Using the Theory of Planned Behavior to Predict Resident Assistants' Intention to Refer Students to Counseling

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Abstract:

GATEKEEPER TRAINING is an approach used to increase mental health-related assistance for students who are at risk for suicide. In this study, the Theory of Planned Behavior (TpB) was used to determine the strongest belief-related predictors of resident assistants' (RAs') intention to refer emotionally overwhelmed students to a mental health professional. Results indicated that RAs' intention to refer was predicted by their beliefs about whether important others (e.g., supervisors, co-workers, family members) would approve of their making a referral and by RAs' self-efficacy in making a referral.

Keywords: Students | Mental Health | Suicidal Behavior | Planned Behavior Theory | Resident Assistants | Mental Health Personnel

Article:

As those who work directly with college students are all too aware, the mental health concerns of college students have received increased attention in the literature and require increased resources on campuses (Gallagher, 2011; Hunt & Eisenberg, 2010; Kitzrow, 2003). The number of students entering college with a history of mental health problems and those who are prescribed psychotropic medication has grown dramatically (Benton, Robertson, Tseng, Newton, & Benton, 2003; Gallagher, 2011). Counseling centers report greater demand for services and larger numbers of students with severe presenting concerns (Gallagher, 2011). Several studies have revealed a growing number of students suffering from depression or thoughts of suicide. The annual National College Health Assessment conducted by the American College Health Association (ACHA) has documented the increasing prevalence of depression among college students (Kay, 2010). The Healthy Minds Study found that 17% of college students screened

positive for depression (Hunt & Eisenberg, 2010). The National College Health Assessment found that one in ten college students reported having seriously considered suicide in the previous 12 months (ACHA, 2007) and that 93% of college students felt overwhelmed (ACHA, 2009).

SUICIDE AND COLLEGE STUDENTS

Suicide is the second leading cause of death among college students in the United States (Suicide Prevention Resource Center, 2004), and a number of accidents (the leading cause of death in this group) actually may have been suicides (Lipschitz, 1990). Suicide ideation and suicide attempts among college students are "surprisingly frequent" (Kisch, Leino, & Silverman, 2005, p. 12), and approximately 1,088 college students die by suicide each year (Kadison & DiGeronimo, 2004). Most of the factors that put students at risk for suicide (e.g., depression, hopelessness, substance abuse) can be treated before they reach an acute stage, if at-risk individuals can be identified and connected with available mental health services (Kadison, 2004).

Most colleges and universities in the United States provide mental health services to students free or at low cost (Center for the Study of Collegiate Mental Health, 2012; Callagher, 2011; Stukenberg, Dacey, & Nagi, 2006). However, students either may not know about these or may be unwilling to seek them out (Kisch et al., 2005). Yet obviously these students need to be reached before counseling services can be offered. For this reason, identification of overwhelmed and at-risk students is a critical component in campus suicide prevention efforts (National Mental Health Association & The Jed Foundation, 2002).

CAMPUS GATEKEEPER TRAINING

One approach that has been used to address students' lack of knowledge and openness to mental health services is to train campus gatekeepers (Wallack, Servaty-Seib, & Taub, in press). These are people who are in a position to have opportunities to recognize problematic behaviors. These individuals, who typically include faculty, academic advisors, deans of students, student affairs staff, residence hall staff, campus police, and Creek life advisors, can play an important role in identifying overwhelmed and at-risk students and referring them to mental health professionals (Yufit & Lester, 2004). Gatekeeper training is not intended to train individuals to act as counselors, but rather to recognize signs of distress and make appropriate referrals. At colleges and universities, resident advisors or resident assistants (RAs) are frequently chosen to be trained as gatekeepers (Taub & Servaty-Seib, 2008; Wallack et al., in press) because they interact with students on a daily basis (Schuh, Stage, & Westfall, 1991). They are also seen as peers, which can help in the process of referral (Tompkins & Witt, 2009) because troubled students are most likely to seek assistance from peers (Sharkin, Plageman, & Manigold, 2003).

The recognition and referral of students with mental health concerns by RAs has been identified as "a critical RA function" that has received "inadequate attention" both in the literature and in RA training (Reingle, Thombs, Osborn, Saffian, & Oltersdorf, 2010, p. 327). In their qualitative

study, Reingle et al. (2010) found that the RAs they interviewed had generally positive attitudes toward referral but experienced the referral process to be emotionally burdensome or stressful. RAs indicated that they would refer only when they perceived the problem to be severe, yet their evaluations of what constituted a severe problem were based more on their own "common sense" than on any formal training (p. 337).

