EXAMINING SECONDARY TRAUMATIC STRESS, JOB SATISFACTION, AND THE RISK OF ATTRITION IN RESIDENT ASSISTANTS

By

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Zachary W. Inman 05/11/2022

I dedicate this project to my wife, my daughter, and the memory of my grandmother. My wife, Sarah, has been a constant source of support throughout this adventure of life. Without her encouragement and taking on extra roles at home during the classes and writing sessions, this would not have been possible. I am thankful to have her as my wife, soulmate, and best friend for life. Always.

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Finally, this dissertation is also dedicated to the memory of my grandmother, Brenda Kay Inman. Although she always challenged me to keep going well before I started this journey, she was unable to see my graduation. This is dedicated to her, her love for her family, and her zeal for life.

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ABSTRACT

This explanatory, sequential mixed methods study aimed to explore (a) the prevalence of secondary traumatic stress (STS) in resident assistants (RAs) at a 4-year public university in the southeastern United States, (b) the personal and institutional supports and barriers that impact resident assistants' responses to this STS, and (c) the roles STS plays in resident assistants' job satisfaction and risk of attrition. Twenty-one resident assistants completed the Secondary Trauma in Resident Assistants survey. Surveys were analyzed using descriptive statistics, hierarchical multiple regression, and logistic regression. Five resident assistants participated in follow-up semistructured interviews, which were analyzed using thematic analysis. Findings indicated that RAs reported moderate-to-severe levels of STS. Factors influencing levels of STS include semesters of experience, quantity and types of trauma incidents, and amount of training. Supports responding to STS include positive self-talk, social and familial supports, locus of control, campus counseling centers, campus involvement, strong supervision, and mental health campus programming. Barriers include negative self-talk, alcohol use, lack of social and familial support, limited training, the RA role, lack of strong supervision, and limited availability of campus counselors within the research setting. Implications for practice include (a) expanded training to address responding to mental health crises as well as coping mechanisms for dealing with STS, (b) training supervisors in best practices of trauma-informed supervision, (c) expansion of counseling center support for residence life programs, and (d) developing protocols for early detection of burnout and STS in RAs as well as interventions to prevent further burnout. Implications for future research include (a) addressing the lack of evidence surrounding resident assistants' mental health, (b) replicating the study in multiple settings with an expanded

population of diverse genders, ages, and ethnicities, and (c) addressing the effects of campus educational programming on STS in RAs.

Keywords: resident assistant, secondary traumatic stress, institutional supports and barriers, job satisfaction, risk of attrition

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Chapter I

Introduction

According to the American Freshmen National Norms Survey: Fall 2019, the emotional health of college students has continued to decline since 2015 (Stolzenberg et al., 2020). In 2015, 59.0% of men and 43.7% of women reported their emotional health as above average; however, by 2019 the percent had dropped to 50.4% and 34.0%, respectively (Stolzenberg et al., 2020). Additionally, many psychological disorders develop during late adolescence and early adulthood, which is often the same time that an individual is enrolled in college (Kitzrow, 2003). With the decline in emotional health of college students and the overlap in development of psychological disorders, college students seem particularly susceptible to emotional distress and trauma.

Trauma, Posttraumatic Stress Disorder, and STS

The definition of psychological trauma has changed with the development of society and every edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The definition of psychological trauma in the DSM-5 (i.e., 5th edition) includes the threat of physical harm or death to the individual or a family member (American Psychiatric Association, 2013). The term "psychological trauma" was first introduced in the DSM-III; however, this edition only identified trauma as an impetus for other diagnosable disorders, as the "existence of recognizable stressors that would evoke significant symptoms of distress in almost everyone" (American Psychiatric Association, 1980, p. 283). It was not until 1994, in the DSM-IV, that trauma was identified as a diagnosable condition (American Psychiatric Association, 2000). According to the DSM-5, traumatic events include: (a) threatened and actual physical assault; (b) threatened and actual violence; (c) natural and manmade disasters or catastrophic events; or (d) observing

threatened or serious injury, unnatural death, physical or sexual abuse, domestic violence, suicide or suicide attempt, serious injury (American Psychiatric Association, 2013).

Trauma has become increasingly prevalent. It is estimated that approximately 70% of individuals experience at least one potentially traumatic event within their lifetime, and as much as 30% of individuals experience four or more potentially traumatic events (Benjet et al., 2016; Knipscheer et al., 2020). Of those individuals experiencing a potentially traumatic event, 2.0% develop some form of posttraumatic stress disorder (PTSD; Knipscheer et al., 2020). PTSD was first identified as a mental disorder associated with traumatic experiences in the DSM-III (American Psychiatric Association, 1980). Although PTSD is relatively new in comparison to other mental disorders, a discord exists among researchers and mental health providers regarding the criterion for trauma (Weathers & Keane, 2007). Sorsoli (2007), for example, argues there are forms of trauma that may not be perceived as life-threatening, such as racial trauma including racism, systemic oppression, and microaggressions.

