has never taken medications, but the psychiatrist has now decided that a medication may be beneficial. Which of the following is the most likely reason the medication is being prescribed now?

A. It is now clear that the mental retardation is not getting better without medicine

B. Medicine may help with problems that are worsening, such as behavior outbursts

C. School demands are now greater and she will need medicine to help with learning

D. She is now an adolescent and can take psychiatric medications

E. The mental retardation has advanced from a moderate to severe level

I2a. Delirium and seizures may occur during withdrawal from heavy, long-term use of which of the following substances?

A. Alcohol

B. Inhalants

C. Marijuana

D. Mushrooms

E. Narcotics

A4b. Which of the following is a common reason why a woman with schizophrenia might not regularly take her medicine?

A. Her anxiety disorder makes her too nervous

B. She does not recognize that she has an illness

C. She needs psychotherapy instead of medicine

D. The medicine is addictive and she is afraid to take it

E. The pills are very large and hard to swallow

B5a. Most people in treatment for depression are treated by which of the following?

A. Case managers

B. Family therapists

C. Primary care physicians

D. Psychiatrists in hospitals

E. The clergy

F4a. Which of the following best describes the treatment approach for developmental disabilities?

A. Combination of medications to control behavior
B. Combination of special supports and services
C. Long-term institutional care
D. Long-term psychotherapy
E. Supervision by a life coach

G5b. A mother and father meet with a mental health professional for three sessions over the course of a month after their 25-year-old son committed suicide. Which of the following is the most likely reason for their meetings?

A. To assess for any mental illnesses
B. To attempt to determine what the warning signs had been
C. To begin processing their grief and loss
D. To determine what could have been done to prevent the suicide
E. E. To make a diagnosis of their son's likely mental illness

H1a. Which of the following is likely a cause of attention-deficit/ hyperactivity disorder in children?

A. An inherited risk
B. Certain medications
C. Eating too much sugar
D. Not getting enough sleep
E. Poor control over classrooms

J3a. Which of the following is the most common long-term course of dementia? A. Improvement

A. Paralysis

B. Progression

C. Remission

D. Stabilization

B1b. A woman is diagnosed with depression by her doctor during a hospital stay for asthma. Her doctor was most likely prompted to screen for depression because the woman has which of the following?

A. A long history of smoking cigarettes

B. Family members with depression

C. Little improvement from asthma treatment

D. Poor understanding of her condition

E. Three children under the age of 18

C2a. Which of the following is a common sign of mania?

A. Becoming forgetful

B. Being more talkative than usual

C. Experiencing repeated flashbacks

D. Feeling helpless or hopeless

E. Having anxiety attacks

F5b. A 25-year-old woman receives a number of services through the local mental health system and social agencies, including someone to visit her at home to help with hygiene and cooking, a job coach, a psychiatrist, and a neurologist. Which of the following conditions does she most likely have?

A. Adjustment disorder

B. Dementia

C. Developmental disability

D. Drug addiction

E. Personality disorder

H2b. An 8-year-old boy is diagnosed as having depression by a psychiatrist. The psychiatrist tells the boy's parents that sometimes depression in children appears different from depression in adults. Which of the following is an example of what the psychiatrist is describing?

A. Having high energy rather than low energy

B. Hearing voices rather than feeling hopeless

C. High self-esteem rather than low self-esteem

D. Homicidal thoughts rather than suicidal thoughts

E. Irritability rather than feeling depressed

I3a. Which of the following best describes an addiction?

A. Family members are often unaware that any problem exists

B. It is a chronic disorder requiring many treatment approaches

C. It is a short-term behavioral problem usually tied to a major life event

D. Recovery is rare when a psychiatric disorder is also present

E. Treatment usually includes a medicine that is taken long-term

B1a. Which of the following is most likely to increase one's risk for depression?

A. Being abused as a child

B. Eating a high-fat diet

C. Moving to a new residence

D. Not relaxing enough

E. Working past the age of 65

C2b. A man at an airport is talking and laughing very loudly, passing out twenty-dollar bills, and telling people he plans to fly around the world to attend sixteen diplomatic meetings. He likely has which of the following?

A. Alcohol abuse

B. Delirium

C. Mania

D. Obsessions

E. Pathological lying

D3a. People who have personality disorders usually have these problems during which of the following life stages?

A. Adolescence and adulthood

B. After major life events

C. Childhood and adolescence

D. Older adulthood

E. When going through puberty

E4b. A man has been having episodes of chest pain, hyperventilation, and extreme anxiety during the past few months. He is afraid that he will die of a heart attack during one of these episodes. He has seen several doctors, who assure him that his heart is healthy. He now avoids driving because it seems to trigger these attacks. Which of the following treatments would be most helpful?

A. Counseling

B. Herbal supplements

C. Mood stabilizer

D. Physical therapy

E. Regular exercise

H2a. Which of the following is a common sign of oppositional defiant disorder in childhood?

A. Arguing with teachers

B. Being teased at school

C. Crying at doctors' offices

D. Feeling depressed

E. Not wanting to get on the school bus