Generally, gatekeeper training has focused on enhancing referral skills and knowledge about risk factors (Garland & Zigler, 1993; King & Smith, 2000). In order to recognize and intervene in problematic behavior, gatekeepers such as RAs must know what the suicidal risk "actors are, be aware of available mental health resources, and develop interpersonal skills used in the referral process. Such knowledge and skill-based training has shown successful outcomes in colleges and universities (Isaac et al., 2009; Pasco, Wallack, Sartin, & Dayton, 2012; Tompkins & Witt, 2009). Although knowledge and skill are arguably important factors, they may not be the only ones that play a role in someone's intention to refer students at risk for suicide. We designed the current investigation in order to explore underlying *beliefs* that might relate to RAs' intentions to refer an emotionally overwhelmed student to counseling.

THEORETICAL FRAMEWORK

The Theory of Planned Behavior (TpB) offers a solid base upon which to build investigations of belief-related factors that influence individuals' intentions to engage in particular behaviors (Ajzen, 1991). According to this theory, a person's intention to perform a behavior is the proximal determinant of performing the behavior. Intentions arise from three considerations: (i) attitudes toward the behavior (e.g., "For me, referring an emotionally overwhelmed student to counseling would be a good thing"); (2) subjective norms (e.g., "Others will look down on me if I refer an overwhelmed student to counseling"); and (3) perceived behavioral control or appraisals of the ability to perform the behavior (e.g., "I don't know how to refer an emotionally overwhelmed student to counseling"). As indicated by Ajzen (1991), "the more favorable the attitude and the subjective norm and the greater the perceived behavioral control, the stronger should be the individual's intention to perform the behavior under consideration" (p. 188). Providing information is not sufficient to change behaviors; interventions designed to change behavior must be directed at its determinants (i.e., attitudes, subjective norms, and perceptions of behavioral control) and at the sets of beliefs that underlie these determinants (Ajzen & Fishbein, 2005).

TpB has considerable empirical support (see Ajzen & Fishbein, 2005; Armitage & Conner, 2001) within the college student population and has been shown to effectively predict college students' intentions regarding a number of behaviors, including alcohol consumption and binge drinking (Collins & Garey, 2007; Gooke, Sniehotta, & Schiiz, 2007; Huchting, Lac, & LaBrie, 2008), safer sex (Bryan, Fisher, & Fisher, 2002; Gha, Kim, & Patrick, 2008), exercise (Gao & Kosma, 2008; Rhodes, Blanchard, Matheson, &Goble, 2006), and weight loss (Schifter & Ajzen, 1985).

More specifically related to the current focus, TpB was used to predict college students' help-seeking attitudes (Halgin, Weaver, Edell, & Spencer, 1987) and intention to use career counseling (Lepre, 2007). Additionally, in a study using TpB to examine counseling clients' intention to refer their college student peers to counseling, it was found that both attitudes and behavioral control related to making referrals were significant predictors of student clients' intentions to refer (Hagenbuch, 2006). Most closely related to the current study, TpB was used to frame a qualitative inquiry into RAs' attitudes and intentions regarding referring students with mental health and substance abuse concerns to counseling (Reingle et al., 2010); the researchers found generally positive attitudes towards referral but inconsistent referral practices.

The purpose of our study was to explore the belief-based predictors of RAs' intention to refer emotionally overwhelmed students to a mental health professional. The Theory of Planned Behavior provided a theoretical grounding for our investigation. Determining the belief-based predictors of RAs' intention to refer overwhelmed students provides direction to those engaged in the process of training RAs in being more effective gatekeepers. Knowing whether RAs' attitudes, internalized subjective norms, or perceived behavioral control influence their intention to refer will allow trainers to develop training approaches that enhance the ability of RAs to identify and refer students in crisis. Those invested in training and supporting RAs cannot, unfortunately, protect them from the inevitability of interacting with students who are in crisis; in fact, their status as peers may contribute to their being among the first on campus to learn about crisis situations (Sharkin et al., 2003). Information that enhances our ability to train RAs to refer, rather than to take on a counseling role themselves, is imperative. Our specific research question was as follows: What are the belief-related predictors of RAs' intentions to refer emotionally overwhelmed students to mental health professionals?

RESEARCH METHODS

We were guided by Ajzen's (1991) Theory of Planned Behavior in the design and implementation of our research and used Francis et al.'s (2004) manual and guidelines for constructing a TpB measure. The focus in the manual is "on assisting researchers to construct a theory based research tool in a systematic and replicable manner" (Francis et al., 2004, p. 7). TpE emphasizes the need to complete all empirical investigations with the specific population of interest. Our investigation was focused on the referral behavior of RAs. Therefore, our development of the TpB quantitative instrument and our investigation of the predictors of RAs' intention to refer, using that TpB instrument were both completed with samples from the same population of RAs at a large, public research university in the Midwest.