Racism is defined as a form of oppression based on race that designates one group as superior and other(s) as inferior (Bulhan, 1985). Furthermore, racism involves the perpetuation of inequity, exclusion, and domination based on the constructed views of inferiority (Bulhan, 1985). According to Jones (1997), racism occurs in three forms: (a) individual (i.e., person versus person), (b) cultural (i.e., devaluation of a racial group's cultural practices), and (c) institutional (i.e., the implementation of discriminatory laws and policies). Racism has been identified as having an inverse effect on mental health including depression and anxiety as well as symptomology similar to PTSD (Lee & Ahn, 2011; Pieterse et al., 2012).

Systemic oppression occurs when a certain social group is permanently subordinated, humiliated, and dominated due to their socially constructed lower societal position in comparison

to the higher position of the oppressing group (Feagin, 2013). Consequences of oppression include both mental health conditions, such as depression and anxiety, and physiological responses, such as hypertension (Din-Dzietham et al., 2004; Fang & Myers, 2001). Microaggressions are instances in which a person's biases influence their language and behaviors (Nadal, 2018). Introduced by Pierce in 1978, microaggressions are defined as "subtle, stunning, often automatic, and non-verbal exchanges which are 'put-downs'" (p. 66). In a hierarchical multiple regression study of 254 individuals of color, Nadal et al. (2014) found a significant relationship between the frequency of exposure to microaggressions and traumatic stress, $F(9, 156) = 3.64$, $p < .001$.

The American Psychiatric Association (2013) has identified several symptoms for psychological trauma and PTSD, including intrusive thoughts regarding the traumatic event, negative alterations to cognition or mood, avoidance of people, places, or things that trigger memories and changes emotional arousal and reactivity. An individual exhibiting intrusive thoughts may experience reoccurring, involuntary memories of the trauma, dreams related to the trauma, and distress from exposure to different trauma aspects through internal and external stimuli. An individual experiencing negative alterations to cognition or mood may express an inability to remember details of the traumatic event; negative beliefs about oneself or others; a persistent, negative emotional state; and diminished interest in hobbies and relationships. Similarly, an alteration to arousal and reactivity may be exhibited through irritability, self-destructive behavior, sleep disturbances, and an inability to concentrate. According to the American Psychiatric Association (2013), an individual may experience any or all symptoms, and they typically last longer than one month to be considered related to PTSD.

Though PTSD focuses on the targeted individual from the trauma, recent research has shifted to include a focus on the effects of psychological trauma of others associated with the targeted individual. Figley (1995) first coined the term "secondary traumatic stress" (STS), and defined it as "the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 32). Although STS is identical to PTSD regarding symptomology, the difference between PTSD and STS involves the individual affected by the traumatic event. The targeted individual in PTSD is the individual directly involved with the trauma, and the targeted individual in STS is the individual who is attempting to assist the targeted individual (Figley, 1995). It is possible, therefore, for an individual to experience symptoms associated with PTSD while their therapist, family members, or close friends experience symptoms associated with STS derived from the same traumatic event.

According to the DSM-5, STS symptomology is similar to the symptomology of PTSD and five criteria must be met to diagnose an individual with PTSD or STS: exposure; intrusive symptoms; avoidance symptoms; negative alterations to cognition or mood; and alterations in arousal and reactivity; all symptoms must have begun after or worsened after the traumatic event (American Psychiatric Association, 2013). First, the individual must have indirectly experienced trauma by learning that a close relative, friend, or acquaintance had been exposed to a form of trauma. Individuals may also experience STS through repeated or extreme indirect exposure to aversive details of the traumatic event(s). According to the American Psychiatric Association (2013), trauma includes actual or threatened death, actual or threatened serious injury, or actual or threatened sexual violence. Intrusive symptomology, the second criterion occurs when an individual experiences at least one of the following symptoms: recurrent, involuntary recollections; traumatic nightmares; dissociative reactions; intense or prolonged distress; marked

physiological reactivity after exposure to trauma-related stimuli (American Psychiatric Association, 2013). Avoidance symptoms, the third criterion occur when an individual intentionally eschews stimuli that may remind them of prior trauma. Avoidance symptoms have two forms: internal and external stimuli (American Psychiatric Association, 2013). Internal stimuli involve thoughts and feelings that may be associated with the trauma, and external stimuli involve people, places, conversations, activities, or objects that may invoke emotions related to the traumatic event. Negative alterations in cognitions and mood, the fourth criterion, may occur after the traumatic event. These symptoms occur when an individual experiences persistent dissociative amnesia; negative beliefs about oneself or the world; distorted blame of self or others; negative trauma emotions; diminished interest in significant activities; feelings of alienation; and constricted positive emotions (American Psychiatric Association, 2013). Finally, alterations in arousal and reactivity may evoke the form of six types of behavior: irritability or aggressiveness; self-destruction or recklessness; hypervigilance; exaggerated startle response; problems in concentration; and sleep disturbance (American Psychiatric Association, 2013). These symptoms along with the symptoms within negative alterations may occur concurrently in individuals with STS.

Similar to PTSD, limitations exist regarding STS. For an individual to be at risk for STS, they must be closely connected to the individual experiencing trauma; individuals are not at risk for STS by learning about the experiences through the media. Research has focused on helping professionals including law enforcement (Boscarino et al., 2004), social workers (Day et al., 2017), clinical mental health professionals (Lee et al., 2018), and nurses (MacRitchie & Leibowitz, 2010). However, there exists a paucity of research on individuals within the postsecondary education realm such as faculty, college administrators, and student leaders

(Lynch, 2019). For example, resident assistants (RAs) are student leaders trained to assist students as they navigate their college experience, and they are often tasked with being first responders to students in crisis (Blimling, 2010).

