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Examining the self-reported health behaviors and the importance of role modeling among resident directors affiliated with the Association of College and University Housing Officers-International (ACUHO-I) institutions

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EXAMINING THE SELF-REPORTED HEALTH BEHAVIORS AND THE IMPORTANCE OF ROLE MODELING AMONG RESIDENT DIRECTORS AFFILIATED WITH THE ASSOCIATION OF COLLEGE AND UNIVERSITY HOUSING OFFICERS-INTERNATIONAL (ACUHO-I) INSTITUTIONS

By

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The purpose of this study was to examine self-reported health behaviors (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations and stress management) of Resident Directors who self-reported being affiliated with ACUHO-I. The second purpose of the study was to examine which areas of health behaviors, do Resident Directors believe, their participation influences the health behaviors of their students. This was completed by inviting Resident Directors to complete the Health Promoting Lifestyle Profile II (HPLPII).

A total of (n=308) Resident Directors completed the HPLPII. The results of this study are ground breaking because it is the first study examining the health behaviors of Resident Directors. Results show that Resident Directors are minimally practicing health behaviors especially in the area of health responsibility.

Key Words: resident director, housing, health behaviors, role modeling

DEDICATION

This dissertation is dedicated to my God, parents Rodolfo (papa) and Renata (mama), teachers, immediate family (Mynor, Tyler, and Tabitha), family, and friends. Especially for my parents whose dreams of coming to America from Guatemala consisted for their children to receive a formal education. "Gracias por el apoyo y la fe de mi triunfos. Los amo mucho."

I also dedicate this dissertation to those who do not have the opportunity to receive a formal education. I hope that my work and dedication to the field of Student Affairs will allow for continuous equality in education. I lastly dedicate this dissertation to Dr. Hosie, I am sorry I did not have the opportunity to finish this dissertation under your leadership; however know that you left me with a wonderful team of leaders and an angelic advisor.

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CHAPTER 1

INTRODUCTION

Today's college students who are living away from home and residing in residence halls for the first time face a new challenge of taking a more active role toward their overall health concerns (Jackson, Tucker, & Herman, 2007). Bylund, Imes, and Baxter (2005) revealed that prior to coming to college, students' health behaviors were modeled by their parents or guardians. Glanz, Lewis and Rimer (1997) define health behaviors as "any activity undertaken by a person believing himself to be healthy, for the purpose of preventing disease or detecting it in an asymptomatic stage" (p.26). Once students arrive on campus, their health behaviors can be influenced by their peers (Okun et al., 2003; Scholly, Katz, Gascoigne, & Holck, 2005) and the people in their new living environment (Cooper & Guthrie, 2007).

Resident Directors are full-time student affairs professionals, who as part of their job requirements, are expected to work and live in the residence halls among students (see Appendix A). Resident Directors are responsible for shaping the environment of the residence halls through programming, daily interactions with students, and building opportunities for students to view themselves as active citizens in their new community. Hence, Resident Directors should be aware of the influence that their own health behaviors may have upon their residents (Schuh, 2004). After conducting a review of

literature of Resident Directors, it was found that no research study has been conducted on the overt health behaviors among Resident Directors. These professionals are expected, by their institution, to conduct their personal lives as a model for student behavior (Blimling, 1993). For this purpose, this study examined the self-reported health behaviors of Resident Directors in the areas of health responsibilities, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management. Secondly, this study also examined which health behaviors (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management) do Resident Directors believe that their participation is important for initiating and motivating their students' health behaviors in those areas.

Presuming that college life can be stressful for first year college students, Brunt and Rhee (2008) found that many college students engage in unhealthy behaviors which can affect the length and quality of their life. Walker, Sechrist, and Pender (1987) further define health behaviors as lifestyle choices practiced by individuals. These choices range from choosing to walk instead of remaining sedentary, choosing foods with nutritional values as opposed to those without nutritional value, or engaging in social relationships instead of living isolated. Sands, Archer, and Puleo (1998) demonstrated that unhealthy behaviors such as poor nutrition, excessive alcohol consumption, physical inactivity, and risky sexual behaviors place college students at a risk for alcohol abuse, inadequate nutrition, and Acquired Immune Deficiency Syndrome (AIDS). Newton, Kim, and Newton (2006) noted that obesity is growing the fastest in the American college age (18-24 years old) population. Brunt, Rhee, and Zhong (2008) found that the increase of obesity in the college age population went from 12% in 1991 to 36% in 2004.

Additionally, a study conducted at Cornell University found that first year college students gained an average of 4.2 pounds which is 11 times greater than the national weight gain of .8 pounds for the average American adult per year (Kasparek, Corwin, Valois, Sargent, & Morris, 2008). The early onset of obesity in the United States may alter the term "Freshman 15", a mainstream terminology used to describe the amount of weight freshman college students gain during their first years to the term " Freshman 30 or 45" (Ford & Torok, 2008). A study conducted by Spencer (2002) showed approximately 29% of college students indicated having high cholesterol levels, 4% indicated experiencing high stress levels, and 21% having high blood pressure. During college years, students develop poor nutritional habits because they usually eat on the go, grab a quick snack between classes, and participate in their extracurricular activities (Baker, Boland, & Laffey, 2006).

Newton et al. (2006) indicated when students arrive on campus, they are still developing behaviors which can contribute to their overall health. Residence halls, where students spend the majority of their time (Boyer, 1987; Etzioni, 1964), are living-learning communities where such behaviors are still being developed. Much of the growth and development of students is influenced as a result of the environment created by the residential staff of residence halls (Strange, 1993).

Resident Directors are influential in shaping the environment of the residence halls through programming and daily interactions with students. These staff members need to be aware that their own health behaviors are emulated by the students (Schuh, 2004). Miller (2003) as stated in The *Council for the Advancement of Standards in Higher*

*Education 2003 (*CAS) illustrated that residence life staff members should plan and deliver educational programs to residential students which produce outcomes such as:

> intellectual growth, effective communication, realistic self- appraisal, enhanced self-esteem, clarified values, career choices, leadership development, healthy behaviors, meaningful interpersonal relationships, independence, collaboration, social responsibility, satisfying and productive lifestyle, appreciation of diversity, spiritual awareness, and achievement of personal educational goals. (Miller, 2003, p.171)

The attitudes and behaviors of Resident Directors related to their health behaviors in health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management are important to research, since these may be the individuals who approve the type of food served at educational programs within the halls; monitor the forms of physical activities promoted in residence halls and frequently have conversations with students on issues of life concerns and aspirations (Miller, 2003).

National attention to health awareness during the early 1980's led toward a model of programming known as "lifestyle education." Emerging in higher education, the lifestyle model includes components of wellness and holistic health allowing for a better understanding of health behaviors (Krivoski & Warner, 1986). Hettler (1980) defined wellness as:

> an active process through which the individual becomes aware of and makes choicestowards a more successful existence…. Each individual develops a unique lifestyle that changes daily in the reflection of his or her intellectual, emotional, physical, social, occupational, and spiritual dimensions. (p. 83)

During the college years, students are considered to be at their prime health stage (CDC, 2009). This allows Resident Directors, in collaboration with faculty, university administrators, and student affairs staff, the opportunity to educate students about health

related choices in nutrition, physical activity, health responsibility, stress management, spirituality, and interpersonal relationship which can impact their future health (Krivoski & Warner, 1986). The American College Health Association (ACHA) has shown that there is a direct link between student learning and student health (ACHA, 2009). College health in the twenty-first century should address health at all levels including individual, group, institutional, and environmental, along with developing partnerships among faculty, administrators, and student affairs staff personnel (Joyce-Brady & Rue, 2006). Today's college students not only have to deal with the "Freshman 15", but also have to be prepared to handle sleep deprivation, high caloric cafeteria food which sometimes includes an all-you-can-eat buffet, as well as the stress of obtaining a degree during economic hardships (Smith, Fada, & Smith, 2006).

Statement of the Problem

The United States has undergone various societal changes, making it difficult for people to engage in healthy behaviors, thereby, contributing to the rise of chronic diseases (Center for Disease Control, 2008). These changes are a result of larger portion sizes, an increase in sedentary jobs, an increase in television and computer viewing by children, as well as a decrease in healthy activities outside due to an increase in crimes (Collins, 2008). According to the Center for Disease Control and Prevention [CDC] (2008), heart disease, cancer, and diabetes are listed as the leading causes of chronic deaths in the United States. Moreover, these chronic diseases are preventable by adopting healthy lifestyles at an early age. Therefore, if Resident Directors practice and model

healthy behaviors, college student will have the support needed to live healthier lives leading to a decrease in chronic diseases.

To date, no research has directly focused on self-reported health behaviors among Resident Directors or what Resident Directors believe about modeling healthy behaviors for their students in the areas of interpersonal relationship, nutrition, physical activity, health responsibility, stress management, and spirituality. These professionals are expected, by their institution, to conduct their personal life as a model for student behavior (Blimling, 1993). The problem is that due to the nature of their live-in position which requires around the clock responsibilities, Resident Directors, have a difficult time balancing and separating their work life from their personal life which can lead to an unhealthy lifestyle (Moore, 2006; Palmer, Murphy, Parrot, & Steinke, 2001). Even though Resident Directors are responsible for developing environments and assisting students to live healthy, Resident Directors in general, are not actively practicing the healthy lifestyles that they espouse for their students. According to Moore (2006), behaviors such as lack of sleep, unhealthy eating, and an ability to manage stress are found among Resident Directors. Furthermore, Moore (2006) noted that Resident Directors use excuses to justify their reasons not to engage in health behaviors such as : (a) The water in the building went out; (b) I was up late counseling a student; (c) I work 24- hours a day; or (d) I have many crises to overcome. According to Leafgren (1993), Resident Directors serve a vital role in the lives of students through the daily interactions with students and planning residential programs. Therefore, it is beneficial to research their self-reported health behaviors and how they role model these behaviors to their students.

Before the 1960's limited research was conducted in the area of residence life buildings, residential students, or staff. However, from 1960's to the present day, there has been an increase in the literature on residence life as it relates to student wellness (Krivoski & Warner, 1986; Leafgren, 1993), living-learning environments (Edwards & McKelfresh, 2002; Schein & Bowers, 1992), and Resident Assistants who are live-in student staff (Hardy & Dodd, 1998; Komives, 1991). Research as it pertains to overall Resident Directors is limited and mostly addresses issues of job satisfaction (Bailey, 1997; Jennings, 2005; Messer-Roy, 2006), recruitment and attrition (Belch, & Muller, 2003; Dunkel & Schreiber, 1992; Kearney, 1993; Scheuermann, & Ellet, 2007) leadership (Kieffer, 2003;Tompkins,2004;) and burnout (Palmer, Murphy, Parrot, & Steinke, 2001). Resident Directors serve a vital role in the lives of students through the daily interactions with students and planning residential programs; therefore, it is beneficial to research their health behaviors and how they role model it to their students (Leafgren, 1993).

Other studies (Cameron, Katch, Anderson, & Furlong, 2004; Wiley, 2002; Yager & O'Dea, 2005) examined how the role modeling of healthy behaviors among health educators, doctors, and elementary teachers can influence their students or patients' health behaviors. In much the same way, Resident Directors have the ability to influence the quality of students' health and academic life at universities, making it essential for universities to begin examining the health behaviors of Resident Directors. After all, these professionals work and live in the same community with the college students whom they are developing as future leaders (Livingston & Watson, 2009).

In 2005, according to the US Department of Education, approximately 17.5 million students were enrolled in the 4,200 degree granting colleges (ACHA, 2007). Universities not only provide health information to students, but also model healthy behaviors for them (Fletcher, Bryden, Schneider, Dawson, & Vandermeer, 2007). Similar to everyday society, universities are environments which mirror the activities engaged by society (MacKinnon, Broido, & Wilson, 2004).

Health concerns on today's campus environments are affected by the changing demographics of students (Grace, 1997). From 1970 to 1995, the percentage of college students over the age of 25 grew 16%, the number of college women surpassed male enrollment by 14%, and college enrollment of under-represented students went from 15.7% in 1976 to 25.3 % in 1995 (Hansen, 1998). The increase of racial diversity among students as well as the increase of women on college campuses is important to consider when discussing health behaviors. The American Heart Association (AHA, 2000) found that cardiovascular disease was the number one disease that killed women in the United States. A study conducted by Economos, Hildebrandt, and Hyatt (2008) showed that females tended to report more stress (22.3%), than their male counterparts (11.6%). Another study conducted by Despues and Friedman (2007) showed college students who identified themselves as Asian American, African Americans, and Hispanic Americans indicated less participation than their Caucasian American counterparts in receiving an annual physical exam, visiting the dentist, and engaging in exercise.

Rationale for the Study

Dorn (1992) found that a connection exists between work and health and that there is a connection between issues related to one's occupation and all other areas of life (Roe, 1972). The support for university personnel to engage in a healthier lifestyle can lead toward reducing work absenteeism, lowering health costs, and increasing work morale (Abood, Black, & Feral, 2003). So evident is this connection, that Marling (2006) researched overall wellness in student affairs professionals through collecting data from a Wellness survey. This study concluded that student affairs professionals scored higher in all factors of the Five Factor Wellness Inventory, compared to the wellness scores of the general population. More specifically, a study conducted by Fedorovich (1991) examined scores from a wellness inventory that served as a factor for selecting Resident Assistants. This study demonstrated that those students who were chosen for the Resident Assistant position showed higher wellness scores than those students who were not hired as Resident Assistants.

Outlining the difference of a Resident Directors' position compared to other student affairs professionals is critical in understanding the context of the life and work of Resident Directors. Weaver (2005) found that the Resident Directors' work environment is challenging because Resident Directors live where they work. A study conducted by Collins and Hirt (2006) demonstrated residence life members differ from their colleagues who work in different areas of student affairs. The study concluded that Resident Directors identified the following differences when compared to their counterparts in student affairs: (a) more workload including evening and weekend work, (b) less likely to have input regarding decisions made within their departments, and (c) more time

performing administrative tasks resulting in less time serving students. Furthermore, Belch and Muller (2003) indicated that it is a challenge to recruit and hire Resident Directors. These challenges include (a) limited quality of life, (b) administrative demands of Resident Directors, and (c) burn-out associated with the Resident Director position. Kearney, as cited in Belch and Muller (2003) stated "Young professionals today are not as willing or interested in taking live-in positions with long hours, lack of privacy, and relatively low pay for a person with an advanced degree" (p.30); making it harder to recruit Resident Directors.

The above studies on residence life members (Belch & Muller, 2003; Collins & Hirt, 2006) indicated that factors such as long work hours, unsuitable quality of life, and increased burnout distinguish Resident Directors from overall student affairs professionals. In particular, Resident Directors not only work long hours with students but have limited privacy to regroup from the long days. In the long run, factors such as poor quality of life, long work hours, and stress related to burnout can take a toll on a person's health behaviors (Abella & Heslin, 1984; Miller, Danner, & Staten, 2008; Piotrowski & Vodanovich, 2008).

The reason for this study is to further support current studies about Resident Directors' quality of life (Belch & Muller, 2003) and burn out (Collins & Hirt, 2006), and also to begin to understand how Resident Directors' health behaviors can impact the initiation and motivation of their students' health behavior.

Justification for the Study

Currently, no study has examined the self-reported health behaviors of Resident Directors and whether or not Resident Directors believe that their practice of role-modeling healthy behaviors will initiate and influence their students' health behavior. For this purpose, it is important to conduct an exploratory study in examining self-reported health behaviors among Resident Directors. The commitment to the total development of an individual has always been a high priority in the mission of higher education in America (Kaplan, Whipple, Wright & Murphy, 2004). The growth of a student is measured not only by the intellectual component, but also by moral and personal development. Factors such as policies, relationships with staff members, and living arrangements are components that create the environment for the well being of a student (Leafgren, 1993). Further, Resident Directors are key leaders in developing programs for students in areas of (a) intellectual development, (b) physical development, (c) social development, (d) occupational development, (e) emotional development, and (f) spiritual development (Leafgren, 1993). These programming areas could provide Resident Directors the opportunity to model health behaviors through the programming conducted in the halls.

Leadership is defined "as the attempt to influence the behavior of an individual or group, regardless of whether the leader's purpose is based on personal goals, professional standards, or organizational priorities" (Reisser & Roper, 1999, p. 124). Resident Directors serve as leaders for their residential students as well as their student staff known as Resident Assistants (RAs) who also live and work in the residence halls. Resident Directors serve in leadership positions that are influential and guide students to

change. They are responsible for mentoring their students and student staff and should strive to maintain an environment that encourages healthy living (Leafgren, 1993).