In accord with Francis et al.'s (2004) recommendations, we carefully defined the target behavior in terms of target, action, context, and time. After much discussion, we defined referral behavior as "referring emotionally overwhelmed students to speak with a mental health professional." We were guided in the use of the word "overwhelmed" by the Cooperative Institutional Research Program (CIRP) Freshman Survey question about "feeling overwhelmed by all I had to do"

(Pryor, Hurtado, DeAngelo, Palucki Blake, & Tran, 2010) and by the use of the term overwhelmed" by Kadison and DiGeronimo (2004) in their book about college student mental health. *College of the Overwhelmed.* The term "mental health professional," used by the American College Health Association (Kraft, 2011), was seen by the team as a broader term than counselor, therapist, or psychologist. Here the *target* was students, the *action* referral, the *context* students' emotional state (emotionally overwhelmed), and the *time* (implicitly) what they committed to their work as RAs.

Participants

The final sample included 60 RAs, consisting of 25 women (41.6%) and 33 men (55%), with 2 participants not indicating gender. There were 50 White (83.3%) and 2 Hispanic (3.3%) students, with one participant not indicating race; 7 students identified themselves as International (11.7%; all from Asian countries). Their ages ranged from 20 to 30 years, and the mean age was 22.42 *(SD* = 1.60). At the time of collecting data, most of these RAs were seniors (66.7%), while 16.7% were juniors and 10% were graduate students. Regarding the question of how long they had been working as a resident assistant, 6.7% *(n* = 4) answered less than six months, 51.7% (n = 31) answered six months to one year, 30% (n = 18) answered 1-2 years, 8.3% (n = 5) answered 2-3 years, and 3.3% (n = 2) answered 3-4 years.

The university from which the sample was drawn has one of the five largest residence life systems in the United States, with a housing capacity of approximately 10,500 students, with 1,000 apartments in family housing (and operating near or over capacity each year). At the time of the present investigation, there was a total of 275 RAs in the system, and all were required to be at least 21 years old.

The TpB Questionnaire

A questionnaire was developed to measure the three belief-related independent variables (attitudes, subjective norms, and perceived behavioral control) and the dependent variable (intention to refer). Items focused on RAs' beliefs regarding the value/benefit of referring an emotionally overwhelmed resident to speak with a mental health professional (MHP) (i.e., attitudes); their perspective related to how others view the idea of their referring a resident to speak with an MHP (i.e., subjective norms); and their perceptions of how much control they have regarding their referring a resident to speak with an MHP (i.e., perceived behavioral control). This questionnaire was based on the findings of a brief, qualitative elicitation investigation.

As recommended by Francis et al. (2004), we conducted a brief, qualitative elicitation investigation to determine RAs' underlying beliefs (i.e., attitudes, subjective norms, and perceived behavioral control) about referring emotionally overwhelmed students to speak with a mental health professional; beliefs were then used to create the quantitative items used in the TpB questionnaire. We collected the elicitation data using a sample from our target population of RAs, and two researchers independently analyzed the content of the responses for themes and

then compared the themes identified and reached consensus regarding the primary assertions present in the data (Patton, 2002). The RAs (8 women, 10 men, M_{age} = 22.88, age range 21 to 27 years, 72% White) were recruited through an email sent to 75 RAs (approximately 25% of the total RA population) randomly selected by residential life administration (a 24% response rate). Participants responded to an online survey including open-ended questions aimed at eliciting their beliefs regarding the advantages and disadvantages of making a referral (attitudes toward referral), the most important people who would approve or disapprove of referral (subjective norms), and the perceived barriers or facilitating factors for making a referral (perceived behavioral control). We also included a question directing RAs to define "emotionally overwhelmed" in order to confirm the alignment between our understanding and their understanding of the term. The data suggested that RAs had a similar understanding of the construct of "emotionally overwhelmed."

Several themes emerged from the brief elicitation study which were used to inform the development of the quantitative items (25 items total) and corresponding subscales used to assess the TpB belief areas of attitudes (9 items), subjective norms (7 items), and perceived behavioral control (5 items). In addition, we used four items recommended by Francis et al. (2004) to assess RAs' intention to refer. In all cases, the TpB quantitative items were rated by participants on a 7-point scale from 1 *(strongly disagree)* to 7 *(strongly agree)* (see Appendix for the complete TpB questionnaire) As recommended by Francis et al. (2004), we used the mean scores of each subscale in the analyses rather than the total score.