Problem of Practice

For the past several decades, a majority (66%–84%) of college students have reported experiencing trauma (Artime et al., 2019; Bernat et al., 1998; Blanchard et al., 2005). Furthermore, the rate of college students experiencing trauma has been steadily increasing since 2010 (Center of Collegiate Mental Health, 2020). Although trauma directly affects the individuals experiencing the trauma, individuals in helping capacities may also experience negative effects of that trauma (Bride, 2007; Figley, 1995; Greinacher et al., 2019). RAs often experience some form of STS (Crumpei & Dafinoiu, 2012), as they are often expected to be a first responder in crises, such as the mental and emotional distress experienced by residential students (Canto et al., 2017). Indirect exposure to trauma is connected to distress (Pearlman & Mac Ian, 1995), negative cognition (Bride, 2007; Greinacher et al., 2019; Pearlman & Mac Ian, 1995), and STS (Elwood et al., 2011). Burnout has continually been identified as a factor preventing students from continuing in their roles as RAs (Hardy & Dodd, 1998; Paladino et al., 2005; Stoner, 2017). The housing department at a public university in the southeastern United States has experienced an increase in RAs expressing job-related stress, and they often state "burnout" as a reason for choosing not to return in subsequent semesters.

Purpose and Research Questions

The purposes of this explanatory sequential mixed methods design were to explore (a) the prevalence of STS in RAs at a 4-year public university in the southeastern United States, (b) the personal and institutional supports and barriers that impact RAs' responses to this STS, and (c)

the roles STS plays in RA job satisfaction and risk of attrition. This study obtained statistical, quantitative results from a sample, then STS was further explained through individual phenomenological interviews with participants within the same research setting. This study focused on the following research questions:

1. To what degree do RAs experience STS?
2. What supports and barriers do RAs identify as having influence on how they respond to STS?
3. To what degree are STS and job satisfaction predictors of risk of attrition in RAs?

Overview of Methodology

This study utilized an explanatory sequential mixed methods approach to determine the STS phenomenon in RAs. The researcher collected and analyzed data from RAs regarding their level of STS, STS self-efficacy, job satisfaction, and risk of attrition. Following the collection and analysis of the quantitative data, the qualitative data were collected through individual phenomenological interviews. According to the original study design, participants for the individual, phenomenological interviews would have been selected using extreme case sampling. Extreme case sampling "focuses on cases that are rich in information because they are unusual in some way" (Patton, 1990, p. 169). This form of sampling allows the researcher to intensively study fewer cases to garner more information about the phenomenon of interest. Furthermore, due to the nature of the topic and the design of the study, extreme case sampling was expected to provide relevant data to support the research questions. Due to the relatively small population of interest, all RAs interested in participating in the phenomenological interviews were chosen to participate.

This study was conducted at a public, 4-year university located in the southeastern United States within a suburban setting. This institution's enrollment is 11,000 undergraduate and graduate students, with approximately 1,800 students living on campus. This campus employs approximately 47 RAs on an annual basis. To participate in the study, participants must meet both of the following criteria:

1. Be employed as an RA within the housing department, and
2. Have supported a student through a traumatic life event while working as an RA.

Participants were asked to complete a researcher-created STS in RAs scale. This scale was developed based on the STS scale developed by Bride et al. (2004) and the Job-Related Demands Scale developed by Maran et al. (2020). This instrument included demographic questions to measure RA-related experiences. The aim of this scale was to provide the quantitative data to answer Research Questions 1–3 as well as identify individuals who met the selection criteria for the qualitative portion of the study.

Following collection of the quantitative data, individual phenomenological interviews were conducted to further explore STS. Additionally, interviews were used to identify and explore any personal and institutional supports and barriers that influenced their experience with STS self-efficacy. Finally, the phenomenological interviews were used to understand the role STS has on job satisfaction and risk of attrition. Each participant was asked to participate in one 30- to 60-minute semistructured interview. These interviews encouraged participants to reflect on their experiences while identifying any factors that may have impacted their experiences with STS.

Data regarding levels of STS and STS self-efficacy were analyzed using descriptive statistics, whereas the impact of experience and the presence of support mechanisms and barriers

was analyzed using separate hierarchical multiple regression analyses. Finally, the impact of STS and STS self-efficacy was analyzed using a binomial logistic regression. Transcripts from the interviews was analyzed using thematic analysis similar to the process outlined by Braun and Clarke (2006). This process included familiarization, initial coding, thematic coding, coding review, definition and clarification, and report development.

Significance of the Study

Although the negative effects of STS are well-documented in professional roles such as counselors, social workers, and medical staff (e.g., Boscarino et al., 2004; Day et al., 2017; Lee et al., 2018; MacRitchie & Leibowitz, 2010), there exists a paucity of research focusing on RAs as helping professionals impacted by STS. Counselors and other professionals participate in rigorous training for their positions (Boscarino et al., 2004) but RAs, in contrast, have limited training opportunities on responding to students in crisis and maintaining their own well-being (Lynch, 2019).