Moore (2006) found that Resident Directors often believe they have to be everything to everyone, 24 hours a day. Resident Directors work long hours to ensure that their residents know who they are by being visible at late night programs (Moore, 2006). These long hours can have an impact on Resident Directors' health, morale, family, and overall wellness (Miller, Danner, & Staten, 2008). Consequently, it is also important to research the self-reported health behaviors of Resident Directors, because it also supports senior student affairs professionals' understanding for planning staff recruitment and retention strategies, which in turn supports the development of programs for many students who will impact the direction of our society's future (Leafgren, 1993).

The purpose of this study is to examine the self-reported health behaviors of Resident Directors who self-reported affiliation with the Association of College and University Housing Officers-International (ACUHO- I). This will be accomplished by administering the Health Promoting Lifestyle Profile II (see Appendix B), developed by Walker, Sechrist, and Pender (1987). Specific health behaviors that will be examined among the Resident Directors include: (a) health responsibility, (b) physical activity, (c) nutrition, (d) spiritual growth, (e) interpersonal relations, and (d) stress management.

Research Questions

This study was designed to answer the following questions:

Research question 1: Do Resident Directors (RDs) affiliated with ACUHO-I institutions practice healthy behaviors in the areas of (a) health responsibility, (b)

physical activity, (c) nutrition, (d) spiritual growth, (e) interpersonal relations, and (d) stress management?

Research question 2: What areas of health behaviors according to the Health Promoting Lifestyle Profile II (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management) do Resident Directors believe their participation is important for influencing the participation of healthy behaviors for their students?

Research question 3: Are there any significant differences between the gender of Resident Directors and their subscale scores from their self-reported health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management?

Research question 4: Are there any significant differences between the race of Resident Directors and the sub-scale scores from their self-reported health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management?

Research question 5: Are there any significant differences between the geographic region of Resident Directors and the sub-scale scores of their self-reported health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management?

Limitations of Study

The first limitation of this study was that Resident Directors are trained in resources about health behaviors and wellness for their students (Weavers, 2005). Prior knowledge

may affect the way Resident Directors rate themselves in their self-reported health behaviors. A second limitation was the Health Promoting Lifestyle Profile II (HPLP II) which was distributed to Resident Directors during the spring season. According to Merril, Sheid, White, and Druce (2005) people during this season tend to engage in the physical health behaviors more frequently; therefore, the physical activity self-reported scores may be higher than the other behaviors. The third limitation was the Health Promoting Lifestyle Profile II was only distributed to Resident Directors at ACUHO-I affiliated universities in the United States; hence, the results cannot be generalized. The fourth limitation of the study was the Health Promoting Lifestyle Profile II was distributed to Resident Directors during the busy end of the academic year for the profession; hence, some Resident Directors may have chosen not to take the survey which could have lowered the final sample size. The fifth limitation was results from the Health Promoting Lifestyle Profile II are self-reported, thereby, threatening the validity of the results because one does not know if the subjects are being truthful with their self-report responses. The last limitation pertains to the researcher of the study. The researcher was a graduate Resident Director for 4 years and has supervised Resident Directors for 6 years, hence, providing the researcher with personal bias to the study. The researcher also served as the Co-chair for the Latino Network within the American College Personnel Association from 2005-2007. These factors could have affected participants' reasons for taking or not taking the survey.

Definition of Terms

The following are definitions to clarify any terms used in the introduction:

1. Association of College and University Housing Officers-International -An International association of college and university housing officers whose members believe in developing exceptional residential experiences at colleges, universities, and other post-secondary institutions around the world.
2. Chronic Diseases - Are non-communicable illness that persists for more than three months. Examples of chronic diseases are heart disease, cancer, and diabetes. These diseases are the most common health problems, but also the most preventable (CDC, 2008).
3. Healthy People 2010 - An initiative supported by the Center for Disease Control that has 2 goals which include to increase the quality of life for Americans and to eliminate health disparities (Healthy People, 2008).
4. Health Promoting Lifestyle Profile II (HPLPII) - A scale that measures the concept of health promoting self care behaviors in the areas of spiritual growth, interpersonal relations, nutrition, physical activity, health responsibilities, and stress management through the reflection of how often a person practices health behaviors (Walker, Sechrist, & Pender, 1987).
5. Resident Assistants - Students who are hired to work and live with other students in the residence halls. Resident Assistants have five roles which include: student, administrator, role model, teacher, and counselor (Blimling, 1998).

6. Resident Director - "A full time student affairs staff member that lives inside a college or university residence hall" (Reslifepro.com, 2008, paragraph 1). In addition, they supervise paraprofessional student staff to ensure students' experiences are enhanced by fostering a community in support of the academic mission of the institution (ResLifepro.com, 2008).
7. Residence Hall - A term that represents a building on a college campus designed to provide students with low-cost, safe, and comfortable living arrangements; As well as an environment for intellectual, social, moral, and physical development of students (Winston, Anchors, & Associates, 1993).
8. Student Affairs Professional - University staff members who believe in educating students by integrating student life and learning (Nuss, 1996).

Organization of Dissertation

This dissertation is organized into five chapters. Chapter One describes the introduction to the study including the statement of the problem, the rationale for the study, justification of the study, as well as limitations of the study and definitions of terms. Chapter Two focuses on the literature review pertinent to the study. Chapter Three includes the research methodology process including information about the demographics of the population, description of the instrument, and the procedure to collect the data. The analysis of the data is detailed in Chapter Four. Finally, Chapter Five provides a summary of the results, the conclusion of the study, as well as further recommendations for research.

CHAPTER II

REVIEW OF LITERATURE

Very little is known about health behaviors of Resident Directors and how their role modeling can impact students' health behavior. Therefore, the purpose of this study is to examine the self-reported health behaviors of Resident Directors working at ACUHO- I affiliated institutions in the area of nutrition, physical activity, health responsibility, spirituality, stress management, and interpersonal relationship. Furthermore, this study will also examine the beliefs Resident Directors attach to their practice in role modeling healthy behaviors for initiating and motivating their students' health behaviors. To begin understanding the importance of this study, the literature review will first highlight health as it relates to the history of college health and wellness, student health behavior, and health theories. Secondly, the literature review will provide an overview of residence life through understanding the history, role, and context of residence halls and the Resident Director position. Finally, role modeling will be reviewed in relation to the concept of health behaviors.

Resident Directors are live-in university staff members who foster community building within residence hall environments and provide support toward intellectual and social growth of students who reside in the halls (Kearney, 1993). Resident Directors provide educational programs to students in areas such as: (a) intellectual, (b) emotional,

(c) physical, (d) social, (e) occupational, and (f) spiritual concerns (Krivoski & Warner, 1986). The literature supports various studies which demonstrate that students who reside in residence halls tend to have greater success in areas such as academic achievement, academic persistence, satisfaction with the university, and personal development than students who live off-campus (Astin, 1993; Chickering 1974; Pacarella, Terenzini, & Blimling, 1994).

First year college students are presented with new opportunities and decisions every day such as making their own choices in food, physical activities, and social activities. The ability to manage these new responsibilities may lead students to the making of unhealthy choices that may affect their length and quality of life (Von Ah, Ebert, Ngamvitroj, Park & Kang, 2004). Heart disease, cancer, and diabetes are noted as the leading causes of death in the United States. Moreover, these chronic diseases are preventable by adopting healthy behaviors (CDC, 2008).

Resident Directors have the opportunity to collaborate with other university administrators, faculty, and staff to promote student health (Joyce-Brady & Rue, 2006). Resident Directors who work and live within these residence halls can influence student health behavior through practicing positive lifestyle health behaviors (Krivoski & Warner, 1986).

The Establishment of College Health

Kaplan, Whipple, Wright, and Murphy (2004) noted that student health care can be traced as far as the beginning days of Harvard University (1636). From the 1600's to the 1850's, the responsibility of health obligation shifted from institutional responsibility

toward students being responsible for their own health. This new shift of health responsibility to students left them depending on community resources and volunteers for their personal health care (Kaplan et al., 2004).

During the early nineteenth century, American scholars who returned from Germany and Scandinavia introduced the physical aspect of health within higher education in the United States by introducing physical activities as part of the curriculum (Kaplan et al, 2004). As early as 1859, Dr. Edward Hitchcock, known as the father of college health, was the first professor who provided health services to students at Amherst College by providing annual general physical examinations, education on hygiene, and opportunities for physical exercise. Dr. Hitchcock believed that "the body and mind should work together harmoniously" (Kaplan et al., 2004, p. 369). In 1861, through the influence of Dr. Hitchcock, Amherst College was the first to develop a comprehensive department of hygiene and physical education. Princeton University followed by opening the first student infirmary in 1893; then in 1901, the University of California developed the first student health center (Kaplan et al.,).

In 1920, the American College Health Association (ACHA) was founded to support colleges in the areas of health promotion education, medical services, and to help identify current health issues. ACHA provides leadership to the members of campus communities by providing the members with education on college health, current health resources, and advocacy of college health (ACHA, 2008). During 1958, *Student Medicine* published by ACHA became known as the journal to support the research of college health (ACHA, 2007). Later in 1962, the name of the journal changed to the *Journal of American College Health Association* in which it is known as today.

Prior to 1960, the concept of student health grew at a slower pace due to students relying on the public health system for their health needs. The results of student activism, the sexual liberation movement, increase of alcohol and drug abuse, along with students demanding that colleges serve their needs, led colleges to creating comprehensive health centers (Kaplan et al, 2004). In response to the turmoil during the late sixties and early seventies, ACHA set forward in 1977 recommendations for university health services to implement the following services: "(a) outpatient and inpatient, (b) mental health, (c) athletic medicine, (d) dental services, (e) rehabilitation/physical medicine, (f) preventive medicine, (g) health education and promotion, (h) environmental health and safety, and (i) occupational health" (Kaplan et al., 2004 p.370).

The increase of ethnic differences and health disparities on a national level encouraged members of ACHA to promote more programs on college campuses that focused on ethnic minority and gay, lesbian, and transgender issues during the 1990's (Brener & Gowda, 2001). Dressler, Orths, and Gravlee (2005) defined health disparities as "the difference in morbidity, mortality, and access to health care among population groups defined by factors of socioeconomic status, gender, residence and especially race and ethnicity" (p. 232). The demographics of the college population have dramatically changed from the 1960's to the current twenty-first century. Results in the *American Association for Higher Education bulletin* 1998 showed that college students over the age of 25 rose from 28% in 1970 to 44% in 1995. This report found that although there was an increase of 9% in male enrollment from 1985-1995, the enrollment for female during that time was 23% (Hansen, 1998). The American Council on Education (ACE) also saw an increase of 49% during 1994 through 2005 among minority students (ACE, 2006).

Despues and Friedman (2007) conducted a more recent study which illustrated that ethnic minority college students are less likely to participate in health promoting behaviors such as exercise and eating healthier food when compared to their Caucasian Americans counterparts. In addition, it showed that ethnic minority college students were also less likely to engage in health-harming behaviors which include binge drinking. The reason for this difference was due to the level of acculturation of the students.

In 1985, the U.S. Department of Health and Human Services (USDHHS) created the Office of Minority Health (OMH) due to results in the *Report of the Secretary's Task Force of Black and Minority Health* which indicated that Americans of different ethnicities or race do experience health disparities. Furthermore, in 1999, the Center for Disease Control and Prevention (CDC) launched the Racial and Ethnic Approaches to Community Health 2010 (REACH 2010). This initiative was designed to reduce disparities in six areas as it relates to racial and ethnic minorities. These six areas are (a) infant mortality, (b) deficient breast and cervical cancer screening, (c) cardiovascular disease, (d) diabetes, (e) HIV/AIDS and (f) child and adult immunization (USDHHS, 2008).

Kittles and Weiss (2003) define race as a cultural construct used by members of a group to understand biological differences among humans in specific ethnographic settings. Information from the Office of Minority Health and Health Disparities (OMHHD) demonstrated that African Americans have a higher death rate compared to Caucasians in the following areas: (a) 40% higher in heart disease, (b) 30% higher in cancer and (c) seven times more in HIV/AIDS. African American and Hispanic Americans have higher rates of sedentary behavior compared to Caucasians. Hispanics

are higher than non-Hispanic whites in the following: (a) twice as high in diabetes, (b) higher blood pressure and, (c) greater chance of obesity. American Indians are known to have twice as high a rate of diabetes than whites. The Pima tribes of Arizona are known to have the highest rates of diabetes in the world based on their genetics, diet and less physical activity. Asian and Pacific Islanders have reported higher cases of hepatitis and tuberculosis compared to their Caucasian counterparts (USDHSS, 2008).

Several studies (Economos, Hildebrandt, & Hyatt, 2008; Gorman & Read, 2006; Lefler, 2004; Verbrugge, 1985) have shown that gender is another indicator that affects overall health. Davies, McCrae, Frank, Dochnahl, Pickering, Harrison, Zakrzewski, and Wilson (2000) indicated that gender role stereotype and male socialization are two factors associated with gender differences. Generally, male stereotypes include being strong and aggressive. These stereotypes may limit men in asking for help and showing emotions. During adolescent years, men tend to engage in high risk behaviors to show their manhood. Therefore, they are socialized in a manner to hide their vulnerability, and to believe that they are immune to health concerns (Davies, et al, 2000). Verbrugge (1985) noted that when compared to males, females have a life expectancy of seven years longer and are more likely to be affected by non fatal chronic diseases due to having a higher percentage of doctor visits, and usually obtaining more prescription medicine. Verbrugge (1985) also found the health disparities in men when compared to women are fewer but more serious in nature, and experience a higher prevalence for life threatening chronic diseases than females. Interestingly enough, Sabo (2000) noted the recent trend and increase of male health clinics in college communities. The typical purposes of these

college clinics are to educate men in the areas of strength and conditioning, nutrition, stress relief, as well as sexual health.

In addition to race and gender, geographic region is also a factor that influences health. The Kaiser Foundation in collaboration with CDC sponsors a website Statehealthfacts.org that shows the comparison of different health disparities within the United States. According to the Kaiser Foundation, the states in the southeast region have the highest death per 100,000 in (a) diabetes in 2004, (b) cancer in 2003, (c) heart disease in 2004, and (d) childhood obesity in 2005. Louisiana was indicated as the highest percentage of death per 100,000 in the areas of diabetes (38.5 %) and cancer (45 %). Louisiana also had the least amount of people participating in physical activity. Mississippi was identified as the highest state per death ration with heart disease accounting for (33%). West Virginia, Kentucky, and Tennessee were among the top three states with the highest childhood obesity (Kaiser Foundation, 2008).

In 1979, the U.S. Department of Health and Human Services (USDHHS) developed a 10 year health objective for the nation. The first health objectives were published in a document known as: *Healthy People: The Surgeon General Report on Health Promotion and Disease Prevention*; followed by *Healthy People 2000*; then, to the current document known as *Healthy People 2010* (USDHHS, 2008). The initiative Healthy People 2010 aims to increase the quality of life in humans and to reduce health disparities among people who are affected by their social economic status, gender, place of residence and specifically their race. Within the objectives of *Healthy People 2010* are the top leading health indicators of health concerns in the United States. Lack of physical activity, obesity, poor mental health, poor environmental quality, high tobacco use and

substance abuse are noted as top leading indicators of health concerns in the United States (USDHHS, 2008).

As a supporting document to Healthy People 2010, the American College Health Association (ACHA) published *Healthy Campus 2010: Making it Happen.* This document encourages the promotion of physical, emotional, social, and environmental well-being of students, faculty, and staff on university campuses. *Healthy Campus 2010: Making it Happen*, recommends that colleges provide information to students in the following six risk behaviors: (a) injuries, (b) tobacco use, (c) alcohol and drug use, (d) sexual behaviors, (e) sexually transmitted disease, and (f) dietary patterns along with insufficient physical activity (ACHA, 2002).

In 1998, the ACHA developed the National College Health Assessment (NCHA), a survey which collects information about health behaviors, health indicators and health perception as it relates to college age students. This assessment addresses the objectives included in Healthy People 2010 and *Healthy Campus 2010: Making it Happen* (ACHA, 2008). Results from the NCHA 2007, which was collected from over 71,860 students, showed that students indicated depression, anxiety disorders, back pain, allergies, and seasonal affective disorder as the top self reported health concerns. Furthermore, results from NCHA 2007 also showed that students indicated stress, sleep difficulties, concern for a friend, depression and anxiety as factors that affected their academic success (ACHA, 2008).

The Council for the Advancement of Standards in Higher Education (CAS), stated that the mission of college health centers is to "provide, promote, and support services that integrate individual health, education for health, prevention of disease,

clinical treatment for illness, and public health responsibilities consistent with the educational mission of the institution and relevant legal requirements" (Miller, 2003, p. 86). Buck (1987) indicated that college health centers today should develop an all-inclusive health program for students within college communities. This can be obtained by developing interactions with the whole academic community to promote academic success along with a healthy and safe community (Miller, 2003). The "four leaf clover" is a model that includes: (a) consumer services, (b) counseling services (c) health promotion prevention and (d) medical/clinical services as necessary elements for building a comprehensive health programs. These services are provided to and influence students who eventually become members of the greater society (Miller, 2003).