Attitudes. In the qualitative elicitation study, RAs emphasized the advantages of making a referral such as linking emotionally overwhelmed students with the assistance they need from *professionals* who have mental health-related expertise, thus keeping the responsibilities of RAs clear and *not* placing them in the role of counselor. With regard to disadvantages, RAs expressed concerns about students overreacting to referrals (e.g., shutting down, feeling stigmatized), which could lead to difficulties in relationships. We developed a measurement of attitudes based upon these themes using bipolar adjectives that were evaluative. Francis et al. (2004) suggest including the good-bad scale to capture overall evaluation. We used nine adjective pairs to measure attitudes. Besides the good-bad scale, we used the qualitative findings as a basis for selecting the pairings. Using the current sample (and reverse scoring as appropriate), internal consistency of the nine items was .86 (Cronbach's alpha). High scores indicated more positive attitudes toward referral.

Subjective norms. We generated items to measure subjective norms based on themes from the qualitative elicitation study. The primary theme was RAs' belief that most people they knew would be supportive of their decision to refer an overwhelmed student to speak with an MHP. Specific groups mentioned included members of the residential life staff (supervisors, upper administrators, and fellow RAs). In addition, many indicated the support of their own family and friends, and a few mentioned church leaders. Interestingly, a few RAs indicated a belief that the students/residents' family and friends may not believe in counseling or may think that the family

should handle all stressful situations. On the basis of this information, we generated seven quantitative subjective norm items focused on RAs' perceptions of how their own family and friends, their residents' family and friends, individuals with whom they work, and religious leaders would view their making a referral of a student to a mental health professional (see Appendix). The internal consistency for the seven subjective norm items was .86 (Cronbach's alpha).

Perceived behavioral control. To measure perceived behavioral control in a manner that was consistent with Francis et al.'s (2004) guidelines, we included items regarding RAs' self-efficacy and their beliefs about the controllability of the referring behavior. The most common theme from the elicitation study data that was related to self-efficacy and perceived behavioral control was RAs' concerns about working with students with intense difficulties (e.g., victims of depression, eating disorders, suicidal thoughts, or rape). The self-efficacy questions included "I am *not* confident that I could refer an emotionally overwhelmed resident to speak with a mental health professional" and "For me to refer an emotionally overwhelmed resident to speak with a mental health professional is [easy to difficult]." Higher scores indicated *lower* self-efficacy.

The theme related to controllability that emerged from the qualitative elicitation study was RAs' belief that having the specific contact information for the agency in terms of cost, location, hours, and name of a professional would help them to refer a resident. An example of a controllability question based on this theme was "Whether I refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist) is entirely up to me."

Intention. We used Francis et al.'s (2004) generalized approach to measuring intention and generated four intention items. One item was "I will try to refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist)." Internal consistency as measured by Cronbach's alpha and using the current sample was .82.

Procedure

The office of residential life provided the emails of all 275 current RAs to serve as the participant pool. RAs were emailed about the study and directed to a website that contained an information form describing the nature and purpose of the study, demographic items, and the TpB quantitative questionnaire regarding referral-related beliefs and intentions. The response rate for the investigation was 23.3% (N = 64). However, calculating response rate is challenging as there is no way to determine how many of the RAs actually received the requirement email. The final sample used was $N = 60$ due to missing data (n = i) and the elimination of outliers (n = 3).

RESULTS

Upon completion of the data screening process (e.g., replacement of random missing data, normality checks), means and standard deviations were obtained for scores on all measures (see Table 1). Correlational analyses were performed to examine the relationships among variables (see Table 2). All correlations among the predictor variables were below .70, indicating minimal likelihood that multicollinearity existed among the variables (Tabachnick & Fidell, 2007).

Multivariate analysis of variance (MANOVA) was performed to determine if the demographic variables (sex, race, years as an RA) were related to "intention to refer." Although we did not have research questionnaires related to these variables, we wanted to assess for possible associations between these variables and intention to refer prior to our primary analysis. For the purpose of analysis, race was dichotomized as White and non-White. The MANOVA results indicated no significant differences on the variables based on sex, $F(4, 53) = .51$, $p > .05$, year in the university, $F(i6, 212) = .79$, $p > .05$, or the length of time working as RAs, $F(i6, 220) = 1.01$, $p > .05$. There was, however, a significant difference in the variables based on race, $F(4, 55) = 4.56$, $p < .01$, q ^ = 0.25. As indicated in Table 3, non-White RAs (seven Asian international students and two Hispanic students) reported more positive attitudes toward referring residents to MHPs than did their White counterparts.