This study attempts fill the gap in the literature regarding the implications of STS in the well-being of RAs as well as any implication on job satisfaction and risk of job attrition. Gaining an understanding of STS may guide the incorporation of trauma-informed practices in RA training and supervision of RAs within the context of the study. The incorporation of trauma-informed practices could result in noteworthy gains in knowledge and understanding of trauma and improved assistance for college students who have experienced trauma (Murray et al., 1999). Finally, as college administrators understand the implications of trauma and implement trauma-informed principles within RA training, staff turnover due to STS and burnout may decrease; thus, residential students may benefit from staff adequately trained in responding to crises (Lynch, 2019).

Definition of Terminology

1. **Post-Traumatic Stress Disorder** – a condition characterized by the persistent alterations of stress hormone secretions resulting from a traumatic event. Symptoms include rapid heartbeat, elevated blood pressure, insomnia, anger and irritability, poor concentration, excessive vigilance, increased startle response, mental distress, intrusive thoughts, distressing dreams, and fearful flashbacks of the traumatic event (American Psychiatric Association, 2013).
2. **Resident Assistant** – a trained student who provides leadership within a residence hall at a college or university. An RA is responsible for building community with residents of the building through programming while serving as a mentor and providing support through policy violations, mental health, and academic concerns (Blimling, 2010).
3. **Secondary Trauma** – a type of trauma that manifests in the reduced interest in "bearing the suffering of clients" and "the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced … by a person" (Figley, 1995, p. 7).
4. **Secondary Traumatic Stress** – "the experience of psychological distress and post-traumatic stress symptoms resulting from helping clients who have been exposed to trauma" (Salloum et al., 2015, p. 55).
5. **Trauma** - the significant distress or impairment in an individual's social interactions, capacity to work, or other important areas of functioning which occurs following exposure to a traumatic event or disturbance (American Psychiatric Association, 2013). Trauma must result from an instance in which the individual: 1) directly experiences a traumatic event, 2) witnesses the traumatic event directly, 3) learns of a close friend or

family member's experience with a traumatic event, or 4) experiences first-hand, repeated exposure to the details of the event. Trauma is not the result of medical conditions, medications, illicit drugs, or alcohol consumption.

Chapter II

Synthesis of the Research Literature

This study focuses on the impact of STS as it impacts RAs within U.S. colleges and universities. To understand the phenomenon, it is important to understand the theoretical framework used in this study along with an understanding of trauma, PTSD, STS, and the impact of trauma on U.S. college students. This study utilizes the constructivist self-development theory along with Piaget's theory of assimilation and accommodation as its theoretical foundations. Through these theories, literature is presented related to PTSD and STS, the prevalence of trauma in college students, as well as a review of institutional supports and resiliency factors that play a role in the assimilation and accommodation of trauma in an individual's perspectives of their world.

Theoretical Framework

The theoretical framework for this study is the constructivist self-development theory by McCann and Pearlman (1992), which is used to explain how individuals make sense of their realities.

Constructivist Self-Development Theory

The constructivist self-development theory is based on the constructivist perspective described by Mahoney and Lyddon (1988). This perspective is grounded on the idea that individuals actively create and construe their personal realities. Furthermore, each individual, in turn, develops a unique perspective and understanding of the world surrounding them. McCann and Pearlman (1992) asserted the construction of these realities occurs through the development and use of psychological schemas, allowing individuals to make assumptions about themselves, others, and the world around them.

Social Learning, Assimilation, and Accommodation

Constructivist self-development theory incorporates social learning theory, assimilation, and accommodation to describe the construction of an individual's personal reality. Piaget (1977) theorizes assimilation as the cognitive process of fitting new information into existing schemas. Assimilation does not alter the established schemas based on the new information. An example of assimilation occurs when a small child learns that the four-legged animal living in their home is a dog. When this same child sees another four-legged animal (e.g., a cow), they assimilate the new information within the "dog" schema, and they incorrectly label the new animal a dog. Accommodation, in contrast, occurs when an individual revises their current schemas based on new information (Piaget, 1977). Accommodation often occurs when the new information does not synthesize with the current schemas. In keeping with the four-legged animal example, the small child sees a frog for the first time. The child realizes, although the frog has four legs, the frog does not have other characteristics similar to a dog, such as fur or the ability to bark. The new information—seeing the frog—does not synthesize with the "dog" schema, and the child is forced to accommodate the dog schema to reflect that not all four-legged animals are dogs. Bandura (1977) defined social learning as a cognitive process that is influenced by environmental factors such as observation, instruction, and modeling. Constructivist self-development theory purports that individuals perceive their reality and their expectations of the outcome of their reality based on past experiences (McCann & Pearlman, 1990).

Trauma and the Constructivist Self-Development Theory

Constructivist self-development theory identifies five components that are impacted by trauma: frame of reference, self-capacities, psychological needs, ego resource, and perceptual

and memory systems (Pearlman & Sakkvitne, 1995). Furthermore, each time an individual experiences a traumatic event, their beliefs surrounding these schemas are altered (McCann & Pearlman, 1990, 1992). Constructivist self-development theory has been used extensively to study trauma, its treatment, and STS (McCann & Pearlman, 1992; Miller et al., 2010; Pearlman, 2013; Pearlman & Mac Ian, 1995; Saakvitne et al., 1998).