Influence of Wellness Programs on College Students' Health Behaviors

College students engage in health behaviors which can place them at a higher risk for health behavior problems (Brunt & Rhee, 2008). Pender (1987) defines health promoting behaviors as activities people engage in not only to prevent diseases but also to increase their level of health. Personal investment in health consists of individual accountability for holistic wellness by practicing health promoting lifestyles (Johnson, 2005). College students' health problems include unintentional injuries, sexually transmitted disease, poor nutrition habits, lack of physical activity and the inability to manage chronic stress (Brener & Gowda, 2001). In an effort to promote healthy lifestyles on campuses, wellness programs were developed to educate and provide students with resources about health behaviors (Fabiano & Swinford, 2004). Owen (2002) identifies several theorists such as Dunn (1961), Ardell (1977), Hettler (1980), Dossey and Keegan

(1988), Travis and Ryan (1988) and Pilch (1989) as leading founders of wellness in the United States.

Hattie, Myers, and Sweeney (2004) indicated that wellness can be described as a combination of health and a sense of well being. Granello (1999) further defined wellness as "the integration of psychological, biological, spiritual, social, and behavioral variables" (p. 110). During the 1980's, Hettler, a health physician and medical educator, promoted a holistic model of wellness which included physical, emotional, intellectual, occupational, spiritual and social health as the six elements of health related behaviors (Owen, 2002).

Beginning in 1970, wellness became a well-known term in higher education which developed into a national movement (Hattie, Myers, & Sweeney, 2004). Many college courses have incorporated wellness topics such as self esteem, stress management, and interpersonal support. Additionally, wellness also has served as a framework to provide wellness programs for university employer-sponsor programs (Yen, Schultz, McDonald, Champagne, & Edington, 2006). Fedorovich (1991) also studied wellness scores from the Lifestyle Assessment Questionnaire as a selection factor when hiring Resident Assistants at a southern university. This study concluded that students who were hired as Resident Assistants showed a higher score in their wellness scores compared to those who were not hired to be Resident Assistants. Research focusing on wellness programs during college years can help university administrators and staff to understand the practice and monitoring of health behaviors among college students who will practice these same health behaviors over their adult lifespan (LaFountaine, Neisen, & Parsons, 2006).

College Students' Health and Health Behavior

Owen (2002) stated "the terms wellness and health have been used interchangeably" (p.7). Defining the term health is not a simple task. Historically many believed that health is solely the absence of disease. It is important to understand that health is not that simple. The English language can date the word health as far back as A.D. 1000 (Simons-Morton, Greene, & Gottlieb, 1995). During that era, health was explained as the quality of soundness and wholeness. In 1947, the World Health Organization (WHO), defined health as the following: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Simons-Morton, Greene, & Gottlieb, p. 6).

Besides the military, higher education is another community which attracts a high rate of 18-24 year olds. Understanding college students' health behavior in the United States is important because it not only affects academic retention, but also the future of our workforce and economy. In 2003, approximately 27% of the adult population in the United States had completed at least four years of college (US Census Bureau, 2003). In 2005, over 17.5 million students were enrolled in higher education in the United States (ACHA, 2008). By 2014, colleges will see an increase of 17% in the population; indicating and encouraging colleges to set up health initiatives and programs which can promote healthy behaviors and reduce the mortality rate (Sandeen & Barr, 2006).

Individuals in the college age population (18-24) are experiencing mortality at a higher rate than previous decades due to environmental, developmental, and behavioral risk behavior (Grace, 1997). The National Vital Statistics Report of 2004, indicated the

following: (a) accidents, (b) homicide, (c) suicide, (d) malignant neoplasm (a form of cancer), and (e) heart disease as the top five leading death indicators in adolescents and young adults ranging from ages 15-24 (Hernon, 2007). High mortality rate has led college health centers toward focusing more on community health than individual health.

Von Ah, Ebert, Ngamvitro, Park, and Kang (2004) found that college students tend to think they are invincible; therefore, the manner in which they seek medical consultation is different from the general population. In general, college students wait until they can find a break from their class, studying, or daily life to visit the doctor. Little is known about all aspects of overall health problems with the college students, but research has focused on smoking (Levison, Campo, Gas-Coigne, Zakharyan, & Tran, 2007; Travis & Lawrance, 2009), drinking behaviors (Dantzer, Wardle, Fuller, Pampalone & Steptoe, 2007; Wechsler & Davenport, 1994), sexual practice (Starkman & Rajani, 2002; Weinstock, Berman, & Cates, 2004), eating behaviors (Brunt & Rhee, 2008; Brunt, Rhee, & Zhong, 2008), and mental health with college age students (Fletcher, Bryden, Schneider, Dawson, & Vandermeer, 2007).

According to Bylund, Imes, and Baxter (2005) 44% of college students identify themselves as binge drinkers, up to 29% of college students considered themselves regular tobacco users, and 14% to 29% have reported high cholesterol. LaFountaine, Neisen, and Parson (2006) have illustrated that 52.1% of college age students have identified feelings of stress. Indicators such as tobacco use, binge drinking, stress, and high cholesterol are risk factors that can contribute to coronary disease (CDC, 2008). According to the National Vital Statistic report of 2005, heart disease was the leading cause of deaths in the United States (Kung, Hoyert, Xu, &Murphy, 2008). Many of the

risk factors of heart disease can begin while students are in college. These risk factors include tobacco use, hypertension, high cholesterol, high fat diets, excessive alcohol consumption, high stress, and sedentary lifestyle (Spencer, 2002). In 2005, the ACHA reported that only 44.2% of students reported exercising for 20 to 30 minutes three times a week. A study conducted by Spencer (2002) found that 29% of college students have high cholesterol over 200 mg/dl and 7% were at high risk over 240 mg/dl. The American Heart Association indicates that the desirable cholesterol level to prevent heart disease is below 200 mg/dl (AHA, 2009).

Health behavior patterns developed during the transitional college years (18-24) can have a critical impact on health through the lifespan of adulthood (Brunt & Rhee, 2008). College students new to the collegiate life, experience increased stress when beginning college because they are now found with the responsibly of balancing their new freedom which includes academic life, social network, and living environment within the residence halls (Jones, Harel, & Levinson, 1992).

Theories and Models to Understand Health Behavior

The goal of health promotion and health education is to prevent disease throughout understanding promoting health behaviors (Glanz et al., 1997). When understanding health behaviors, theories and models are important to consider because they help guide health promotion and health education. Rodgers (1980) defined theory as "a set of prepositions regarding the interrelationship of two or more conceptual variables relevant to some realm of phenomena. It provides a framework for explaining the relationship among variables and for empirical investigations" (p.81). In simpler terms,

Dicaprio (1974) indicated the role of theory is to describe, explain, predict, and control. Similar to theory, models are designed by putting together various theories to understand a specific problem (Glanz et al., 1997).

During 1992-1994, many theories and models were applied in research studies to examine health behaviors (Glanz et al., 1997). During these years, it was found that the Health Behavior Model (1950), Social Learning Theory (1941) later known as Social Cognitive Theory (1987), and Theory of Reasoned Action (1967) were noted as the top three theories and models identified most frequently in health behavior research. As this research is examining the self-reported health behaviors of Resident Directors who work and live in the same environment, it is appropriate to also review the ecological models used to understand health behavior.

Girvan and Reese (1990) reviewed the Health Behavior Model (HBM) developed by Hochbaum (1950) the most well known model to understand why humans did not engage in preventive health programs or disease prevention programs. In later years, the model was expanded to understand peoples' responses and their behavior in response to diagnosed illness. Within the United States, the HBM has been used to study two major health concerns such as smoking related behaviors and AIDS related behaviors. Hochbaum's HBM includes six key factors for understanding health behaviors. These factors are: (a) perceived susceptibility, (b) perceived severity, (c) perceived benefits, (d) perceived barriers, (e) cues to action and (f) self-efficacy (Girvan & Reese, 1990).

Perceived susceptibility occurs when people believe that they are invincible to the risk of unhealthy behaviors. Humans reach perceived severity when they finally understand that the risks associated with unhealthy behaviors can become a reality. After

noticing that engaging in a healthy behavior may produce positive outcomes, people finally reach perceived benefits. However, negative perception to a particular health behavior may lead to perceived barriers. Cues to action is also needed to understand the HBM because although a person may understand the perceived susceptibility, perceived severity, and perceived benefits, they still may choose not to engage in behavior until some external cue is demonstrated to them. Finally, humans reach self efficacy when they feel that they succeeded in the health behavior that produces the positive outcome (Strecher & Rosenstock, 1997).

Bandura's (1986) Social Cognitive Theory (SCT) is important when explaining health behavior. Social Cognitive Theory (SCT) is a theory that deals with the cognitive and emotional aspects of behavior change. The SCT stems from the work of Miller's and Dollar's (1941) Social Learning Theory (SLT). The SLT was developed to explain imitation of behavior among animals and humans and stressed that rewards had to be given in order for learning to occur. However, during 1962, Bandura and Walters studied how children could learn new behaviors by observing others without receiving a reward. The application of SCT is evident when children model the behaviors of their parents and adolescents model the behaviors of what their peers do in situations. The effectiveness of SCT does however depend on certain factors held by the model when being observed. The observer most likely will model the behavior, if the model is someone they respect, is competent, powerful and they find attractive (Soeken, Bausell, Winkleteins, & Carson, 1989).

Bandura's SCT noted several concepts which are important to understand behavioral change. These concepts include (a) environment, (b) situation, (c) behavioral

capability, (d) expectations, (e) expectancies, (f) self-control, (g) observational learning, (h) reinforcements, (i) self-efficacy, (j) emotional coping responses, and (k) reciprocal determinism (Glanz et al., 1997). Several studies such as binge drinking (Borsari & Carey, 2006; Sharma & Kanekar, 2008) and internet use (Lin, Ko, & Wu, 2008; Liu & LaRose, 2008) have examined how SCT can be applied with college students health behaviors.

Compatible with the concepts of environment and observational learning from Bandura's Social Cognitive Theory, is the Ecological Perspective Model developed by McLeroy, Bibeau, Steckler and Glanz (1998). The Ecological Perspective Model looks at the transactions between human beings and the environment systems (Voisin, DiClemente, Salzar, Crosby, & Yarber, 2006). Specifically, this model identifies factors such as: a) intrapersonal factors, b) interpersonal factors, c) institutional factors, d) community factors, and e) public policy which influence the health and behaviors of humans (Glanz et al., 1997).

The intrapersonal factors include individual characteristics that influence human behaviors. The interpersonal factors are known as family, friends, peers, and those groups that provide support. Included in the institutional factors are the rules and policies such as informal understanding of appropriate behaviors. The community factors are network and norms that are included in the environment. The public policy factors are considered as the local and federal policies that support the healthy choices for disease prevention (Novilla, Barnes, De La Cruz, & Williams, 2006).

Lastly, the Theory of Reasoned Action (TRA), developed by Fishbein & Ajzen (1975 & 1980) was to understand the connection between a person's attitude and

behavior. TRA has also been applied to understanding health promoting behaviors and to the use of condoms (Beadnell, Baker, Gillmore, Morrison, Huan, Stielstra, 2008). TRA indicates that it is necessary to have three constructs which include: (a) attitudes, (b) subjective norms, and (c) behavioral intentions (Glanz et al., 1997). In simple terms, this means that people will engage in a behavior depending on what their own attitudes are about the behavior and what their peers may think about the behavior. TRA has been applied when understanding college student health in the areas of condom use (Munoz-Silvia, Sanchez-Garcia, Nunes, & Martins, 2007), dieting (Sherpherd & Towler, 2007), and testicular examination (Trumbo, 2004).

The purpose of this study was to examine the self-reported health behaviors of Resident Directors who have a different work and home environment from their colleagues in Student Affairs. Due to the nature of their position, Resident Directors' health behaviors may be different than their colleagues in other student affairs positions because they are required to work and live in a certain environment known as a residence hall. Because of this, the two concepts of environment and observation learning from Bandura's Social Cognitive Theory (1986) and the factors from the ecological model developed by McLeroy, Bibeau, Steckler, and Glanz (1988) will serve as the foundational framework of theory for this specific study.

The Ecological Perspective Model is serving as a foundation for this study because Resident Directors health behaviors may be influenced by the behaviors of their residents who are college age students. According to Sands, Archer, and Puleo (1998), college students engage in unhealthy behaviors such as inadequate nutrition and low physical activity which lead to chronic diseases. Simply, by living in the same

environment with college age students, Resident Directors are exposed to the unhealthy behaviors of the community, making it difficult for them to engage in healthy choices (Glanz et al.,1997) . Stress is the leading factor college students report as health concerns (American College Health Association, 2008). Resident Directors are surrounded by this stress and may engage in the same coping skills in which their residents practice such as inadequate sleep and unhealthy choices in nutrition. The Ecological Perspective Model supports that all individuals within an environment influence and guide the behaviors of each other due to the social and psychological influences (Mcleroy, Bibeaus, Steckler, & Glanz, 1988). Residence halls are prime examples of environments of community living. By implementing the Ecological Perspective Model, Resident Directors work toward implementing healthy lifestyles within the policies of the residence community. The Social Cognitive Theory notes that human interactions affect choices in health behavior. Resident Directors who follow the health behaviors of their college students contribute to the cycle of unhealthy living within the residence hall environment, leading to chronic diseases (Glanz et al.).

Theories and models are essential because the information provided by these frameworks can enrich the practical use of health education (Glantz et al., 1997). Understanding health theories and models benefits researchers by continued development of strategies by which the general population can adopt healthy behaviors into their daily lives.

History of Residence Halls

Student housing can be traced back to the twelfth century when the mass of male students between the ages of 14 to 15 years old, were drawn to universities located in Bologna, Paris, and Oxford. During this era, there was no formal housing facilities for the students therefore, the students lived in tents outside around the campus and crowded these small towns (Blimling, 2003). The root of today's American residence life can be traced back to the influence of the European culture. The two European countries that influenced residence halls within the United States are England and Germany (Frederiksen, 1993).

The concept of bringing faculty and students together was a core principle to establish a strong mentoring relationship between the faculty and students at universities such as Oxford and Cambridge located in England. The live-in faculty within the English residential system strived to develop men into young scholars by focusing on the students' character and intellectual capacity (Blimling, 2003). When the English settlers colonized in America, they brought with them the educational beliefs similar to Oxford and Cambridge. American universities like Harvard College (1636), Yale University (1701) and College of New Jersey (1746) belong to the nine colonial colleges and were established by graduates of Oxford and Cambridge. The residential facilities in these universities referred to as "dormitories" became known as the collegiate way of life which is "a notion that a curriculum, a library, a faculty, and students are not enough to make a college" (Rudolph, 1962, p. 87). Unlike the English faculty in Oxford and Cambridge who had the support of deans and proctors to work with student discipline, the American faculty in the United States was responsible for both the teaching and

conduct of students. English faculty focused their time teaching and forming friendships with their students; American faculty taught students while also having to serve in the role of parents known as the "*in loco parentis"* (Schroeder & Mable, 1994).

During the 1840s through the 1890s, the American higher education system was influenced by the German educational system. It was during this time that American faculty returned to their positions after the Civil War (1861-1865) with a focus on research and expertise in their respective disciplines with little effort to the consideration of student development (Boyer, 1990). They were not interested in fostering relationships with students in the residential halls. While in Germany, the American faculty noticed that student housing was not the responsibility of the institution. The influence of German educational philosophy led Americans to decrease the importance of allocating monetary resources for building residence halls, which eventually led to the movement of abandoning residence halls from colleges and universities during the early nineteenth century (Frederiksen, 1993). President Francis Wayland of Brown University (1827-1855) "argued and enforced that residential pattern encouraged the spread of disease, fostered unsanitary habits, reinforced the disinclination of students to exercise… [and] diverted funds needed for building up libraries and classrooms" (Schuh, 2004, p. 271), which promoted the abandonment of residence halls in the United States (Kaplan et al., 2004).

During the mid nineteenth century, students needed to begin to find a place to live while attending the university. Students were moving into private homes around the university which provided little amenities. This era led to the beginning of fraternities, which built chapter houses for students to live in, since institutions were not providing

housing facilities for students. Later, sororities were built for women attending higher education (Blimling, 2003). The increase of extracurricular activities such as inter-collegiate sports, debating societies, and involvement in school newspapers encouraged students to spend more time on campus which in turn grew the demand for student housing (Schuh, 2004).