Table 1. *Means and Standard Deviations (N = 60)*

Variable	**M**	***SD***
Intention to refer	5.53	6.01
Subjective norms	5.18	0.68
Attitude toward referral	5.18	0.79
Perceived behavioral control: self-efficacy	2.63	1.29

Note. *Intention, subjective norms, and perceived behavioral control: self-efficacy items were rated based on a 7-point scale (I* = strongly disagree to 7 = strongly agree). *Attitude was also based on a 7-point scale but with unique anchors for each item (see Appendix). Higher scores were indicative of greater intention, supportive subjective norms, and positive attitudes, whereas higher scores on "perceived behavioral control: self-efficacy" were indicative of less self-efficacy.*

Table 2. *Correlations Among Variables (N = 60)*

Variable	1	2	3
1. Intention to refer			
2. Subjective norms	.49**		
3. Attitude toward referral	.46**	.47**	
4. Self-efficacy	-.44**	-.19	-.58**

*Note. **p < .01 Higher scores were indicative of less self-efficacy*

When the data were examined more closely, the means suggested (statistical analysis was not possible based on the low n with international and Hispanic respondents separated) that international students exhibited more positive attitudes (M = 5.78) than did Hispanic (M = 5.39)

or White (M = 5.09) RAs. Because race influenced intention to refer, this variable (White versus non-White) was included in the first step of our primary regression analysis.

Table 3. Correlations Among Variables (N = 60)

Variable	White	non-White	F(4,55)
1. Intentions			2.10
M	5.44	6.08	
SD	1.28	0.88	
2. Subjective norms			2.10
M	6.11	5.76	
SD	0.68	0.63	
3. Attitudes			4.61*
M	5.09	5.69	
SD	0.75	0.87	
4. Self-efficacy			2.09
M	2.73	2.06	
SD	1.36	0.58	

Note. *p < .05. Higher scores were indicative of less self-efficacy.

Our goal was to determine the best belief-related predictors of RAs' intentions to refer a resident to speak with an MHP. A hierarchical regression was performed to determine which, if any, variables (subjective norms, attitude, and self-efficacy) contributed to the statistical prediction of the intention to refer. Race (White versus non-White) was entered in step 1, and subjective norms, attitude, and self-efficacy were entered together in step 2 to predict the RAs' intention to refer (see Table 4).

In the first step, race did not account for a significant variance of the intention to refer *(*R = .19; R^2 = .04 (Adjusted R^2 = .02), F(1, 58) = 2.09, p > .05). In the second step, the model accounted for a significant amount of additional variance (36%) in the intention to refer after controlling for the variance explained by race *(*R = .63; R^2= .40 (Adjusted R^2= .36), F(4, 55) = 9.24, p < .001). Subjective norms and self-efficacy (higher scores indicated lower self-efficacy) were found to be significant unique predictors of the intention to refer in step 2.

DISCUSSION

Campus gatekeeper training programs have most commonly focused on increasing knowledge about the warning signs of suicide and improving skills at communicating with those at risk (Gould & Kramer, 2001). Although knowledge and communication skills are important, the Theory of Planned Behavior offers a framework for investigating the potential associations between gatekeepers' *beliefs* (i.e., attitudes, subjective norms, and perceived behavior control) and their referral behavior. Findings from the current study suggest that RAs' intentions to refer emotionally overwhelmed students are also influenced by their beliefs related to subjective

norms and their self-efficacy in making a referral. Therefore, these beliefs warrant attention in RA training.

Attitudes

In our qualitative elicitation study, RAs emphasized the *value* of linking emotionally overwhelmed students with professionals having specialized expertise and emphasized that the referral process allowed for clarification of the boundaries of their RA responsibilities (i.e., RAs are not counselors). They expressed *concerns* that residents would not interpret a referral as a sign of concern but rather would feel judged and stigmatized, thus disrupting the RA-student relationship. These findings are similar to the qualitative results of Reingle et al. (2010). 'They found that the RAs they interviewed had generally positive attitudes about referral and considered mental health professionals to be useful resources with specialized training. Furthermore, among the RAs who expressed the possible negative outcomes of referral, the concerns expressed were similar to those we found: that referral might create a negative reaction on the part of the resident (Reingle et al., 2010).

Table 4. Hierarchical Regression Analysis Predicting the Intention to Refer (N = 60)

Variable	B	SE B	β
Step 1			
Race	.65	.44	.19
Step 1			
Race	.76	.40	.22
Subjective norms	.87	.24	.47*
Attitude towards referral	-.01	.24	-.01
Self-efficacy	-.30	.12	-.31*

Note. R^2= .04 for step 1; R^2 = .40 for step 2, *p< .05. Higher scores were indicative of less self-efficacy.

Although RAs' attitudes toward referral appear to be positive, findings from our study indicated that attitudes toward referral were not statistically associated with RAs' intention to refer an emotionally overwhelmed student to a mental health professional. Similarly, Reingle et al. (2010) did not find that favorable attitudes toward referral led to actual referral *behavior.* Perhaps fear of the possible negative interpersonal consequences of making a referral outweighed the advantages of making a referral in the minds of RAs.