Review of Literature

The review of the research literature synthesizes information related to trauma and PTSD, STS, and their impacts on U.S. college students.

Trauma and PTSD

Psychological trauma has been identified as an enigmatic concept for many scholars (American Psychiatric Association, 2013; May & Wisco, 2016). According to Weathers and Keene (2007), psychological trauma was first introduced in the DSM-III; however, this edition only identified trauma as a catalyst for other diagnosable disorders. According to the American Psychological Association in 1980), trauma was defined as "existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone" (p. 283). This definition received criticism due to non-individualistic definition (Davidson & Foa, 1991). For instance, this definition requires an individual's response to an experience be compared to the responses of others instead of considering the victim's specific vulnerabilities to the situation. It was not until the DSM-IV that trauma was identified as a diagnosable condition (American Psychiatric Association, 2000). According to the current edition of the DSM (i.e., DSM-5), traumatic events include a) threatened and actual physical assault; b) threatened and actual violence; c) natural and manmade disasters or catastrophic events; or d) observing threatened or serious injury, unnatural death, physical or sexual abuse, domestic violence, suicide or suicide attempt,

serious injury (American Psychiatric Association, 2013). Table 2.1 provides a summary of the varying definitions of trauma as they have evolved.

Table 2.1

Summary of Trauma Definitions

Source	Definition
American Psychiatric Association (1988)	"Existence of a recognizable stressor that would evoke significant symptoms of distress in almost everyone"
American Psychiatric Association (2000)	"The person has been exposed to a traumatic event in which both of the following have been present: 1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others, and 2) the person's response involved intense fear, helplessness, or horror."
American Psychiatric Association (2013)	"[Trauma] must result from one or more of the following scenarios, in which the individual: 1) directly experiences the traumatic event 2) witnesses the traumatic event in person; 3) learns that the traumatic event occurred to a close friend or family member; or 4) experiences first-hand repeated or extreme exposure to aversive details of the traumatic event. The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work, or other important areas of functioning."

This evolution of trauma within the DSM coincides with the views of clinicians of the 20th century. Prior to the mid-20th century, clinicians believed that psychological trauma only occurred in individuals who had previously diagnosed or undiagnosed mental health disorders—in essence, psychologically compromised individuals (May & Wisco, 2016). However, following World Wars I and II, the Holocaust, and the Vietnam War, researchers recognize the negative implications of trauma on individuals regardless of existing mental health conditions (May

& Wisco, 2016). Recently, scholars have continuously explored trauma as it relates to individual perspectives and cultures. Shalev (2002) asserted that events, such as those defined by the DSM-5, are not traumatic in their own right; however, an individual's reaction and accommodation of traumatic events are compounded by their susceptibility to trauma. These findings were corroborated by May and Wisco (2016) and supported the prior findings by Herman (1992) who suggested that an individual's proximity to the traumatic event had an impact on the development of negative trauma-based outcomes.

Similarly, researchers have explored the implications of race and historical trauma on individuals. Sotero (2006) postulated that "populations historically subjected to long-term, mass trauma—colonialism, slavery, war, genocide—exhibit a higher prevalence of disease even several generations after the original trauma occurred" (p. 93). There are several studies that align with Sotero's historical trauma theory (e.g., Harvey, 1996; Sorsoli, 2007). Furthermore, racism, such as microaggressions, has been hypothesized as a predictor of trauma (Bryant-Davis, 2007). According to Carter (2007), people of color often experience difficulty in accommodating traumatic experiences and exhibit pervasive symptoms similar to PTSD when experiencing trauma related to their race or ethnicity. Furthermore, numerous studies have identified connections between racial discrimination and negative physical and mental health outcomes (e.g., Britt-Spells et al., 2018; Lee & Ahn, 2011; Paradies et al., 2015). For example, Roberts et al. (2011) found Blacks have higher rates of PTSD in comparison to Whites (1.3%). Racism, for example, has been identified as having an inverse effect on mental health including depression and anxiety as well as symptomology similar to PTSD (Lee & Ahn, 2011; Pieterse et al., 2012). In a 2010 study of Black college students by Pieterse et al., racial discrimination was a stronger predictor of trauma-related symptoms than other stressors. Similarly, Loo and colleagues (2005),

found that race-related stressors were associated with more severe PTSD symptoms in comparison to individuals with no race-related stressors. Other forms of trauma related to race or ethnicity includes systemic oppression and microaggressions. Systemic oppression occurs when a certain social group is permanently subordinated, humiliated, and dominated due to their socially constructed lower societal position in comparison to the higher position of the oppressing group (Din-Dzietham, 2004). Consequences of oppression include both mental health conditions, such as depression and anxiety, and physiological responses, such as hypertension (Din-Dzietham et al., 2004; Fang & Myers, 2001). Microaggressions are instances in which a person's biases influence their language and behaviors (Nadal, 2018). Introduced by Pierce in 1978, microaggressions were defined as "subtle, stunning, often automatic, and non-verbal exchanges which are 'put-downs'" (p. 66). In 2014, Nadal et al. explored the relationships between microaggressions, racial trauma, and PTSD. Utilizing data from 506 participants involved in various identity-based, community organizations (e.g., Asian-American Psychological Association, LGBTQ Scholars of Color Network), Nadal et al. (2021) utilized a correlation analysis and found a significant relationship between racial microaggressions and mental health, $r = -.417$, $p = .047$. Furthermore, Nadal et al. (2014), through a linear regression model, found racial microaggressions as a significant predictor of mental health scores, $F(1, 354) = 6.19$, $p = .013$. These results are consistent with other studies that identified racism as a predictor of PTSD symptomology and decreased mental health (e.g., Bean et al., 2017; O'Keefe et al., 2015).