In 1890, Harvard College became the first American University to assign two deans; one dean to the academic life and another dean for student life. Later, in 1891, during the establishment of the University of Chicago, William Harper, the president of the University of Chicago, encouraged the rebirth of residence halls and promoted that residential housing become a critical aspect of student life.

During the renewal of rebuilding residence halls, college environments welcomed the growth of African American students after passing the Thirteenth Amendment (1865) and the growth of women on college campus (Frederiksen, 1993). The creation of Shaw University (1868) and Howard University (1867) began the era of formal higher education for Black Americans. Private colleges for women were being developed, and these institutions such as Vassar College (1861), Smith College (1875), and Mount Holyoke College (1837) built housing facilities to watch over the women students. As these women graduated and furthered their education in graduate schools, they brought with them the expectation of their previous housing experience, which included learning activities of social grace and participating in charity events (Blimling, 1993). The first time the title dean of women was addressed was in 1892, at the University of Chicago, with Alice Freeman Palmer and Marion Talbot serving as leading figures in this position (Rhatigan, 2000).

The beginning of the twentieth century brought the most changes to the residence halls in the United States due to the increase of student enrollment (Schroeder & Mable, 1994). The G. I. Bill of 1944, officially known as the Servicemen's Readjustment Act of 1944, granted opportunities to attend college or vocational institutions for returning World War II veterans known as G.I.s. Implementation of Title IV of Housing Act of 1950, known as "Housing for Educational Institution", provided colleges and universities with low interest monetary loans for building bulk housing facilities in order to maximize the number of students they could house and feed (Nuss, 1996). Under the Housing Act of 1950, dormitory furniture was built attached to the walls because the monetary loans supported this effort. These housing facilities, known as dormitories, were built under the leadership of business personnel, who focused more on efficiency of space issues rather than building community. Eventually, during the 1950's the English influence of residential systems, which focused on faculty and student interaction and mentorship was deferred in American residential systems because these new structures focused on efficiency rather than community building (Frederiksen, 1993).

Following World War II (1939-1945), many Americans returned to college and were taken back by the strict policies enforced on them and the rules enforced in the residence halls (Frederisksen, 1993). Students no longer wanted the university to treat them like children. The concept of *in loco parentis*; includes the idea where the institution staff members take on the duties of the college students' parents by having total supervision of the students (Rudolph, 1962) came to an end during the late 1960's. By the 1970's residence halls became extremely suitable for students because it provided a low cost place to live during the economic turmoil the American nation was

experiencing. During the 1980's there were more residents requesting to live on campus producing a shortage in bed space and universities not being able to accommodate students' desire to live on campus. Furthermore, the structures of residence halls during the 1990's, presented a challenge because students desired to have more space and technology available within their residence halls (Schuh, 2004).

The History of Residence Life Staff as a Profession

The increase of college students living on campus changed the dynamic and job responsibilities of the residence life staff members. The first change in residence life staffing took place during the colonial period (1636-1780) when faculty members took on the role of residence life professionals by living with, dining with, and supervising students while simultaneously teaching in the residential facilities (Frederiksen, 1993). It was during this time, that the students who lived in the residential facilities were mostly young men from the age of 11 to 15 who traveled great distances and needed a place to live. However, the increase of student-faculty interaction and close living proximity caused conflict and led faculty members to discontinue living in residential colleges. The lack of faculty living in residence halls became more prominent during the second stage of residence life professionals which occurred during the late nineteenth century when American universities adopted the German education philosophy. Faculty members during this time allowed more time to focus on their research and they no longer wanted to be known as the substitute parent or the disciplinarian (Frederiksen, 1993).

As a result of the German education influence, students had to take care of their own room and board by looking for residence in the local community. Eventually, the

empty spaces that once were assigned to live in faculty members were re-assigned to university coaches, elderly housemothers, and retired military officers. In return for the housing cost, the coaches, housemothers and retired military officers had to enforce institutional policy, practice loyalty to the institution, and maintain order within the halls (Weaver, 2005). It was during this time that non faculty members served in implementing in *loco parentis* to the students. The practice of *in loco parentis* includes the idea that the institution staff members take on the duties of the college students' parents by having total supervision of the students (Rudolph, 1962).

Mass construction of dormitories between 1950's and 1960's ushered in the third stage of the residence life profession. The main objective of housing professionals during this period was to emphasize administrative and facilities maintenance (Frederiksen, 1993). It was during this time that the Resident Director position, as known today, became formalized. Additionally, the passing of Title IX of the Higher Education Act in1972, required equality in education treatment for both men and women. The increase of students living on campus gave residence life professionals the opportunity to focus on various aspects of the residence halls which include housing administration, facilities maintenance, food services, and residence life.

Despite all of these transitions, the last 30 years has brought the formalization of the Resident Director position as the living learning specialist (Frederiksen, 1993). Resident Directors are full-time, live in, entry level positions implementing the duties of programming, supervision, and policy enforcers for residents (Dunkel & Schreider, 1992). Many young student affairs professionals begin their career as a Resident Director. The Resident Director title also varies in names ranging from head resident, resident

director, hall director, to building manager (Schuh, 2004). The minimum education required to be considered to become a Resident Director is a Bachelors degree. However, recent job posting for Resident Directors from the Chronicle of Education are requiring candidates to have a masters degree in student affairs, counseling, or a related field (Chronicle of Higher Education, 2008). Resident Directors have multiple roles in their profession because their position requires them to perform multiple duties including supervision of student staff, known as, Resident Assistants; serve as liaisons to other staff in student affairs; advise and counsel students; enforce residence life policies; organize and coordinate student activities; hold student conduct meetings while continuing to be the facilitator of programs and manager of the residence halls (Schroeder &Mable, 1994).

Resident Directors can gain the support as part of their professional development by belonging to the Association of College and University Housing Officers-International (ACUHO-I), founded in 1988, an association supporting programs, research, and networking opportunities for housing professionals (ACUHO-I, 2009). MacKinnon, Broido, and Wilson (2004) found that these professionals need to live a balanced life. The importance of applying a healthy lifestyle is imperative to promote good role modeling as well as preventing work burnout among these professionals.

Wellness and Health in Residence Halls

Wellness models are intended to show students how their lifestyle can impact their current and future health behaviors. Hettler's wellness model (1980) addresses emotional wellness, intellectual wellness, physical wellness, social wellness, occupational wellness, and spiritual wellness (Leafgren, 1994). At many institutions Resident

Directors train their resident assistant staff to incorporate the wellness model in their resident assistant programming.

In order for wellness programming to be effective with students, residence life staff needs to focus on the individual student, the culture of the community, and their own health behaviors. Leafgren (1994) indicated there are four challenges that residence life staff should consider when implementing wellness programs: (a) continuous support for students who never engaged in healthy behaviors, (b) build support models to discourage disengagement, (c) promote rewards for active participation, and (d) assess the amount of success and change of participants.

Along with individual attention, it is also important to be current with the cultural norm of the residence halls. What are the unwritten rules and traditions of the community? Allen (1989) cited in Leafgren (1993) "Asking people to change their health practices without changing their culture is like asking them to reach over the Twinkies for the celery and the carrots" (p.458). Resident Directors can continue their education on wellness by joining the Commission of Wellness, a sub-component to the American College Personnel Association, another leading student affairs professional organization founded in 1924, to provide student affairs practitioners with a vision of advocacy, outreach and research to student learning. The Commission of Wellness assists student affairs practitioners such as Resident Directors with up-to-date trends and resources as it pertains to wellness (ACPA, 2008). Every year during the annual conference, the Wellness Commission sponsors seven programs entailing the latest information about college student wellness (ACPA, 2008).

Student Development and Residence Hall Environment

Boyer (1987) found that other than the 48 hours per week students spend in the class or studying, the majority of their time is in the residence halls. Residence halls are environments where students learn about human interaction, diversity, communication skills, and civic citizenship (Schroeder, Mable, & Associates, 1994). The goals of Residence Life staff members include: a) securing well maintained and safe buildings, b) developing socially enriching community environment, c) creating programs for residents to develop and grow, and d) designing living/learning environments that promote the academic mission of the university (Miller, 2003; Decoster & Mable, 1974).

Approximately 38 years ago, Riker and DeCoster found two assumptions for the educational role in residence halls which entailed that (a) environment influences behaviors and (b) learning is a total process. Environment influences behavior through either the physical environment which includes the facilities of the building or the social environment which includes the interpersonal relationships (Riker & DeCoster, 2008). Furthermore, Banning and Kaiser (1974) as cited in Grimm (1993) noted the following about residence halls:

> The ecological perspective is based on the belief that the environment has an effect on people and their behavior and that people also have an effect on their environment. The perspective also assumes that different people respond differently to different types of environment. (p.374)

Life within the resident hall environment contributes significantly to the growth and development of students. According to Pascarella and Terenzini (1991) residence hall environments are "perhaps the single most consistent within-college determinant of impact on student's experience" (p. 611). Several studies have shown the benefits such as high academic engagement (Astin, 1993); greater opportunities for social and

interpersonal relationships (Pascarella & Terenzini, 1991); greater gains in psychosocial development and self concept (Pascarella, Terenzini, & Blimling, 1994) students receive by simply living on campus.

Evans, Forney, and Guido-DiBrito (1998) defined student development as "a philosophy that has guided student affairs practice and served as the rationale for specific programs and services" (p.4). More in depth, student development theories are applied to understand the transitions young adults take in intellectual development (Perry, 1970); moral development (Kohlberg, 1969, 1984); psychosocial development (Heath, 1968; Chickering, 1993), and career development (Super, 1957, Hollands, 1985, 1992). Understanding student development theory can assist Resident Directors in understanding students needs when designing programs for their students, developing policies for students, and creating healthy communities (Evans, Forney, & Guido- DiBrito, 1998).

Role Modeling

Health is a value that humans view as important (Girvan & Reese, 1990). Studies have shown that health is influenced by a person's lifestyle choices. With this in mind, it is important to encourage positive health habits early in life (Girvan & Reese, 1990). In early educational settings, teachers have opportunities to prevent various chronic diseases because of the time that students spend in educational settings (Yager & O'Dea, 2005). Glover (1978) states "For better or worse, teachers serve as models, and their actions are imprinted on the minds of the students*"* (p.175*).* In our society, people learn by observing what those around them are doing (Chio & Yang, 2006). A role model can be defined as someone who influences a person in life decisions. This influence can either be positive

or negative (Bascow & Howe, 1980). Bandura (1986) and Sternberg (2000) as indicated in Chiou and Yang (2006) indicated that there are four factors of role modeling which promote others to imitate a behavior that they observe. These factors include the following: (a) the manner in which the role model is compared to other role models, (b) the manner in which the role model is admired and respected by their peers and others, (c) the manner in which the observer believes the role model has similarities to them, and (d) the manner in which the role model practices the consistency of the behaviors.

Doctors, nurses, teachers and university administrators work diligently in advocating health for the people that they serve. Cameron et al. (2004) found that doctors who engage in healthy behaviors are more prone to regulate health behaviors in their patients than doctors who engage in unhealthy behaviors. In 2003 the American Medical Student Association (AMSA) launched a nationwide course to be taken by all first year medical students known as "train the trainer." The goal of this course is to teach first year students that the overall practice of their health behavior will have an impact on their patients (Cameron et al.). Wells-Feldman (1996) noted that *"*We must remember, however, that if health is to be sustained, those who provide the help must be capable of caring for both themselves and others" (p. 29). When a person engages in healthy role modeling, it allows a person to reflect on their own health values, as well as enabling one to understand how change of behavior can lead others to maintaining healthy life.

Role modeling does not end at high school, but also continues during the college years. During college, students have a tendency to mimic their peer behaviors. Resident Assistants are seen as peers to the college students they serve on a daily basis. As a result,

Resident Assistants experience the "fish bowl" life, which means that their students are continuously watching them around the clock.

Resident Directors are responsible for supervising Resident Assistants. Their responsibilities are similar because their positions require them to be classified as role models for the university. Although Resident Assistants tend to be seen more on the front lines with residents, Resident Directors still work closely with students on a daily basis. According to Blimling (1993), Resident Directors are expected to conduct their personal lives as a role model for student behaviors. What messages are Resident Directors sending to their Resident Assistants and students if all they do is work around the clock (Palmer, Murphy, Parrot, & Steinke, 2001). College students are still developing their health behaviors; therefore, Resident Directors should model, encourage and support healthy lifestyles conducive to optimal health (Leafgren, 1993).

Conclusion

The CDC (2008) has found that practicing healthy behaviors can aid in the decrease of heart disease, cancer, and diabetes. Given that over 73 million adults in the United States have completed 4 years of college education, it is essential to further research about health behaviors on college campuses (ACHA, 2002) and how higher education institutions can impact the overall quality of creating a healthier society.

Many college students start their university life by living in residence halls. They are away from the influence of their parents or guardians who once modeled for them and monitored their health behaviors (Bylund et al., 2005). Gaining autonomy and freedom overnight, students may be overwhelmed with their new responsibilities which can

produce stress leading them to engage in unhealthy behaviors (Brunt & Rhee, 2008). By living in the residence halls, students may begin to follow the behaviors of those living around them (Cooper & Gunthrie, 2007;Okun et al., 2003).

Universities serve as a primary venue for modeling healthy behaviors and delivering health information to students (Fletcher et al., 2007). Resident Directors play a key role in the health of college students who will serve as future leaders of the nation (Leafgren, 1993). By modeling health behaviors and partnering with other university faculty, administrators, and staff, Resident Directors can learn to provide and model experiences about health to their students (Livington & Watson, 2009). Therefore, it is important for this study to examine the self reported health behaviors of Resident Directors in the areas of health responsibility, physical activity, nutrition, spiritual growth, stress management, and interpersonal relations. Due to the nature of their live-in job, Resident Directors have a challenge to find balance in their lives and dedicate time to monitor their health (Reisser, 2002). The lack of Resident Directors practicing and modeling healthy behaviors can produce a negative ripple effect onto residential students who eventually may become tomorrows' front liners in various workforces (Lee & Loke, 2005). Therefore, this research will examine health behaviors of Resident Directors in the areas of healthy responsibility, physical, nutrition, interpersonal relations, stress management, and spiritual growth as well as the importance of role-modeling in the Resident Director profession. Furthermore, this study will also examine how important do Resident Directors believe that their practice in role modeling healthy behaviors is for initiating and motivating their students health behaviors. Lastly, this research will

examine if there is a significant difference between the self-reported overall health behaviors of Resident Directors affiliated with ACUHO-I institutions and their race.

CHAPTER III

METHODOLOGY

This chapter describes the procedures, materials, and instrumentation utilized to answer the research questions stated in Chapter One. The structure of this chapter includes the following sections: (a) research design, (b) participants, (c) instrumentation, (d) reliability and validity, (e) procedures, (f) data analysis, and (g) research questions.

Research Design

The research design and research questions of this study are similar to a study conducted by Wiley (2003), who examined health behaviors among health educators in Mississippi. Gall, Borg, and Gall (1996), explained descriptive research as the most straightforward quantitative research.

Mean scores were used to assess the six measures of health behaviors from the Health-Promoting Lifestyle Profile II (HPLPII) completed by Resident Directors. The researcher also obtained the percentiles for each subscale area of health behaviors (health responsibility, physical ability, nutrition, spiritual growth, interpersonal relationship, and stress management) by asking Resident Directors which areas of health behaviors they believe their participation influences the behaviors of their students. Furthermore, the researcher also ran a Multivariate analysis of variance (MANOVA) to measure whether there were any statistically significant differences in the areas of gender, race, and

ACUHO-I geographic affiliation of the Resident Directors and the subscales areas of the HPLPII, which consists of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, or stress management .

Participants

Of the 900 institutions of higher education that are members of ACUHO-I, approximately 2,516 Residence Life members belong to the ACUHO-I on-line directory of which approximately 694 Resident Directors are members (Walt Vivod, personal communication, 2009), this includes international and United States Resident Directors. The researcher recruited only United States Resident Directors (n=587) directly through an e-mail invitation (Appendix C), inviting them to take the Health-Promoting Lifestyle Profile II (HPLPII) and instrument developed by Walker, Sechrist, and Pender (1987).The final sample of this study consisted of 308 full time Resident Directors residing in the United States who self-reported as being affiliated with the Association of College and University Housing Officers-International (ACUHO-I). The ACUHO-I's Chair of research commissioned approved and supported this research study by allowing the researcher to obtain the e-mail addresses of Resident Directors from the ACUHO-I on-line directory (Appendix D).