Subjective Norms

In our qualitative elicitation study, we found that most RAs indicated that members of the residence life staff, as well as their family and friends, would be supportive of their making a referral for an emotionally overwhelmed student. This finding is consistent with, although broader than, the finding of Reingle et al. (2010), who found that all the RAs whom they

interviewed indicated that their residence hall directors wanted them to refer students with mental health or substance abuse problems.

Our results indicated that RAs' beliefs about whether or not others (e.g., co-workers, family members, friends) would approve of their referring an emotionally overwhelmed student to counseling was a significant predictor of RAs' intention to make such a referral. The present data suggest that explicitly emphasizing the fact that important others would approve of RAs' referring an emotionally overwhelmed student actually may help in increasing their likelihood of doing so.

Perceived Behavioral Control

The most common theme from our elicitation study was RAs' concerns about working with students with intense difficulties (e.g., depression, eating disorders, suicidal ideation). This emphasis in our qualitative data could be related to Reingle et al.'s (2010) finding that RAs were likely to refer a resident to counseling only when they judged the concern to be severe. It appears that RAs may be engaging in a process of screening and triage in their daily work with overwhelmed students, a task for which they may lack sufficient skills.

RAs' *self-efficacy* with regard to their ability to make a referral was a significant predictor of their intention to make a referral. Self-efficacy was measured using two items: "I am *not* confident that I could refer an emotionally overwhelmed resident to speak with a mental health professional" and "For me to refer an emotionally overwhelmed resident to speak with a mental health professional is [easy to difficult]." Higher scores indicated *lower* self-efficacy. Therefore, RAs who were confident and viewed the referral process as easy (versus difficult) were more likely to indicate an intention to refer emotionally overwhelmed students. This result also is aligned with the findings of Reingle et al. (2010) that many of the RAs they interviewed indicated that referring a resident would be challenging and "emotionally taxing" (p. 335). Reingle et al. theorized that perceived behavioral control may be the TpB variable with the greatest impact on intention to refer.

The relationship we found between self-efficacy and referral reinforces the importance of offering RAs skill training, as it may be related to self-efficacy (Bandura, 1986). However, the added point is that RAs' *beliefs* about their abilities also may be critical.

Intention to Refer and Race

The unanticipated racial difference (White versus non-White) found in RAs' intention to refer at-risk students—with non-White students (primarily Asian international students) scoring higher in their intention to refer than did their White peers—may be related to the racial makeup of their residents. At first glance, this finding appears contradictory to past research, which has indicated that non-White students as a group and international students in particular are less open to seeking mental health assistance than are White students (Bradley, Parr, Lan, Bingi, & Gould,

1995; Mori, 2000; Sue & Sue, 1999). However, the focus in the present study was on the intention to *refer another* to counseling rather than the intention to seek services for oneself It is likely that the non-White, and primarily Asian international, students who participated in the present study were working with primarily White students. It is possible that they may have perceived themselves as less equipped to directly assist the students due to cultural differences and were therefore more comfortable making a referral. Regardless, the finding, although based on a relatively small number of respondents, is intriguing and does suggest the need for further research related to potential racial differences in RAs' intentions to refer at-risk students.

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LIMITATIONS

The present study is limited in terms of design, sampling, and instrumentation. Although the response rate was not high, the demographics of the current sample do appear to mirror fhat of the overall population of RAs on the campus (personal communication, Julie Talz, Director of Residential Life, April 15, 2012). Because the data collection was all performed online, it is possible that RAs who did not access their email during the time of the study or those who did but chose not to respond were somehow different along the dimensions explored in this study from RAs who did participate. Therefore, the generalizability of the current findings must be viewed in light of this limitation. It also should be noted that RAs on the campus of focus were all required to be 21 years of age or older, which is not the case at many campuses. It may be possible that the variables in this study may associate differently for RAs who are younger.

IMPLICATIONS FOR PRACTICE

The increasing prevalence and severity of mental health problems among college students has made the gatekeeper role of RAs particularly critical (Pasco et al., 2012; Reingle et al., 2010;

U.S. Department of Health and Human Services, 2001). The findings of the present study offer some suggestions for enhancing the training of RAs to fulfill this crucial role. Training should address RAs' beliefs and attitudes in addition to their skills and knowledge (Taub & Servaty-Seib, 2011).