Trauma, for the purposes of this study, was defined as "[the] result from one or more of the following scenarios, in which the individual: (1) directly experiences the traumatic event (2) witnesses the traumatic event in person; (3) learns that the traumatic event occurred to a close

friend or family member; or (4) experiences first-hand repeated or extreme exposure to aversive details of the traumatic event. The disturbance, regardless of its trigger, causes clinically significant distress or impairment in the individual's social interactions, capacity to work, or other important areas of functioning" (American Psychiatric Association, 2013, p. 272).

Trauma and the U.S. College Student

This section provides an understanding of the population identified for this study, and the role trauma plays within the population. Particular attention was given to the history of trauma in college students, the types of trauma exhibited by college students today, as well as trends and sources of support.

History of Trauma in U.S. College Students

Although colleges and universities have existed for several centuries, college mental health services have existed for approximately 150 years. Prior to the 20th century, individuals with mental health disorders were not forced to accommodate their experiences within trauma, instead were institutionalized in an attempt to address their health needs. This response often prevented individuals from being able to pursue a postsecondary education (Kraft, 2011). In the early 20th century, Princeton University observed that many students were leaving school without completing their degree program due to emotional and personality issues, and in 1910, Princeton University developed a mental health services program in which psychologists focused on the *mental hygiene* of the students (Kraft, 2011). This mental hygiene movement was based on Clifford Beers's 1908 publication, *A Mind that Found Itself.* Through this movement, psychiatrists were challenged to incorporate psychosocial therapies in treating mental illnesses rather than relying upon chemical and physical treatments such as medications or surgical procedures (Kraft, 2011). Following the development of the program at Princeton, several other

colleges and universities followed with the establishment of similar programs to help students navigate the accommodation of mental health issues into their lives: University of Wisconsin in 1914; Washburn College and the US Military Academy at West Point in 1920; Dartmouth College in 1921; Vasser College in 1923; and Yale University in 1925 (Kraft, 2011). From 1910 to the 1950s, these programs focused on the mental hygiene of their students and empowering students to effectively incorporate their mental health experiences into their worldviews, and they developed strong representations in professional organizations including the American College Health Association and the National Conference on Health in Colleges.

By the 1960s, there were several external factors impacting college enrollment. Specifically, the Servicemen's Readjustment Act (1944) funded educational expenses for veterans to return to schools, and the Baby Boomer generation reached college age during the 1960s. By this point, mental health services were well-developed programs; however, the increase in enrollment caused by the Servicemen's Readjustment Act (1944) and the Baby Boomer generation placed a heavier burden on the mental health programs. Following the college-enrollment growth of the 1960s and 1970s, college mental health professionals began advocating to revise the DSM-5 to include diagnostic categories that may be specifically applied to college students such as adjustment concerns and learning problems (Kraft, 2011).

Within the last 40 years, college mental health programs have further shifted to address the needs of their students. Enrollment has continued to grow, and new populations have access to post-secondary education that were not previously able to attend such as first-generation students, students from low socioeconomic statuses, students of color, and first-generation students (Kraft, 2011). Furthermore, policies have been implemented to address trauma incidents in college students such as the Jeanne Clery Disclosure of Campus Security Policy and Campus

Crime Statistics Act of 1990 and the Americans with Disabilities Act of 1990. These policies have increased access to higher education for populations of students who have been historically excluded from pursuing postsecondary education (Reynolds, 2009).

Types and Trends of Trauma in the U.S. College Student

The emotional health of college students has been declining since 2015 (Stolzenberg et al., 2020). In 2015, 59.0% of men and 43.7% of women reported their emotional health as above average; however, the percentages of men and women who reported similar levels of emotional health dropped to 50.4% and 34.0% respectively (Stolzenberg et al., 2020). Silverman and Glick (2010) identified nine common crisis situations that college students experience: loss of loved ones; academic crises; developmental issues; suicidal ideation and behavior; mental health such as anxiety, depression, and psychosis; loss of control; impulse control; physical or emotional trauma such as domestic or sexual violence; and natural disasters. This review of literature focused on three of these types of crises, as these three are most prevalent within the location of this study.