Instrumentation

The instrumentation used in this study was the Health-Promoting Lifestyle Profile II (HPLPII). HPLPII is a 52 item survey (see Appendix B) which measures self-reported health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual

growth, interpersonal relations, or stress management (Walker, Sechrist & Pender, 1987). The HPLPII uses a 4 point Likert scale, with the metric of responses ranging from: "Never" (1), "Sometimes" (2), "Often" (3), "Routinely" (4). A mean score of 4 indicates a higher level of practicing health behaviors than a mean score of 1 (Walker & Hill-Polerecky, 1996). Many researchers have utilized the HPLPII to examine health promoting behaviors with various populations such as health educators (Wiley, 2002), university students, adolescents (Callaghan, 2003), Hispanic adults (Hulme et el,2003), and women(Grace, Grewal, Abramson, & Steward, 2008).

In the HPLPII, health responsibility health behaviors were assessed by questions 3, 9, 15, 21, 27, 33, 39, 45, and 51. Physical activity health behaviors were assessed by questions 4, 10, 16, 22, 28, 34, 40, and 46. Nutritional health behaviors were assessed by questions 2, 8, 14, 20, 26, 32, 38, 44, and 50. Spiritual growth health behaviors were assessed by questions 6, 12, 18, 24, 30, 36, 42, 48, and 52. Interpersonal relations health behaviors were assessed by questions 1, 7, 13, 19, 25, 31, 37, 43, and 49. Finally, stress management health behaviors were assessed in questions 5, 11, 17, 23, 29, 35, 41, and 47 (Walker & Hill- Polerecky, 1996). For the purpose of this specific study, the researcher received permission to use the instrument by contacting through e-mail, Susan Noble Walker. The author of the instrument granted the researcher permission to transfer the instrument questions onto an on-line survey (Appendix E).

Table 1

Sample Questions from the Health Promoting Life Style Inventory II

Sample questions	Health behavior being measured
Read or watch TV programs about improving health. (Question #9)	Health Responsibility
Exercise vigorously for 20 or more minutes at least three times a week. (Question #10)	Physical Activity
Eat 2-4 servings of fruit each day. (Question #20)	Nutrition
Feel I am growing and changing in positive ways. (Question #6)	Spiritual Growth
Discuss my problems and concerns with people close to me. (Question #1)	Interpersonal Relations
Take some time for relaxation each day. (Question #11)	Stress Management

The researcher also added a demographics section before the questions of the actual survey, instructing participants to identify their gender, race, regional affiliation as defined by ACUHO-I (see Appendix F), age, and length of years in the Resident Director position. The researcher included one additional question regarding the concept of role modeling. The question asked Resident Directors "Which areas of health behavior do you believe your participation is important to influence the health behaviors of your students"? Participants answered this question by placing a check next to the health behaviors (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management), which they believed their personal participation in would influence the behaviors of their students.

Reliability and Validity

Reliability is a term used to measure error in the yielded score of tests (Gall et al., 1996). Test scores that produce stable and consistent measurements are considered reliable (Gravetter & Wallnau, 1996). Walker and Hill-Polerecky (1996) assessed the reliability of the HPLPII by using data of the scores from 712 adults ranging in age from 18 to 92. From these results, the alpha coefficient of internal reliability for the total scale score for the HPLPII was .943. The alpha coefficient for internal reliability for the subscales' scores of the HPLPII ranged from .793 to .872. The Cronbach's Alpha coefficients for each subscale within the HPLPII are as follows: health responsibility (.86), physical activity (.85), nutrition (.80), spiritual growth (.86), interpersonal relations (.87) and stress management (.79). Additionally, a three week test-retest was also conducted, and the stability coefficient for the total scale was found to be .892.

When an instrument measures what it claims to measure then the instrument is said to be valid (Gravetter & Wallnau, 1996). Walker and Hill-Polerecky (1996) also assessed the validity of the HPLPII by using data of the scores from 712 adults ranging in age from 18 to 92. Content validity was found by conducting an established literature review on health behaviors accounting for the subscale areas of health behaviors, including health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, or stress management (Walker & Hill- Polerecky, 1996). The construct validity of the HPLP II is (r = .678) and was supported by a theoretical comparison of theory that confirmed the six subscales with another instrument known as the Personal Lifestyle Questionnaire developed by Muhlenkamp and Brown (1983) which also measured health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual

growth, interpersonal relations, and stress management. The Personal Lifestyle Questionnaire has a construct validity of (r = .83), and a test-retest reliability of 4 weeks interval of (r = .78). The criterion validity for the HPLPII is r's = .269 to .491and illustrates significant correlations by measuring the quality of life and perceived health status which are activities and behaviors most prominent in the health literature (Callaghan, 2003, Walker & Hill-Polerecky, 1996).

As part of their job responsibilities, Resident Directors are trained and educated about the six areas of health behaviors such as, health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, or stress management measured by the HPLPII (Leafgren, 1993). Therefore, it is important to understand that their responses may be influenced by social desirability which occurs when people rate themselves higher in a self-reported measure because they want to be represented in a favorable light (Gall et al., 1996).

Procedures

After receiving permission from the author of the HPLPII to use the instrument for the study, the researcher entered the HPLPII onto an on-line format survey through a company known as SurveyMonkey. This company is based in Portland, Oregon and began in 1999. It provides researchers the opportunity to conduct on-line surveys by allowing them to create on-line surveys with their own template, themes, design of questions and most importantly confidentiality (www.surveymonkey.com, 2008). The company does not collect the e-mail addresses or IP addressed of the participants. Therefore, confidentiality is kept. The researcher then submitted the Institution Review

Board (IRB) form (see Appendix G) to the Office of Regulatory Compliance at Mississippi State University. After receiving permission from the Institutional Review Board for the Protection of Human Subjects in Research (IRB) from Mississippi State University to conduct the study, the researcher received permission from the chairperson of ACUHO-I's commissioned research committee to obtain the names and e-mail addresses of full-time Resident Directors who were listed in the ACUHO-I on-line directory. The researcher sent an e-mail invitation, soliciting participation from Resident Directors affiliated with ACUHO-I who were listed within the on-line directory. The invitation e-mail (see Appendix C) explained the study and provided the Uniform Resource Locator (URL) that directed them to the on-line version of the HPLPII. When the researcher e-mailed the first batch of invitations, of the 587 e-mails approximately 242 e-mails were returned to the researcher as undelivered. Since so many e-mails bounced back, to gain a larger sample of participants the researcher requested and received additional permission from the IRB (see Appendix G) to include lisertservs in the study. The listservs included Discuss-h@lists, which is a Housing and Residence Life listserv and North Carolina Housing Officers listserv, which is also a listserv for Housing and Residence Life professionals in North Carolina. The e-mail stated that only Resident Directors affiliated with ACUHO-I could participate in the study. Therefore, it is important to note that Resident Directors who took the survey from the listservs self-reported their affiliation with ACUHO-I. Two weeks following the first e-mail sent to participants, the researcher sent a reminder e-mail to all the participants (see Appendix H). A total of four weeks from April 7, 2009 to May 25, 2009 was allocated for

participants to complete the survey. At the end of the allocated time, the researcher obtained 367 Resident Directors who responded to this study.

The first item participants read after clicking the URL survey link within the e-mail, was the informed consent form (see Appendix I). Before taking the HPLPII survey, participants were asked to acknowledge reading the consent form by checking a box. At that time, the participants were allowed to print the informed consent form. After completing the demographic questions and the on-line survey of the HPLPII, the participants were directed to an on-line thank you message from the researcher along with three on-line links about healthy habits derived from (a) The Center for Disease Control and Prevention, (b) The National Institute of Health, and (c) The Mayo Clinic (see Appendix J). The researcher contacted the above organizations via telephone to receive permission to use their URLS in the study.

The results from the surveys automatically went into an excel spreadsheet. The researcher then converted data from the excel spreadsheet into Statistical Package for the Social Sciences (SPSS). After reviewing the data, the researcher found of the 367 survey respondents that 52 surveys were incomplete; therefore, the researcher deleted those subjects' responses from the study. To eliminate Type I error, which occurs when a significant difference is found when it really does not exist, the researcher deleted seven more subjects from the Northwest Association of College and University Housing Officers (NWACUHO) because the sample size for NWACUHO was dramatically smaller than the other ACUHO-I regions, posing a threat for Type I error to occur. After these deletions, the total sample of acceptable surveys was n=308. The researcher then added a median score for the questions that were left blank by rounding the scores to the

nearest whole number for responses to questions which some subjects skipped. This was only computed if the subject skipped four or less questions in the survey; leaving the final sample size to 308 (44%) participants.

Before analyzing the data by SPSS, the researcher also computed the raw scores from the 52-items HPLPII to obtain the overall means for each of the individual six subscale areas which include health responsibility, physical activity, nutrition, spiritual growth, interpersonal relationship, and stress management. At the end of the allocated time for completion of surveys, the researcher obtained 367 Resident Directors who participated in the study.

Data Analysis

After receiving all the raw data scores from Survey Monkey in Microsoft Excel format, the researcher converted the data onto the software known as SPSS version 16. The statistic measurement of percentages was used for the five demographic questions pertaining to gender, race, regional affiliation as defined by ACUHO-I (see Appendix F), age, and length of years in the Resident Director position. Percentages were also used to represent the areas of health behaviors (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management) that Resident Directors believed their participation influences the behaviors of their students.

Mean scores were used to assess the six measures of health behaviors from the Health-Promoting Lifestyle Profile II (HPLPII) completed by Resident Directors. The researcher also obtained the percentiles for each of the sub-scale areas of health behaviors (health responsibility, physical ability, nutrition, spiritual growth, interpersonal relations,

and stress management) by asking Resident Directors which areas of health behaviors do they believe their participation influences the behaviors of their students. The researcher also ran a Multivariate analysis of variance (MANOVA) to measure if there were any statistically significant differences in the areas of gender, race, and ACUHO-I geographic affiliation of the Resident Directors and the subscales areas of the HPLPII, which consist of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, or stress management.

Analysis of Research Questions

The five research questions are listed below with the statistical procedures that were used to answer the questions:

Research question 1: Do Resident Directors (RDs) practice healthy behaviors in the areas of (a) health responsibility, (b) physical activity, (c) nutrition, (d) spiritual growth, (e) interpersonal relations, and (f) stress management? Mean scores were calculated for the above subscales. In addition, mean scores were also calculated on overall scores from the 52-items of the HPLPII in the areas of demographic questions, which included gender, race, geographic region, age, and length of time in the Resident Director role.

Research question 2: What areas of health behaviors according to the Health Promoting Lifestyle Profile II (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, or stress management) do Resident Directors believe their participation is important for influencing the participation of healthy behaviors for their

students? Percentages were obtained in each of the subscale areas that Resident Directors believed were important to participate in for influencing the behaviors of their students.

Research question 3: Is there a statistical significant difference between the gender of Resident Directors and their subscale scores from their self-reported health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relationship, and stress management?

The assumptions essential to be met before running a MANOVA include: a) sample size, b) normality, c) outliers, d) linearity, e) multicollinearity, and f) homogeneity of variance-covariance. All assumptions were met. The sample size assumption was met because there were more cases in each cell than the number of dependent variables. The univariante normality test demonstrated a violation because there was a violation of all of the dependent variables. This was demonstrated because the Kolmogorov-Smirnov normality test was used and all of the dependent variables showed significance level less than standard .05 significance indicating violation of normality (Pallant, 2001). The multivariate test of normality was also met because the Mahalanobis distance was 21.953 which is less than the critical value of 22.46 (Pallant, 2001). The multicollinearity assumption was passed in that all of the correlations for the dependent variables were less than the standard .08 used to check the strength of the correlations (Pallant, 2001).

Lastly, a few outliers did show up for the dependent variables of health responsibility, interpersonal relationship, and stress management. After the majority of assumptions were met, a multivariate analysis of variance (MANOVA) with an established significant value of $p \leq .01$ was used to analyze this research question.

Research question 4: Is there a statistical significant difference between the race of Resident Directors and the subscale scores from their self-reported health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relationship, and stress management?

The assumptions essential to be met before running a MANOVA include: a) sample size, b) normality, c) outliers, d) linearity, e) multicollinearity, and f) homogeneity of variance-covariance. All assumptions were met. The sample size assumption was met because there were more cases in each cell than the number of dependent variables. The univariante normality test demonstrated a violation because there was a violation of all of the dependent variables. This was demonstrated because the Kolmogorov-Smirnov normality test was used and all of the dependent variables showed significance level less than standard .05 significance indicating violation of normality (Pallant, 2001). However, the multivariate test of normality was met because the Mahalanobis distance was 21.953 which was less than the critical value of 22.46 (Pallant, 2001). The multicollinearity assumption was passed and all of the correlations for the dependent variables were less than the standard .08 used to check the strength of the correlations (Pallant, 2001).

Lastly, a few outliers did show up for the dependent variables of health responsibility, interpersonal relationship, and stress management. After the majority of assumptions were met, a multivariate analysis of variance (MANOVA) with an established significant value of $p \leq .01$ was used to analyze this research question. After checking for assumptions, a multivariate analysis of variance (MANOVA) with an established significant value of $p \leq .01$ was used to analyze this research question.

Research question 5: Is there a statistical significant difference between the geographic affiliation of Resident Directors and the sub-scale scores of their self-reported health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management? The assumptions essential to be met before running a MANOVA include: a) sample size, b) normality, c) outliers, d) linearity, e) multicollinearity, and f) homogeneity of variance-covariance. All assumptions were met. The sample size assumption was met because there were more cases in each cell than the number of dependent variables. The univariante normality test demonstrated a violation because there was a violation of all of the dependent variables. This was demonstrated because the Kolmogorov-Smirnov normality test was used and all of the dependent variables showed significance level less than standard .05 significance indicating violation of normality (Pallant, 2001). However, the multivariate test of normality was met because the Mahalanobis distance was 21.953 which was less than the critical value of 22.46 (Pallant, 2001). The multicollinearity assumption was passed in that all of the correlations for the dependent variables were less than the standard .08 used to check the strength of the correlations (Pallant, 2001).

Lastly,a few outliers did show up for the dependent variables of health responsibility, interpersonal relations, and stress management. After the majority of assumptions were met, a multivariate analysis of variance (MANOVA) with an established significant value of $p < .01$ was used to analyze this research question.

CHAPTER IV

RESULTS AND DISCUSSION

The primary reason for conducting this study was to determine the self-reported health behaviors of Resident Directors who self-reported affiliation with the Association of Colleges and University Housing Officers-International (ACUHO-I). In addition, this study also examined what specific health behaviors (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management) do Resident Directors believe are important to practice in order to influence the health behaviors of their students. The independent variables were Resident Directors' gender, race, and geographic affiliation to ACUHO-I. The dependent variables were the subscales from the HPLPII which included health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management. A .01 alpha level was used for all test of significance. This chapter will be organized into a descriptive section, a results section, and a discussion section.

Descriptive Data

From the completed surveys, the demographic data showed that 191 female Resident Directors (62 %) completed the HPLPII and only 117 male Resident Directors (38 %) completed the survey. The racial profiles of survey respondents are as follows: (a)

Caucasian Resident Directors (78%), (b) African American Resident Directors (12%), (c) Hispanic American Resident Directors (4%), (d) Asian American Resident Directors (2%), (e) Native American Resident Directors (1%), and (f) other (2%). The age range of the Resident Directors included 21- 25 years old (27 %), 26-30 years old (59%), 31- 35 years old (9%), and 36 years or older (1%).

Furthermore, Resident Directors were predominately from the following specific regions of ACUHO-I: 41% from the Southeastern Association of Housing Officers (SEAHO), respectively followed by the 11% from the Northeast Association of College and University Housing Officers (NEACUHO), 9% from the Great Lakes Association of Colleges and University Housing Officers(GLACUHO), 9% from the Western Association of Colleges and University Housing Officers(WACUHO), 8% from the Southwest Association of College and University Housing Officers(SWACUHO), 8% from the Association of Intermountain Housing Officers (AIMHO), 7% from the Upper Midwest Region- Association of College and University Housing Officers (UMR), and 6% from the Mid-Atlantic Association of College and University Housing Officers (MACUHO).

Table 2

Descriptive Data (N=308)

Variable	Frequency	Percentages
Resident Directors' Gender		
Female	191	62
Male	117	38
Resident Directors' Race		
African American	40	12
Asian American	4	2
Caucasian American	240	78
Hispanic American	15	4
Native American	2	1
Other	7	2
Resident Directors' Geographic Affiliation		
AIMHO	24	7
GLACUHO	29	9
MACUHO	19	6
NEACUHO	35	11
UMR	22	7
SEAHO	127	41
SWACUHO	25	8
WACUHO	27	9

Research Question One

Research Question 1: Do Resident Directors (RDs) practice healthy behaviors in the areas of (a) health responsibility, (b) physical activity, (c) nutrition, (d) spiritual growth, (e) interpersonal relations, and (f) stress management? The results illustrated that overall Resident Directors self-reported practicing healthy behaviors in the areas of

health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management in the range of 2 which means sometimes. Table 2 demonstrates that the mean scores for the areas of interpersonal relationship (M=3.04) and spiritual growth (M=2.99) were found to be the highest among the health behaviors. Table 2 also illustrates the means' scores for the remaining subscales as follows: nutrition (M=2.43), stress management (M=2.31), physical activity (M=2.29), and health responsibility (M=2.11). A mean score of 2 indicated that Resident Directors self-reported that they sometimes engage in the health behaviors. With physical activity (M=2.29) and health responsibility (M=2.11) being the lowest subscale scores. The overall mean from the 52-item questionnaire was (M= 2.52).