Emphasizing the professional expertise of counseling center staff in dealing with mental health concerns may be helpful in enhancing RAs' attitudes about the value of referring residents. In addition, however, it may be important to draw out RAs' concerns about the perceived risks of referral. Both our findings and those of Reingle et al. (2010) suggest that the potential negative consequences perceived by RAs (loss of trust, disruption in the RA/student relationship) may outweigh the value RAs place on referral to a professional. Overtly raising these concerns and then addressing them directly in training may help weaken this barrier.

It is also important to make explicit in training that important others (such as the residence hall director) want RAs to refer emotionally overwhelmed students to mental health professionals. Although students appear to be drawn to working as RAs out of a desire to be of assistance to their peers (Blimling, 2003; Reingle et al., 2010), it is critical that RAs are also trained to recognize the limits of their own abilities and to determine when referral is the most appropriate course of action. Historically, perspectives within the field of residential life have varied with regard to the most appropriate role for RAs to play when interacting with students who are experiencing emotional struggles (see, for example, Boswinkel, 1986); more recent scholarship suggests the importance of RAs being clearly directed to refer students who express serious psychological difficulties (Blimling, 2003). RAs can be at risk of becoming too involved with their residents and, out of a desire to be helpful, may slip into a counseling role that is beyond their skill level. Clear indications of expectations regarding referral can be helpful in addressing this possibility.

Training could be enhanced by inclusion of overt conversations about RAs' perceptions of their abilities to make a referral. It may help to discuss appropriate expectations regarding their sense of self-efficacy. For example, it is unreasonable for RAs to expect that they will feel no anxiety about encountering a student in crisis. Even mental health practitioners with years of training, when placed in the position of assessing and referring a client who has expressed suicidal ideation, are likely to have some difficulty managing their anxiety and vocalizing their thoughts (Reeves & Mintz, 2001). The process is stressful, and normalizing that stress may be one strategy for encouraging RAs to accurately perceive their abilities to make an effective referral. Anxiety does not necessarily indicate a lack of skill or inability to follow through on a referral.

The Theory of Planned Behavior as used here functions both as a guide to the empirical process and as a practical tool for designing interventions that target specific populations effectively. It does so by using population-specific data to guide the investigation. The results of the study can then be used, as we did, to guide the development of training about the desired behavior (Taub et al, in press.). We used TpB to target RAs' referral behavior; however, it could be used for other

desired behaviors as well. Examples of such behaviors would be those that RAs on any given campus are reluctant to perform, such as enforcing unpopular policies, intervening in roommate conflicts, or fulfilling programming requirements. It is important to note that we developed a particular TpB measure for our study, but those using the theory must develop measures for their specific target behaviors based on data from their unique populations of focus.

IMPLICATIONS FOR FUTURE RESEARCH

The present investigation suggests that the Theory of Planned Behavior could be a useful tool in assessing how RAs' beliefs about making a referral may relate to their intention to refer emotionally overwhelmed students. TpB has an established track record of use with the college student population, and there are many opportunities for future researchers to use the theory in an attempt to replicate and expand upon the current findings. The theory lends itself well to the assessment of interventions and could be used to develop a belief- based module for an RA training curriculum. Pre- and post-assessments developed using TpB could be used to assess if training was effective in changing beliefs and if those changes and beliefs resulted in subsequent changes in RAs' intentions to refer emotionally overwhelmed students. Future research could also include measures of both crisis/suicide knowledge and referral skills to examine if the beliefs about making a referral predict intention to refer above and beyond these more commonly studied variables.

As was the case for Reingle et al. (2010), our findings suggest that perceived behavioral control may be a key factor influencing RAs' referral-related intentions and behaviors. Future research should fine-tune the assessment of the concept of perceived behavioral control, as it appears to be quite dynamic in the present context. Reingle et al. focused most on the *emotional* elements of perceived behavioral control, including RAs' sense of burden and anxiety in the process. In addition, they found that RAs expressed confidence in their ability to refer yet doubted that students would actually follow through on referrals. In the present study, we operationalized perceived behavioral control through items focused on perhaps the more *cognitive* elements, including direct questions about RAs' confidence and perception of ease/difficulty in approaching a referral situation. We found these items to be significantly associated with RAs' intention to refer, which appears counter to Reingle et al.'s findings related to confidence. The complex nature of perceived behavioral control and intentions to refer could be examined in conjunction with a multidimensional measure of empathy, such as perspective taking, empathic concern, and personal distress (Davis, 1983). It is possible that the different belief-related elements of perceived behavioral control are aligned with different facets of dispositional empathy.