Suicidal Ideation and Behavior. Historically, leaders within higher education have recognized the risks of negative health mental health as students navigate college-related stressors (Barreira & Snider, 2010; Kraft, 2011). However, mental health rates in college students have steadily increased. In 2018, the World Health Organization conducted a study entitled the Mental Health International College Student project in which 19 colleges across eight countries, including the United States, were studied to understand the prevalence of mental health issues in college students (Auerbach et al., 2018). Of the 13,984 participants, 35% screened positive for some of the most common mental disorders: major depression, mania/hypomania, generalized anxiety, panic disorder, alcohol use, and substance use (Auerbach

et al., 2018). In 2020, the Center for Collegiate Mental Health reported demand for student counseling center services has increased five times faster than average institutional enrollment, and students reporting suicidal ideation has increased 6.9%. According to the Center for Disease Control (2021), suicide continues to be the second leading cause of death in adolescents, and during the COVID-19 pandemic, young adults, aged 18-24 years, reported significantly greater rates of suicidal ideation (25.5%) than the general population (10.7%). Furthermore, suicidal behaviors among college students may have adverse effects on academic achievement (Auerbach et al., 2018) and career attainment (Goldman-Mellor et al., 2014).

Mental Health. Similar to suicide, mental health disorders are steadily increasing. Auerbach et al. (2018) found that the most common disorder exhibited was depression (21.2% of respondents) followed by generalized anxiety (18.6% of respondents). This emerging mental health crisis identified by the World Health Organization has been affirmed by numerous organizations including the American College Health Association (ACHA). In 2020, the ACHA found that in undergraduate students, 57.5% of students "felt things were hopeless;" 67.4% of students "felt very lonely;" 66.4% of students "felt overwhelming anxiety;" 46.2% of students "felt so depressed it was difficult to function;" and 14.4% had "seriously considered suicide" (p. 14). In a comparison of the same study conducted in 2018, the ACHA found an increase greater than two percent in all responses with the most significant increase (+ 3.3%) in "felt so depressed it was difficult to function" (ACHA, 2020, p. 14). Both studies indicate an increasing concern for college student mental health, and this emerging college student mental health crisis has sparked significant scholarship in the exploration of mental health in college students (Bruffaerts et al., 2019; Ebert et al., 2019; Lattie et al., 2019).

Sexual Abuse. Sexual abuse has been identified as a major public health issue for college students (Coulter & Rankin, 2020; Krebs et al., 2007; Tjaden & Thoennes, 1998). According to the ACHA in 2020, 3.5% of college students identifying as men and 12.3% of those identifying as women reported a form of sexual assault within the past 12 months. This statistic is congruent with prior studies that identified cisgender women as being at greater risk of sexual assault than cisgender men (Cantor et al., 2015; Krebs et al., 2016; Sinozich & Langton, 2014). Furthermore, sexual assault is significantly more prevalent in transgender students (Cantor et al., 2015; Coulter & Rankin, 2020; Krebs et al., 2016) and homosexual and bisexual students (Coulter & Rankin, 2020; Krebs et al., 2016) in comparison to heterosexual students. Trauma related to sexual assault may be severe and long-lasting (American Psychiatric Association, 2013), and Hanson (1990) found sexual assault victims often exhibit PTSD symptomology, specifically self-blame, distorted cynicism, intrusive thoughts, and increased negative arousal. In a study of 793 women, Ullman et al. (2013) found that sexual assaults occurred at an average age of 19.2 (SD = 7.9), and 69.7% of participants qualified for a PTSD diagnosis based on their responses. This study aligns with prior research, such as a study by Kitzrow (2003), which found that many psychological disorders develop during the late adolescence and early adulthood stages. These stages often overlap with the periods in which a student is enrolled in college. With the decline in emotional health of college students and the overlap in development of psychological disorders, it is apparent that college students are particularly susceptible to emotional distress and trauma. Furthermore, the rate of traumatic incidents on college campuses has increased in recent years (Fisher, 2000; Silverman & Glick, 2010), thus causing a need for formalized institutional supports for college students.

Institutional Supports for Trauma

One of the major factors impacting mental health in college students is social support. The impact of social support in individual development was originally identified by Vygotsky (1930–1934/1978). Vygotsky (1930–1934/1978) asserted that learning and development were products of the social contexts n which students engage with their peers. Vygotsky's theory of social learning was further codified by Mariani (1997) with their model of challenge and support. Mariani asserted for development to occur, individuals needed the appropriate level of challenge and support. If a student experiences a higher-level challenge with limited support, they may experience feelings of frustration and being overwhelmed. Students with high support and little challenge may feel as though the work is pointless or ineffective.

This theory of challenge and support may be applied to the support systems utilized by college students when dealing with trauma. Hefner and Eisenberg (2009) found that individuals with low quality social support were more likely to experience mental health issues including depression or suicidal ideation. Furthermore, Hefner and Eisenberg (2009) found that males and those living alone were more prone to social isolation than their counterparts (p. 496). This study was affirmed by Chao (2011) and Whiteman et al. (2013). Although many see peer support regarding family members and close friends, there are three sources of support explored within this review of literature: faculty, staff, and RAs.