Discussion

The highest mean score for Resident Directors was in the areas of interpersonal relations (M=3.04), followed by spiritual growth (M=2.99). These results are comparable to a study conducted by Fedorovich (1991) which showed that hired Resident Assistants scored higher than non hired Resident Assistants in the area of spirituality when given the Wellness Lifestyle Assessment Questionnaire. Additionally, these results are comparable with other studies that used the HPLPII and showed that participants indicated a higher frequency of participation in the areas of interpersonal relations and spiritual growth (Carlson, 2000; Walker, Kerr, Pender, & Sechrist, 1990; Wiley, 2002). Research has shown that religion and spirituality affect health in a positive manner (McCullogh, Hoyt, Larson, Koeing, and Thorenson, 2000; Powell, Shahabi, & Thorenson, 2003). A study

conducted by Dunkel and Schreiber (1992) indicated that interpersonal relationships were a necessary component for success with residence life professionals.

The areas which Resident Directors self-reported the lowest practice in health behaviors where in the areas of physical activity (M=2.29) and health responsibility (M=2.11). These results are comparable to a study conducted by Palmer, Murphy, Parrot, and Steinke (2001) that studied burnout among Resident Directors and showed that Resident Directors had indicated low level of exercise habits. Furthermore, Resident Directors may have self-reported lower in the area of health responsibility, which consists of a person intentionally putting forth accountability for one's total wellness (Walker, Sechrist, & Pender, 1987), because for the most part Resident Directors job duties leave them with little privacy which can contribute to few opportunities for personal time (Weaver, 2005).

Table 3

Means scores of the subscale items from the HPLPII

Variable	HPLPII Items	Mean	SD
Health Responsibility	3,9,15,21,27,33,39,45,51	2.11	.51
Interpersonal Relations	1,7,13,19,25,31,37,43,49	3.04	.51
Nutrition	2,8,14,20,26,32,38,44,50	2.43	.56
Physical Activity	4,10,16,22,28,34,40,46	2.29	.66
Spiritual Growth	6,12,18,24,30,36,42,48,52	2.99	.53
Stress Management	5,11,17,23,29,35,41,47	2.31	.52
Overall Total	Questions 1-52	2.53	.40

Mean Scale: 1 = Never; 2 = Sometimes; 3 = Often; 4 = Routinely

Research Question Two

Research Question 2: What areas of health behaviors according to the Health Promoting Lifestyle Profile II (health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management) do Resident Directors believe their participation is important for influencing the participation of healthy behaviors for their students?

The results are listed from most believed in practice for influences for the health behaviors of their students to the least believed in practice and are as follows: (a) interpersonal relations (87%), (b) stress management (85%), (c) health responsibility (60%), (d) physical responsibility (51%), (e) spiritual growth (33%), and (f) nutrition (30%).

Discussion

Results from this question showed that Resident Directors believed that their practices in the area of interpersonal relations (87%) and stress management (85%) as the highest areas of health behaviors to influence the health behaviors of their students. Results from the National College Health Assessment (2005) demonstrated that stress was the top indicator that students identify to impact their academic performance (Dusselier, Dunn, Wang, Shelley, & Whalen, 2005). Furthermore, the forming of interpersonal relationships is an area that Resident Directors are trained in for their job responsibilities. Resident Directors are trained about the importance for students to form strong interpersonal relationships in order to help eliminate additional stressors (Darling,

Mcwey, Howard, & Olmstead, 2007). The results also indicated Resident Directors viewed that their practice in nutrition was the least influential for their students' health behaviors. A study conducted by Lafountaine, Neisen, and Parson (2006) found that first year students, who live on campus, scored the lowest in nutrition in the Wellness Evaluation Lifestyle as compared to those student who lived off campus. The results showed that Resident Directors believed that their practice in nutrition is not considered important to influence the behaviors of their students. Base on Bandura's Social Cognitive Theory, this behavior may lead to students to practice inadequate nutrition lifestyles. (Bandura, 2005).

Table 4

Resident Directors areas of most believed practice for health behaviors

Area of health	Percentages
Health Responsibility	60
Physical Activity	51
Nutrition Activity	30
Spiritual Growth	33
Interpersonal Relations	87
Stress Management	85

Research Question Three

Research Question 3: Is there a statistically significant difference between the gender of Resident Directors and their subscale scores in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relationship, and stress management?

It was found that there was a statistically significant difference between male Resident Directors and Female Resident Directors in three of the six dependent variables: F (6, 301) = 7.20, p=.00; Wilk's Lambda = .88; partial eta squared = .13. When the results of the dependent variables were considered separately, it was concluded that statistical significance was in the area of a) health responsibility: F (1, 306) = 15.07, p=.00. partial eta square =.05; b) nutrition: F (1, 306) = 11.34 p = .00, partial eta square = .04; and c) interpersonal relations: F (1, 306) =9.06, p =.00, partial eta square = .03. Further inspections of the mean scores indicated that in the area of health responsibility females (M = 2.20, SD =.53) reported higher than males (M = 1.97, SD =.43). It was also found that in the area of nutrition, females scored higher (M = 2.51, SD = .58) than males (M =2.29, SD =.50). Lastly, it was found that in the area of interpersonal relations, females scored higher (M =3.108, SD =.49) than males (M =2.93, SD =.52).

Discussion

The results concluded that female Resident Directors self-reported higher frequency in the practice of health responsibility, nutrition, and interpersonal relations than the self-report of the male Resident Directors. Research has shown that women live longer than males by an average of seven years (WHO, 2006). According to the results of the 2008 Behaviors Risk Factor Surveillance Survey (BRFSS) which is the largest phone health survey conducted in the United States, males self-reported a higher practice in smoking, binge drinking, and being over-weight than female participants (BRFSS, 2008). In general, females tend to schedule more doctors appointments and are more preventative about their health than males which may be the reason why female Resident

Directors self-reported higher practice in the area of health responsibility than the male, Resident Directors (Courtnay, McCreary, & Merighi, 2002). Additionally, males in general have reported eating fewer vegetables and fruits, fewer low-fat food, and less high fiber food (Courtnay, McCreary, & Merighi, 2002; Furnham & Kirkalday, 1997). Results to this study are also similar to another study conducted with college students that showed that interpersonal relationships were more important for female college students than male students (Darling, McWey, Howard, & Olmstead, 2007). The reason for this is because females need the support from their social surroundings to continue to develop.

Table 5

Test of Between Subjects Effects
For Gender of Resident Directors

Source	Dependent Variable	Type II S Sum of Square	df	Mean Square	F	Sig	P
Gender							
	Health Responsibility	3.811	1	3.811	15.07	.000	.05
	Physical Activity	.478	1	.478	1.113	.292	.004
	Nutrition	3.375	1	3.375	11.34	.001	.04
	Spiritual Growth	.067	1	.067	.242	.623	.001
	Interpersonal Relations	2.253	1	2.253	9.06	.003	.03
	Stress Management	.209	1	.209	.777	.379	.003

Research Question Four

Research Question 4: Is there a statistical significant difference between the race of Resident Directors and their subscale scores in the areas of health responsibility,

physical activity, nutrition, spiritual growth, interpersonal relations, and stress management?

It was found that there was a statistically significant difference between Caucasian Resident Directors and under-represented Resident Directors in one of the six dependent variables: F (6, 301)=3.51 p=.00; Wilk's Lambda =.93; partial eta squared =.07. When the results of the dependent variables were considered separately, it was concluded that statistical significance difference was in the area of nutrition F (1, 306) =12.66, p=.00, partial eta square =.04. Further inspections of the mean score found that in the area of nutrition, Caucasian Resident Directors scored higher (M= 2.491, SD= .56) than under represented Resident Directors (M=2.225, SD=.50).

Discussion

Previous research with under-represented racial group have shown a higher rate of obesity and a higher rate of sedentary behaviors which contributes to lower practice of health behaviors than Caucasian Americans (Johnson, 2005). A study conducted by Despues and Friedman (2007) showed that African Americans, Asian Americans, and Hispanic Americans college students always reported lower in the areas of exercising, going to the dentist for check-ups, and eating salads more than the Caucasian students. These results show that Resident Directors from under-represented racial groups self-reported lower practices in the area of nutrition. In 1985, the US General Task force found that the majority of deaths in the under-represented groups were related to nutrition or diet related. It also has been noted that diet related factors are associated with chronic

disease (WHO, 2003). Interesting enough, research by Goel, McCarthy, Phillips and Wee (2004) showed that people from under-represented groups receive less dietary counseling.

Table 6

Test of Between Subjects Effects
For Race of Resident Directors

Source	Dependent Variable	Type II Sum of Square	df	Mean Square	F	Sig	P
Race							
	Health Responsibility	.042	1	.042	.163	.686	.001
	Physical Activity	2.270	1	2.270	5.357	.021	.017
	Nutrition	3.754	1	3.754	12.662	.000	.04
	Spiritual Growth	.016	1	.016	.056	.813	.000
	Interpersonal Relations	.279	1	.279	1.094	.297	.004
	Stress Management	1.254	1	1.254	4.736	.379	.003

Research Question Five

Research Question 5: Is there a statistically significant difference between the ACUHO-I geographic region of Resident Directors affiliation and their subscale scores in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relationship, and stress management?

No significant effect was found between the geographic affiliation of the Resident and the subscale areas of the HPLPII: F (6, 295) = 1.25 p =.13; partial eta squared .03. Therefore, there was no statistically significant relationship of Resident Directors geographic affiliation and their subscale scores in the area of health responsibility,

physical activity, nutrition, spiritual growth, interpersonal relations, and stress management.

Discussion

Research in higher education about geographic location and health is sparse; however, the Southeast has experienced a high rate of cerebrovascular mortality in causing it to become known as the stroke belt region (Lackland & Moore, 1997). In 2007, the United Health Foundation noted that 4 of the top ten healthiest state to live in are located in the Northeast (Vermont, New Hampshire, Connecticut, and Maine) with the lowest healthiest states located in the south (Alabama, Tennessee, Oklahoma, Arkansas, Louisiana, and Mississippi). Perhaps there is no statistically significant difference found between the Resident Director and the ACUHO-I geographic affiliation because for the most part Resident Directors are not native to their geographic ACUHO-I affiliation since Resident Directors move to a new state for the position.

Summary

In conclusion, the overall results from Resident Directors self-reported health behaviors illustrate that Resident Directors are scratching the surface in practicing healthy behaviors with an overall mean score of $\underline{M}$=2.53. The fact that Resident Directors self-reported highest in the area of interpersonal relations with a mean score of $\underline{M}$=3.04 may be because Resident Directors are trained to help students emotional development. Resident Directors are trained in understanding their residents' personality and how those traits influence their residents' social relationships.

Overall, Resident Directors self-reported that they believe their practice in the areas of spiritual growth (33%) and nutrition (30%) are the areas of health behaviors least influential for their residents. This finding is surprising because Resident Directors reported high self practice in spirituality in question one but lower importance of modeling spirituality for their students. Moreover, research has shown that living arrangement influences food choices and dietary patterns (Trockel, Barnes, & Egget, 2000).

Among the self-reported scores, there was a statistical significant difference between the gender of Resident Directors and the subscale areas of the HPLPII. Female Resident Directors scored higher than male Resident Directors in the area of nutrition, interpersonal relations, and health responsibility. Research has shown that male gender role socialization such as masculinity affects how males engage less time with their personal health responsibility and interpersonal relationships (Nicholas, 2000).

The results also indicated that there was a statistically significant difference with the race of the Resident Directors and the subscales of the HPLPII specifically in the area of nutrition. The results showed that Resident Directors who identified themselves as an under-represented member self-reported lower practices in nutrition health behaviors. The findings are not surprising because research has shown that chronic disease such as obesity and diabetes are more prevalent in under-represented groups (Kumanyika, 2006).

Lastly, this study showed that there was no statistical significant difference between the ACUHO-I geographic affiliation of the Resident Director and the subscales of the HPLPII. This is not surprising because many Resident Directors are not natives to that specific geographic location and have not been influenced from their surroundings

because the majority of their time is spent on the college campus not allowing them ample time to understand the influences of the region. Overall, research is still limited to Resident Directors as professionals, due to the nature of their position, senior level staff members need to understand how the health behaviors of these professionals can not only impact their work but also the health practices of their residents, since these practices are still being developed during the college years.

CHAPTER V

SUMMARY, CONCLUSIONS AND IMPLICATIONS, AND RECOMMENDATIONS

This chapter will focus on presenting a summary of the research by including implications and recommendations as well as future research to continue the growth of knowledge within the literature needed for student affairs specifically Resident Directors.

Summary

The foundation for this study began with an explanation of how chronic diseases such as heart disease, cancer and diabetes are preventable by lifestyle choices. The rationale and justification for this study was accomplished in chapter one by first demonstrating that research, as it pertains to Resident Directors, is limited (Belch & Muller, 2003; Collins & Hirt, 2006) as well as showing that the literature of student affairs does not provide any study focusing on the wellness or health behaviors of Resident Directors. Additional rationale and justification was also established because Resident Directors are unique, in that their work position requires them to live and work in the same environment (Weaver, 2005).

In the second chapter, the researcher presented a review of literature outlining college health, student health behaviors, and health theories and health models. It was noted that Social Cognitive Theory (1986) and the Ecological Perspective Model (Sallis,

Owen, & Fisher, 2008) served as the foundation for this study. The review of literature also provided an overview of residence halls and the effects of how influential the residence halls environments created by Resident Directors have been with student retention, academic success, and psychosocial development (Astin, 1993; Pascarella & Terenzi, 1991). Lastly, the literature review discusses how Resident Directors' staff positions are visible allowing the opportunity for role modeling healthy behaviors for first time college students (Leafgren, 1993).

An explanation of the methods and procedures used in this study are presented in chapter three. A combination of descriptive statistics including examining mean scores and percentages along with multiple analysis of variance (MANOVA) were applied to answer questions regarding the self-reported health behaviors of Resident Directors according to the HPLPII in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relationship, and stress management. Chapter three also discusses the procedures taken to conduct the study. The researcher sent out 587 e-mail invitations to Resident Directors, as well as a request on two housing listservs asking Resident Directors to participate in the on-line study. The researcher allocated four weeks for the participants to complete the HPLPII. At the end of the allocated time, the researcher received 308 completed surveys to include in the research.

In chapter four, the researcher provides the results of the study. Results demonstrated that Resident Directors self- reported practicing in healthy behaviors at a minimal level with the overall mean of $\underline{M}$= 2.53. Additionally, results also showed that Resident Directors self-reported the areas of nutrition and health responsibility as the areas which they least practice. Resident Directors also indicated that interpersonal

relations and stress management are the areas of health practice in which they believe are influential for their students' health behaviors. Lastly, the results demonstrated that there is a difference of practicing certain health behaviors in relation to the gender and the race of the Resident Directors.

Conclusions and Implications

This study was conducted to improve the understanding of Resident Directors' health behaviors as it relates to the field of Residence Life and to the role modeling for their residents. It is the first study that examines the health promoting behaviors of Resident Directors. The results of this study provided substantial findings that will aid with the training, recruitment, and supervision of Resident Directors.

Scores from the HPLPII indicated that Resident Directors self-reported an average of M=2.53 inferring that Resident Directors sometimes engage in a lifestyle that practices health behaviors in the areas of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations, and stress management. Other studies (Belch & Mueller, 2003; Collins & Hirt, 2006; Palmer, Murphy, Parrott, & Steinke, 2001) have shown that Resident Directors do differ from their other student affairs colleagues in areas such as they have higher burnout, and want higher levels of relationships instead of focusing on administration life. Resident Director have lower retention rate and can be difficult to recruit. For this reason, the results found in this study are essential for assisting Chief Housing Officers (CHOs) and Senior Leadership Personnel (SLP) who supervise, hire, and mentor Resident Directors. This information could provide CHOs and Senior Leadership Personnel with information they could share with other student affairs staff to

form purposeful sub-committees to address the health for Resident Directors and possibly entry level student affairs staff members.