CONCLUSIONS

The training of RAs as gatekeepers is a popular suicide prevention strategy on college and university campuses (Yufit & Lester, 2004). Because of their unique positions as both peers and

helpers and as individuals who live with and interact with students frequently (Taub & Servaty-Seib, 2011), RAs are an obvious choice for gatekeeper training. The Theory of Planned Behavior appears to offer promise for designing RA gatekeeper trainings that will more effectively result in a change in behavior. To obtain the desired outcome of gatekeeper training—that students at risk will be referred to counseling—the findings of this study suggest that RA training must address not only knowledge and skills but also RAs' subjective norms about referral and the self-efficacy they feel about referral.

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Appendix

The TpB Questionnaire
Intention
1. I expect to refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
2. I would want to refer an emotionally overwhelmed resident to speak with a mental health

professional (e.g., counselor, psychologist).
3. I will try to refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
4. I plan to refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
Subjective Norms
5. The individuals I work with (e.g., RLM, staff resident, fellow RAs) expect me to refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
6. The individuals I work with (e.g., RLM, staff resident, fellow RAs) would approve of my referring an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
7. My family would approve of my decision to refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
8. My friends would approve of my decision to refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
9. My resident's friends would approve of my decision to refer him/her to speak with a mental health professional (e.g., counselor, psychologist) when he/she is feeling emotionally overwhelmed.
10. My resident's family members would approve of my decision to refer him/her to speak with a mental health professional (e.g., counselor, psychologist) when he/she is feeling emotionally overwhelmed.
11. My resident's religious group/leaders would approve of my decision to refer him/her to speak with a mental health professional (e.g., counselor, psychologist) when he/she is feeling emotionally overwhelmed.
Perceived Behavioral Control
12. I am not confident that I could refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
13. For me to refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist) is: easy/difficult
14. Whether I refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist) is entirely up to me.
15. I am aware of a number of places where I could refer an emotionally overwhelmed resident to speak with a mental health professional (e.g., counselor, psychologist).
16. Whether a student follows through on my referral to speak with a mental health professional (e.g., counselor, psychologist) is entirely up to me.

Perceived Behavioral Control								
For me, referring an emotionally overwhelmed resident to speak with a mental health professional (e.g. counselor, psychologist) is:								
Strong	1	2	3	4	5	6	7	Weak
Worthless	1	2	3	4	5	6	7	
Valuable	1	2	3	4	5	6	7	
Pleasant	1	2	3	4	5	6	7	
Unpleasant	1	2	3	4	5	6	7	

Good	1	2	3	4	5	6	7	Bad
Harmful	1	2	3	4	5	6	7	
Beneficial	1	2	3	4	5	6	7	
Difficult	1	2	3	4	5	6	7	Easy
Cowardly	1	2	3	4	5	6	7	
Uncomfortable	1	2	3	4	5	6	7	
Comfortable	1	23	4	5	6	7		
Responsible	1	2	3	4	5	6	7	
Irresponsible	1	2	3	4	5	6	7	

Note. All intentions, subjective norms, and perceived behavioral control items were rated based on a 7-point scale (I = strongly disagree *to* 7 = strongly agreed *with the exception of 13. The scaling for 13 was from 1* = easy to 7 = difficult. *The two perceived behavioral control items that formed the self-efficacy subscale were items 12 and 13, and higher scores indicated lower self-efficacy.*

Discussion Questions

1. Review the RA training program pertaining to suicide prevention and referral used on your campus. Does the program address beliefs and attitudes about referring students to mental health professionals in addition to the skills and knowledge needed? If not, what changes would you make to the training program that would target both the beliefs and attitudes about referring students?

2. The authors purport that RAs' intention to refer students to counseling is largely impacted by "their beliefs about whether important others (e.g., supervisors, co-workers, family members) would approve of their making a referral." Has your experience supported this finding?

3. The authors purport that RAs' intention to refer students to counseling is largely impacted by "RA self-efficacy." According to a well-known theorist, Albert Bandura *(Self Efficacy in Changing Societies,* 1995, Cambridge University Press, p. 2), self-efficacy refers to "beliefs in one's capabilities to organize and execute the courses of action required to manage prospective situations." In other words, self-efficacy is a person's belief in his or her ability to succeed in a particular situation. Bandura described these beliefs as determinants of how people think, behave, and feel. From a student development perspective, how does the theory of self-efficacy relate to traditional-aged RAs and their ability to assist residents in crisis?

4. In the discussion of study limitations, the authors point out that their sample of RAs were all 21 or older and warn that the results may not be generalizable because many other programs employ RAs that are younger. How might the study results differ for younger respondents?

5. As noted in the article, "the Theory of Planned Behavior offers a solid base upon which to build investigations of belief-related factors that influence individuals' intentions to engage in particular behaviors." What other student and/or campus issues could be investigated using this theory?

Discussion questions developed by Diane "Daisy" Waryold, Appalachian State University, and Pam Schreiber, University of Washington