Resident Directors self-reported insufficient in the areas of health responsibility and nutrition. This is alarming since our nation is currently struggling with the highest level of preventable chronic diseases (CDC, 2008). Knowing this information could benefit the Resident Directors supervisors to educate their entire residence life staff about resources and encourage participation in personal programs available from the health promotion office at the university. Several universities have health promotion offices that are often under utilized by departments. With the collaboration between the university office of health promotions and housing offices, Resident Directors can become knowledgeable about the personal benefits from practicing healthy behaviors (Haines, Davis, Rancour, Robinson, Neel-Wilson, & Wagner, 2007). A suggestion would be to have a health promotion staff member come once a month to focus on different areas of health and the implications of practicing health promoting behaviors. This type of professional development would not only benefit the Resident Director but also benefit the Resident Assistants as well as the residents of the residence halls. An additional implication would be to have a competition among the Resident Directors to examine and make food choices with the residence hall vending machines. Working together with their students, Resident Directors could model to the students that they are taking time not only to care for themselves, but also for the entire community. Additionally, since Resident Directors are responsible for guiding their Resident Assistants who choose the food served during educational programs in the residence halls. The supervisors of Resident Directors can invite the campus nutritionist to discuss healthy food choices. The

Resident Directors receive information to share with their Residents Assistants to assist with the food choices for their residents, as well as nutritional information for themselves.

This study also found that female Resident Directors self-reported higher participation than male Resident Directors in the areas of health responsibility, nutrition, and interpersonal relations. Understanding this finding is important for supervisors to become more intentional in providing additional resources about health during a professional development series for male Resident Directors. Implementing a program allowing for peer to peer support among male Resident Directors would provide male Resident Directors the opportunity to have a supportive group to disclose trends and concerns about men's health. Collaboration between male Resident Directors, and other student affairs male staff members, can build a supportive subculture among male staff members.

The results also indicated that Resident Directors who identified with an under-represented ethnicity group self-reported less practice in the area of nutrition health behavior. These results are crucial because the CDC has shown the leading cause of preventable chronic diseases, in the under-represented population, is due to diet related factors. Knowing this information is beneficial because the CHOs of residence life can collaborate with the Multi-cultural office and health promotion offices on campus to develop an educational training awareness program about culture and food. This will not only benefit the Resident Directors who identify with the under-represented population but will also benefit the Resident Assistants and the residents in the residence hall community.

The results show that it is evident that Resident Directors know the importance of interpersonal relationships and emotional wellness. Resident Directors self-reported the highest practice in the area of interpersonal relations and also indicated a high belief in the practice of stress management to influence their students' behaviors. Several resident life programs invest in assessments such as the Myers-Briggs Type indicator or True Colors, which are personality assessments (Leafgren, 1993). Since the results of this study showed that Resident Directors indicated minimal involvement in physical activity, health responsibility, and stress management, it would be wise for the CHOs of the residence life staff to invest in Wellness Personal Assessments which could serve a preventative tool to decrease the risk of chronic diseases among Resident Directors.

It is also hoped that these results spark an interest with CHOs and Senior Personnel members to work more closely with the health promotion office. These new collaborations could lead towards an increase of wellness benefits for Resident Directors which could be beneficial to show reports for recruiting new Resident Directors. Lastly, more research about health behaviors with Resident Directors is necessary to share with ACUHO-I. Currently, ACUHO-I supports on-line groups such as (new professionals, professional development, and apartment managers) but does not have an on-line group for wellness. Perhaps sharing these results can promote the creation of a new on-line support group for the professionals associated with ACUHO-I.

Recommendation for Further Research

The purpose of this study was to examine the self-reported health behaviors of Resident Directors affiliated with ACUHO-I. From this study, further research is

necessary in order to continue the importance of health in higher education as well as student affairs practitioners.

Research is needed to examine all live-in staff members for the area of Residence Life within student affairs. This study only examined the self-reported health behaviors of Resident Directors who were affiliated with ACUHO-I. To increase the generalizations of this study, Residence Life staff positions not associated with ACUHO- I, or other positions such as Area Coordinators, Assistant Directors, and even Directors, whose position requires them to live-in, should participate in a study that examines their self-reported health behaviors. The reason for this is because all live-in staff members could influence the behaviors of residents living in the halls.

Because this study found that Resident Directors who identified themselves from an under-represented racial group, self-reported lower practices of health behaviors in the area of nutrition, further research is needed to examine the health behaviors of Resident Directors working predominantly at Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions (HSIs), Native American-Serving Non-Tribal Institutions, and other under-represented institutions. One area for future study could be to examine a comparison of dining services at under-represented institutions and predominately white institutions. This research could help implement programs necessary to eliminate the health disparities with the under-representative population.

Further research is necessary to examine if male Resident Directors, or other male live-in Residence Life staff, are utilizing and are informed about the health promotion programs available at many higher education institutions as compared to their female colleagues. This study showed that male Resident Directors self-reported lower levels of overall

health behaviors especially in the areas of health responsibility, nutrition, and interpersonal relations.

Since this study examined what areas of health behaviors do Resident Directors believe are influential to their residents' health behaviors, it would be interesting to do a further study to examine what areas of health behaviors residents believe are important for their Resident Directors to participate to influence their residents' behaviors. After all it is the influences and experiences that these residents receive that will impact our greater society. Additionally, this study could further the support of the effects from the Ecological Perspective Model and overall health.

Since this study showed that Resident Directors self-reported the least practice the health behaviors of physical activity and health responsibility, it would be beneficial to do a further study to examine the differences of Resident Directors who are trained, educated and mentored in health behaviors as opposed to those who are not trained, educated, or mentored.

Lastly, as a student affairs practitioner, I believe that these results are helpful and continue to support the college student development theories. Knowing that these health behaviors are being met minimally by Resident Directors could impact the way Resident Directors implement and practice student development theories with their students.
All of these future recommendations are necessary to implement because our society is struggling with the increase of chronic diseases which could be prevented if took the time to educate and model healthy lifestyles to college students who are the future leaders of our world.

Conclusions

A review of the literature as it relates to college students indicate that these individuals engage in unhealthy behaviors (Baker, Boland, & Laffey, 2006; Brunt, Rhee, & Zhong, 2008;Sand, Archer, & Puelo, 1998). The primary focus of this study was to examine the self-reported health behaviors of Resident Directors. Secondly, this study examined various areas of health behaviors and whether Resident Directors believe their participation influences the behaviors of their students. This study found that Resident Directors are engaging in health behaviors at a minimal level. In addition, this study found that there was difference in the practice of health behaviors between female Resident Directors and male Resident Directors. This study found that female Resident Directors engage more frequently than male Resident Directors in the health promoting behaviors of nutrition, health responsibility, and interpersonal relations. This study also noted that Caucasian Resident Directors engage more frequently than male Resident Directors in the health promoting behavior of nutrition. These results are important because they can provide Chief Housing Offices and Senior Leadership personnel with up-to-date knowledge about the health behaviors of Resident Directors who are hired to influence positive role modeling for students and promote a healthy living environment.

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APPENDIX A

RESIDENT DIRECTOR JOB DESCRIPTION

Mississippi State University

Division of Student Affairs

Department of Housing and Residence Life

Position Description

Title: Graduate Residence Director

Summary: Responsible for the implementation of the developmental and operational Housing and Residence Life program within one residence hall. The multi-faceted program requires coordination of Resident Assistants, desk staff, and student leaders to achieve goals and objectives. The Graduate Residence Director, as an administrative official of the university and a member of the residence life staff, is expected to develop the skills required in the position and to integrate them with an understanding of student development and accept the responsibilities that come with being a role model for students and staff. The Graduate Residence Director is required to live in an apartment within the residence hall. The Graduate Residence Director reports directly to the Assistant Director for Residence Life.

Skills and Responsibilities

Team Builder and Supervisor

1. Works to create an environment of mutual support for resident assistants and encourages team work between resident assistants.

2. Select staff through the RA selection process. The staff should represent and be sensitive to the needs of a diverse student population.

3. Assist in training as needed.

4. Conduct regular staff meetings to provide relevant information, build trust and unity, and improve communications within the staff.

5. Supervise RAs in performance of their duties.

6. Provide ongoing feedback to RAs in regarding personal and professional development.

7. Attend weekly RD staff meetings and other meetings as needed.

8. Participate in various scheduled workshops and training sessions.

9. Contribute to the professional growth of colleagues by sharing ideas, participating on committees, providing constructive criticism to peers, and experimenting with new concepts and programs.

Educator

1. Works with staff and students to establish and affirm standards of conduct appropriate to communal living and supportive of the academic mission.

2. Implement hall programs based on student development theory and needs assessment. Encourage resident participation in hall programs.

3. Transmit through both example and statement, an impartial attitude toward persons regardless of race, color, religion, natural origin, sex, sexual orientation or group affiliation, age, disability, or veteran status.

Community Builder

1. Works to provide an environment of cooperation between resident assistants and officer and delegates of the Hall Association.

2. Serve as the Advisor to the residence hall's individual Hall Association.

3. Support the programming and policy-making efforts of the Association to create a more beneficial living environment and facilitate the development of students.

4. Help the Hall Association evaluate the effectiveness of policy decisions, programs, and officer performance.

5. Facilitate election of officers in accordance with hall constitution and university policies.

6. Supervise the VP-Finance in maintaining accurate and up-to-date financial records and reviewing/processing requests for purchases in accordance with university and housing policies. Work with the Assistant Director for Budget and Finance to periodically audit hall accounts. Ensure that hall accounts are balanced and not deficient at year's end.

Crisis Manager

1. Provide leadership during any crisis in the residence hall, including injuries, fire alarms, natural disasters, facility emergencies, etc.

2. Become familiar with and follow all institutional and departmental guidelines regarding emergencies.

3. Successfully complete prescribed training course in CPR and First Aid, Food Preparation, and TIPS Alcohol Training.

4. Coordinate efforts during a crisis with appropriate university departments, such as the Dean of Students and Campus Police, and community agencies, such as the Starkville Fire Department.

5. Whenever possible, seek to ensure an environment that is secure for residents and staff.

Counselor

1. Take a proactive interest in the personal development of residents including areas of interpersonal relationships, development of autonomy and management of emotions.

2. Serve as an advisor and counselor for academic and personal concerns.

3. Be familiar with the resources available to students and make referrals when appropriate.

4. Coordinate with the Dean of Students' office in handling judicial incidents and situation reports. Keep all files confidential.

5. Mediate student conflicts.

Administrator

1. Assume overall responsibility for the administration of the residence hall.

2. Assume responsibility for hall openings and closings. Coordinate check-in and check-out procedures.

3. Keep complete and accurate information of all residents including floor charts and me emergency contact information. Work closely with the Assignments Staff regarding room changes, consolidation, and hall transfers.

4. Be familiar with university policies, procedures, and forms. Interpret these to students as needed.

5. Be familiar with and implement a fair and consistent application of university regulations as they relate to standards of behavior.

6. Assume responsibility for hall security. This includes assuring that the building is properly secured, supervising fire safety procedures, providing leadership in emergencies, educating residents about security needs, and informing the Housing Office of potential security risks.

7. Ensure that administrative work delegated to RAs is completed.

8. Maintain an accurate key inventory.

9. Report needed maintenance and repairs. Report unsatisfactory custodial and maintenance service to the Assistant Director for Housing Facilities. Work with the custodial supervisor to insure that high levels of cleanliness are maintained.

10. Attempt to reduce damage from vandalism, and when necessary, assess charges to students who are responsible for the damages.

11. Establish and supervise an effective desk operation, including hiring of desk workers and providing necessary service to residents and visitors. Fill out and turn in time sheets for Desk Assistant Staff.

12. Report problems with vending machines, washers, and dryers.

13. Ensure that managerial duties delegated to RAs are completed.

14. Perform all other duties are assigned.

Terms of Employment

The Graduate Residence Director must live within the residence hall community assigned and be enrolled at Mississippi State University as a graduate student during the period of employment.

Period of Employment

A twelve-month period, beginning with the fall training workshop and ending in mid-May and after RD is properly checked out with the Housing Office. Summer employment may be available. Graduate Residence Directors must be able to work both fall and spring semesters of an academic year. Residence Directors observe the same holidays as students; however, they are expected to remain on campus until the halls close before any holiday period and should return to campus prior to the hall re-opening following the holidays. Residence Directors may not hold other jobs or assistantships.

Time Commitment

The Residence Director must be willing to commit a significant amount of time to the position. Some specific time requirements are daytime and evening meetings and special hall/campus events that require staff support. Additionally, the very nature of the position requires that the Residence Director be available to residents and staff. As a result, he/she is expected to spend the majority of his/her time in the residence hall.

Remuneration

Includes a stipend paid twice a month; including utilities, cable, and local telephone, as well as in and out of state tuition and fees. May be eligible for student health insurance.

APPENDIX B

HEALTH PROMOTING LIFESTYLE PROFILE II WITH SUBSCALES

LIFESTYLE PROFILE II

DIRECTIONS: This questionnaire contains statements about your *present* way of life or personal habits. Please respond to each item as accurately as possible, and try not to skip any item. Indicate the frequency with which you engage in each behavior by circling:

N for never, **S** for sometimes, **O** for often, or **R** for routinely

1. Discuss my problems and concerns with people close to me. N S O R
2. Choose a diet low in fat, saturated fat, and cholesterol. N S O R
3. Report any unusual signs or symptoms to a physician or other health professional. N S O R
4. Follow a planned exercise program. N S O R
5. Get enough sleep. N S O R
6. Feel I am growing and changing in positive ways. N S O R
7. Praise other people easily for their achievements. N S O R
8. Limit use of sugars and food containing sugar (sweets). N S O R
9. Read or watch TV programs about improving health. N S O R
10. Exercise vigorously for 20 or more minutes at least three times a week (such as N S O R
brisk walking, bicycling, aerobic dancing, using a stair climber).
11. Take some time for relaxation each day. N S O R
12. Believe that my life has purpose. N S O R
13. Maintain meaningful and fulfilling relationships with others. N S O R
14. Eat 6-11 servings of bread, cereal, rice and pasta each day. N S O R
15. Question health professionals in order to understand their instructions. N S O R
16. Take part in light to moderate physical activity (such as sustained walking N S O R
30-40 minutes 5 or more times a week).
17. Accept those things in my life which I cannot change. N S O R
18. Look forward to the future. N S O R
19. Spend time with close friends. N S O R
20. Eat 2-4 servings of fruit each day. N S O R
21. Get a second opinion when I question my health care provider's advice. N S O R
22. Take part in leisure-time (recreational) physical activities (such as swimming, N S O R
dancing, bicycling).
23. Concentrate on pleasant thoughts at bedtime. N S O R
24. Feel content and at peace with myself. N S O R
25. Find it easy to show concern, love and warmth to others. N S O R
26. Eat 3-5 servings of vegetables each day. N S O R
27. Discuss my health concerns with health professionals. N S O R
28. Do stretching exercises at least 3 times per week. N S O R
29. Use specific methods to control my stress. N S O R
30. Work toward long-term goals in my life. N S O R
31. Touch and am touched by people I care about. N S O R
32. Eat 2-3 servings of milk, yogurt or cheese each day. N S O R
33. Inspect my body at least monthly for physical changes/danger signs. N S O R

34. Get exercise during usual daily activities (such as walking during lunch, using N S O R
stairs instead of elevators, parking car away from destination and walking).
35. Balance time between work and play. N S O R
36. Find each day interesting and challenging. N S O R
37. Find ways to meet my needs for intimacy. N S O R
38. Eat only 2-3 servings from the meat, poultry, fish, dried beans, eggs, and N S O R
nuts group each day.
39. Ask for information from health professionals about how to take good care N S O R
of myself.
40. Check my pulse rate when exercising. N S O R
41. Practice relaxation or meditation for 15-20 minutes daily. N S O R
42. Am aware of what is important to me in life. N S O R
43. Get support from a network of caring people. N S O R
44. Read labels to identify nutrients, fats, and sodium content in packaged food. N S O R
45. Attend educational programs on personal health care. N S O R
46. Reach my target heart rate when exercising. N S O R
47. Pace myself to prevent tiredness. N S O R
48. Feel connected with some force greater than myself. N S O R
49. Settle conflicts with others through discussion and compromise. N S O R
50. Eat breakfast. N S O R
51. Seek guidance or counseling when necessary. N S O R
52. Expose myself to new experiences and challenges. N S O R

For information about this scale go to www.unmc.edu/nursing/.

HEALTH-PROMOTING LIFESTYLE PROFILE II

Scoring Instructions

Items are scored as Never (N) = 1
Sometimes (S) = 2
Often (O) = 3
Routinely (R) = 4

A score for overall health-promoting lifestyle is obtained by calculating a mean of the individual's responses to all 52 items; six subscale scores are obtained similarly by calculating a mean of the responses to subscale items. The use of means rather than sums of scale items is
recommended to retain the 1 to 4 metric of item responses and to allow meaningful comparisons of scores across subscales. The items included on each scale are as follows:

Health-Promoting Lifestyle 1 to 52

Health Responsibility 3, 9, 15, 21, 27, 33, 39, 45, 51

Physical Activity 4, 10, 16, 22, 28, 34, 40, 46

Nutrition 2, 8, 14, 20, 26, 32, 38, 44, 50

Spiritual Growth 6, 12, 18, 24, 30, 36, 42, 48, 52

Interpersonal Relations 1, 7, 13, 19, 25, 31, 37, 43, 49

Stress Management 5, 11, 17, 23, 29, 35, 41, 47

3/95: snw

APPENDIX C

E-MAIL INVITATION TO PARTICIPANTS

Dear Housing and Residence Life Professional,

I hope that your 2009 is going well. Based on your institution's affiliation with ACUHO-I, you have been selected to participate in a research study that will examine the health behaviors of live- in staff members, specifically known as Resident Directors. As a researcher and former Resident Director, I understanding your busy schedule during this time of the year; this survey will take **10** minutes of your time. Your participation in this study will contribute valuable information to the limited research that has been conducted on Resident Directors.

As a current doctoral student completing her dissertation from Mississippi State University, I would greatly appreciate your participation in this study by taking the on-line survey known as the *Health Promoting Lifestyle Profile II.* Participating in this survey is ***completely voluntary*** and you can refuse to answer any questions that you wish. Be assured that your responses to the survey will be confidential.

To take the survey, please go to the following site
https://www.surveymonkey.com/s.aspx?sm=LqezY8mdMLiP3raVaq0qiQ_3d_3d

You will have until May 25, 2009 to complete the survey.

Thank you for your time. If you have any questions or concerns regarding this research project, please contact me at mla7@msstate.edu or 504-330-6461. If you have additional questions regarding human participation in research, please feel free to contact Mississippi States University Regulatory Compliance Office at 662-325-5220 and refer to research study #09-090.

Sincerely,

Maylen Lizeth Aldana

Doctoral Candidate at Mississippi State University

APPENDIX D

LETTER OF SUPPORT FROM ACUHO-I

March 5, 2009

Maylen Aldana
6823 St. Charles Street
Central Building ST. #104-Campus Life
New Orleans, LA 70118

Ms. Aldana:

This letter is to confirm that the Commissioned Research Committee of ACUHO-I has given its endorsement to your research study titled *"Examining Self-Reported Health Behaviors and Role Modeling among Resident Directors affiliated with ACUHO-I institutions"*.

This endorsement allows you to use the following statement on all communication:

> The following research study, *"Examining Self-Reported Health Behaviors and Role Modeling among Resident Directors affiliated with ACUHO-I institutions",* has been reviewed and endorsed in principle by ACUHO-I's Commissioned Research Committee – Dr. Doug Hallenbeck, Commissioned Research Chair.

To gather data you may utilize ACUHO-I's on-line directory if you have access. If you have additional questions feel free to contact me.

Sincerely,
Douglas A. Hallenbeck, Ph.D.
Commissioned Research, Chair
ACUHO-I

UNIVERSITY HOUSING
101 Mell Hall Box 344075 Clemson, SC 29634-4075
864.656.1151 FAX 864.656.6844

APPENDIX E

AUTHOR'S PERMISSION TO USE INSTRUMENT

COLLEGE OF NURSING
Community-Based Health Department
985330 Nebraska Medical Center
Omaha, NE 68198-5330
402/559-6382
Fax: 402/559-6379

Dear Colleague:
Thank you for your interest in the *Health-Promoting Lifestyle Profile II.* The original *Health-Promoting Lifestyle Profile* became available in 1987 and has been used extensively since that time. Based on our own experience and feedback from multiple users, it was revised to more accurately reflect current literature and practice and to achieve balance among the subscales. The *Health-Promoting Lifestyle Profile II* continues to measure health promoting behavior, conceptualized as a multidimensional pattern of self-initiated actions and perceptions that serve to maintain or enhance the level of wellness, self-actualization and fulfillment of the individual.

The 52-item summated behavior rating scale employs a 4-point response format to measure the frequency of self-reported health-promoting behaviors in the domains of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relations and stress management. It is appropriate for use in research within the framework of the Health Promotion Model (Pender, 1987), as well as for a variety of other purposes.

The development and psychometric evaluation of the English and Spanish language versions of the original instrument have been reported in:

Walker, S. N., Sechrist, K. R., & Pender, N. J. (1987). The Health-Promoting Lifestyle Profile: Development and psychometric characteristics. Nursing Research, 36(2), 76-81.
Walker, S. N., Volkan, K., Sechrist, K. R., & Pender, N. J. (1988). Health-promoting lifestyles of older adults: Comparisons with young and middle-aged adults, correlates and patterns. Advances in Nursing Science, 11(1), 76-90.
Walker, S. N., Kerr, M. J., Pender, N. J., & Sechrist, K. R. (1990). A Spanish language version of the Health- Promoting Lifestyle Profile. Nursing Research, 39(5), 268-273.

A copy of the instrument (English and Spanish versions), scoring instructions, an abstract of the psychometric findings, and a list of publications reporting research using all versions of the instrument are available for download.

Sincerely,
Susan Noble Walker, EdD, RN, FAAN
Professor Emeritus

APPENDIX F

DEMOGRAPHIC QUESTIONNAIRE AND ADDITIONAL QUESTION

Demographic Question

A. Gender : ☐ Male ☐ Female

B. Race : ☐ African American ☐ Asian American ☐ Caucasian

☐ Hispanic ☐ Native American ☐ Other _____

C. Geographic Location According to ACUHO-I :

☐ Association of Intermountain Housing Officers (AIMHO) represents member institutions in: Montana, Idaho, Wyoming, Utah, Colorado, Arizona and New Mexico

☐ Great Lakes Association of College and University Housing Officers (GLACUHO) represents member institutions in:

Illinois, Indiana, Michigan and Ohio

☐ Mid-Atlantic Association of College and University Housing Officers (MACUHO) represents member institutions in:

Delaware, District of Columbia, Maryland, New Jersey, Pennsylvania, and West Virginia)

☐ Northeast Association of College and University Housing Officers (NEACUHO) represents member institutions in:

Connecticut , Maine, Massachusetts, New Hampshire, New York, Rhode Island and Vermont)

☐ Northwest Association of College and University Housing Officers (NWACUHO) represents member institutions in:

Alaska, Hawaii, Oregon, and Washington

☐ Southeastern Association of Housing Officers (SEAHO) represents member institutions in: Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia

☐ Southwest Association of College and University Housing Officers (SWACUHO) represents member institutions in:

Texas, Oklahoma, and Arkansas

☐ Upper Midwest Region-Association of College and University Housing Officers (UMR-ACUHO) represents member institutions in: Wisconsin, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

☐ The Western Association of College and University Housing Officers (WACUHO) represents member institutions in:

California

D. Years of Experience as a full time Resident Director

☐ < 1year

☐ 1-2 years

☐ 3 or > years

☐ Graduate Student: If you are a graduate student you cannot participate in this study.

E. Which of the following health behaviors do you believe your participation influences the behaviors of your students (Check all that Apply)?

- ☐ Health Responsibility
- ☐ Physical Activity
- ☐ Nutrition
- ☐ Spiritual Growth
- ☐ Interpersonal Relations
- ☐ Stress Management

APPENDIX G

INSTITUTIONAL REVIEW BOARD LETTERS

Mississippi State University
Office of Regulatory Compliance
Post Office Box 6223
Mississippi State, MS 39762

Compliance Division
Administrative Offices
Animal Care and Use (IACUC)
Human Research Protection
Program (IRB)
1207 Hwy 182 West
Starkville, MS 39759
(662) 325-3496 - fax

Safety Division
Biosafety (IBC)
Radiation Safety
Hazardous Waste
Chemical & Lab Safety
70 Morgan Avenue
Mississippi State, MS 39762
(662) 325-8776 - fax

http://www.orc.msstate.edu
compliance@research.msstate.edu
(662) 325-3294

April 7, 2009

Maylen Aldana
1400 North Atlanta Street
Metaire, Louisiana 70003

RE: IRB Study #09-090: Examining Self-Reported Health Behaviors and the Practices of Role-Modeling Among Resident Directors Affiliated With the Association of College and University Housing Officers - International (ACUHO-I)

Dear Ms. Aldana:

The above referenced project was reviewed and approved via administrative review on 4/7/2009 in accordance with 45 CFR 46.101(b)(2). Continuing review is not necessary for this project. However, any modification to the project must be reviewed and approved by the IRB prior to implementation. Any failure to adhere to the approved protocol could result in suspension or termination of your project. The IRB reserves the right, at anytime during the project period, to observe you and the additional researchers on this project.

Please note that the MSU IRB is in the process of seeking accreditation for our human subjects protection program. As a result of these efforts, you will likely notice many changes in the IRB's policies and procedures in the coming months. These changes will be posted online at http://www.orc.msstate.edu/human/aahrpp.php.

Please refer to your IRB number (#09-090) when contacting our office regarding this application.

Thank you for your cooperation and good luck to you in conducting this research project. If you have questions or concerns, please contact me at cwilliams@research.msstate.edu or call 662-325-5220.

Sincerely,

Christine Williams
IRB Compliance Administrator

cc: Debbie Wells

Maylen,

Your IRB procedural modification request has been approved. You may implement the change in recruiting materials effective immediately. The wording approved is what is in this email message. It is the wording that was in the email that you sent to me on 4/16/09 asking about the changes to recruitment. The wording that you submitted with the fax of the modification paperwork had a few redundant words in the first paragraph and it was missing some of the contact information in the last paragraph, so please use the wording from your 4/16/09 email as it is pasted below:

Dear Housing and Residence Life Professional,

I hope that your 2009 is going well. If your institution is affiliated with ACUHO-I, you are invited to participate in a research study that will examine the health behaviors of live- in staff members, specifically known as ***Full Time*** *professional Resident Directors. As a researcher and a former Resident Director, I understanding your busy schedule during this time of the year; this survey will take* ***10*** *minutes of your time. Your participation in this study* ***will contribute valuable information*** *to the limited research that has been conducted on Resident Directors.*

As a current doctoral student completing her dissertation from Mississippi State University, I would greatly appreciate your participation in this study by taking the on-line survey known as the Health Promoting Lifestyle Profile II. Participating in this survey is ***completely voluntary*** *and you can refuse to answer any questions that you wish. Be assured that your responses to the survey will be confidential.*

To take the survey, please go to the following site

https://www.surveymonkey.com/s.aspx?sm=LqezY8mdMLiP3raVaq0qiQ_3d_3d

Please complete the survey by May 25, 2009.

Remember that only full time professional Resident Directors can participate in this survey.

Thank you for your time. If you have any questions or concerns regarding this research project, please contact me at mla7@msstate.edu or 504-330-6461. If you have additional questions regarding human participation in research, please feel free to contact Mississippi States University Regulatory Compliance Office at 662-325-5220and refer to research study #09-090.

Sincerely,

Maylen Lizeth Aldana

Mla7@msstate.edu

Doctoral Candidate at Mississippi State University

Of course, if you need to change the formatting for the email that is fine as long as it contains this wording. If you need to change the completion request date b/c of the time required for the review, that is fine also.

Regards,

Christine

Christine

Christine Williams
Compliance Administrator
Office of Regulatory Compliance
PO Box 6223
Mississippi State, MS 39762
662-325-5220 (phone)
662-325-3496 (fax)
Campus Mail Stop: 9563
Physical address:
1207 Hwy 182 W.
Starkville, MS 39759

APPENDIX H

REMINDER E-MAIL TO PARTICIPANTS

Dear Housing and Residence Life Professional,

I hope that your 2009 is going well. In April you received an e-mail from me inviting you to participate in a study that will be examining health behaviors among Resident Directors. This e-mail is being sent to you as a reminder that you still have time to participate in the study. **If you already took the survey, I thank you for your time and please ignore the following message.**

I understand that you time is valuable, this on-line survey about your health behaviors, will only take 10 minutes. Your participation in this study will contribute valuable data to the limited research that has been conducted among Resident Directors.

As a current doctoral student completing her dissertation from Mississippi State University and a former Resident Director, I would greatly appreciate your participation in this study by taking the on-line survey known as the *Health Promoting Lifestyle Profile II*. Participating in this survey is completely voluntary and you can refuse to answer any questions that you wish. Be assured that your responses to the survey will be confidential.

To take the survey, please go to the following site
https://www.surveymonkey.com/s.aspx?sm=LqezY8mdMLiP3raVaq0qiQ_3d_3d

You will have until May 25, 2009 to complete the survey.

Thank you for your time. If you have any questions or concerns regarding this research project, please contact me at mla7@msstate.edu or 504-330-6461. If you have additional questions regarding human participation in research, please feel free to contact Mississippi States University Regulatory Compliance Office at 662-325-5220 and refer to study #09-090.

Sincerely,

Maylen Lizeth Aldana

Doctoral Candidate at Mississippi State University

APPENDIX I

INFORMED CONSENT FORM

Consent Form

Title of Study: Examining self –reported Health Behaviors and the Importance of Role Modeling Among Resident Directors who are affiliated with the Association of College and University Housing Officers-International (ACHUHO-I) .

Study Site: Mississippi State University

Name of Researcher(s) & University affiliation: Maylen Lizeth Aldana, Doctoral Candidate, Mississippi State University

You are being asked to participate in this research projected conducted through Mississippi State University. The Office of Regulatory Compliance of Mississippi requires that you give a signed agreement to participate in this project. This will be accomplished by checking the signature box in the on-line survey.

What is the purpose of this research project? The research design will provide information regarding Resident Directors' overall health behaviors in the area of health responsibility, physical activity, nutrition, spiritual growth, interpersonal relation, and stress management. Additionally, the study will explore the importance of Role Modeling among Resident Directors. The study will use quantitative methodologies to gather necessary data to answer the research questions.

How will the research be conducted? You were selected to participate in this study because of your status as a full time Resident Director and your affiliation to ACUHO-I. As the researcher, I received permission from ACUHO-I to search the on-line directory for your contact information. All of the participants in this study will receive an e-mail from the researcher containing the on-line URL to take the survey known as Health Promoting Lifestyle Profile II.

Are there any risks or discomforts to me because of my participation? Participating in this survey will not subject you to any specific risks. However, it is important to understand that when exploring personal health behaviors, some participants could experience some psychological discomfort**.**

Does participation in this research provide any benefits to others or myself? The benefits of participating in this study will contribute additional knowledge of Resident Directors in the literature. Specifically, it will be the first study to examine health behaviors among Resident Directors. Additionally, the study will examine how important do Resident Directors believe that role modeling is for initiating and motivating health behaviors to their residents.

Will this information be kept confidential? Results of the survey will go directly to an excel spreadsheet. The participants' results will not be connected to their e-mails. The company Survey Monkey has a confidential system in place for secured information. *Also, please note that these records will be held by a state entity and therefore are subject to disclosure if required by law."

Who do I contact with research questions? If you should have any questions about this research project, please feel free to contact Maylen Lizeth Aldana at 504-330-6461 or mla7@msstate.edu. For additional information regarding your rights as a research subject, please feel free to contact the MSU Regulatory Compliance Office at 662-325-5220 and refer to study # 09-090.

What if I do not want to participate?

Please understand that your **participation is voluntary**, your **refusal to participate will involve no penalty or loss** of benefits to which you are otherwise entitled, and you **may discontinue your participation** at any time without penalty or loss of benefits.

You will be able to copy this form for your records.

_____ _____

Participant Signature Date

_____ _____

Investigator Signature

Maylen Lizeth Aldana

Special Note: The participant will check a box within the on-line survey that indicates he or she will participate in the study. If the participant indicates yes, the on-line survey will continue. If the participant indicates no, the on-line survey will end.

APPENDIX J

THANK-YOU MESSAGE TO PARTICIPANTS

Dear Resident Director,

Thank you for completing the on-line survey which assessed health behaviors among Resident Directors. It is because of dedicated professionals like yourself, that together, we can increase information about Resident Directors in the professional literature.

I know that the time you dedicated to fill out this survey is valuable. If you would like to have more information regarding healthy living, I invite you to visit the following websites which I personally found helpful information while conducting this study.

1. The Center for Disease Control and Prevention: http://www.cdc.gov
2. National Institutes of Health http://www.nih.gov
3. Mayo's Clinic Website about Healthy Living : http://www.mayoclinic.com

If you have additional questions or comments about this research project, please contact me at mla7@msstate.edu or 504-330-6461. If you have additional questions regarding human participation in research, please feel free to contact Mississippi States University Regulatory Compliance Office at 662-325-5220 and refer to study #09-090.

Thank you again, and have a Healthy 2009!

Maylen Lizeth Aldana

Doctoral Candidate of Mississippi State University