Programs and Services

With the steadily increasing enrollment since the 1960s, colleges and universities have been challenged to expand programs and services to meet the needs of the students. During the 1960s and the political activity surrounding the Vietnam War and the so-called "hippie movement," colleges were faced with the challenge of addressing the needs of individuals

experiencing trauma related to these movements (Kraft, 2011). Specifically, colleges and universities were looking to expand mental health services to include peer counseling and alcohol or drug education programs. In 1961, the ACHA published its first version of the *Recommended Standards and Practices for a College Health Program*. This provided a framework for colleges and universities to provide effective health services, including mental health services (ACHA, 1961). Following the release of these guidelines and the incorporation of college-related mental health concerns in the DSM-III, college mental health services became a prevalent branch of mental health within the United States (Kraft, 2011). In 2020, Conley et al. studied the effectiveness of small group, mental health programs with participants from three different universities located in two urban areas in the United States. Specifically, Conley et al. (2020) attempted to explore the program's effects on self-stigma, awareness of resources, and mental health self-efficacy. Using a sample of 118 students and an analysis of variance, Conley et al. (2020) identified a significant effect on self-stigma and resource awareness; however, there was not a significant effect on mental-health self-efficacy. These results are consistent with other studies exploring mental health programming initiatives (e.g., Corrigan & Penn, 1999; Mulfinger et al., 2018)

Though college campuses have offered mental-health related services since the early 20th century, recently these services have expanded to offering peer-to-peer programs to address mental health-related concerns (Kirsch et al., 2014). These programs often include peer counseling initiatives as well as educational programming facilitated by trained peers (e.g., alcohol-related programming within residence halls; Kirsch et al., 2014). Utilization has been identified as a weakness in addressing the growing mental health concerns in college students (Kirsch et al., 2014).

Campuses often offer various forms of mental health-related programs and services included general health care, women's care, mental health care, disability services, and career counseling, and alcohol/drug education (Bourdon et al., 2020); however, mental-health related programs are often not utilized by students due to the perceived risks, stigma, and knowledge of these services (D'Amico et al., 2016). It is estimated that 93% of college students are aware of mental health-related programs and services; however, as little as 13% of students utilize the services (Eisenberg et al., 2011). Furthermore, a student's identity may play a role in the level of utilization of mental health programs and services. Females are more likely than males to receive treatment for all health concerns (Eisenberg et al., 2011; Eisenberg et al., 2012; Sontag-Padilla et al., 2016), and students who identify as Black, Asian, or Hispanic are less likely to seek mental health-related services than White students (Eisenberg et al., 2012; Herman et al., 2011; Miranda et al., 2015).

Faculty and Staff Supports

Faculty have been identified as having a positive influence on student's academic and personal success (Kuh, 2008; Pascarella & Terenzini, 2005). Often, students seek out faculty with shared identities. For example, females in science, technology, engineering, and math programs with significant exposure to female faculty within their programs of study developed positive attitudes about their future careers (Stout et al., 2011). Furthermore, racial minority students find support in faculty with whom they share a racial identity (Diggs et al., 2009). Although students benefit from their relationships with faculty, colleges and universities rely on professional staff to assist students when faculty are unavailable, or the scope of the student's needs exceeds the role of the faculty member. Examples of staff on college campuses include non-faculty academic advisors, student affairs staff, counselors, and other administrators.

Schreiner et al. (2011) interviewed 62 high-risk students to identify attitudes and behaviors of faculty and staff that impacted the success of these students. Through semistructured interviews, Schreiner and colleagues found that staff often focus on the individual development of the student in contrast to the academic focus of faculty. Furthermore, staff who built individual relationships (e.g., getting to know the student, knowing them by name, and showing empathy) had an impact on the students identified for the study.

RAs as Supports

Similar to professional staff, RAs are used by many colleges and universities within their on-campus housing to provide extended support to students. RAs are student employees hired to serve as leaders for their peers, and this position is often a 24-hour a day, 7-day a week job (Paladino et al., 2005). Blimling (2010) identified five major roles of the RA position: student, role model, counselor, teacher, and administrator. In addition to these roles, there are additional duties that are common to the position, as identified by Winston and Buckner (1984). These roles include educational programming and community development. Other researchers have identified the importance of programming and community development to provide holistic development of the student (Blimling, 2010). In essence, RAs are expected to provide pertinent campus information; mediate disputes among roommates; counsel on academic and personal matters; and enforce college and residence hall policies (Blimling, 2010; Winston & Buckner, 1984). Furthermore, peer counseling is an integral role for RAs (Hardy & Dodd, 1998; Winston & Buckner, 1984). RAs often respond to severe concerns including suicidal ideation, gender identity, and homophobia; sexual assault and misconduct; eating disorders; anxiety; and stress. RAs are often one of the first individuals to become aware and respond to the individuals in crisis (Blimling, 2010). As peer counselors, RAs are expected to provide support to individuals

experiencing trauma; however, they often are not provided the training to adequately support these students while mitigating the risks of STS (Lynch, 2019).

RA Role. The RA position is unique in that students are hired to serve as leaders for their peers, and this position is often 24 hours a day, 7 days a week (Paladino et al., 2005). Blimling (2010) identified five major roles of the RA position: student, role model, counselor, teacher, and administrator. In essence, RAs are expected to provide pertinent campus information (Winston & Buckner, 1984); mediate disputes among roommates; counsel on academic and personal matters; and enforce college and residence hall policies (Blimling, 2010). Other important roles within the RA position, including programming (Blimling, 2010; Hardy & Dodd, 1998) and community development (Blimling, 2010; Hardy & Dodd, 1998; Paladino et al., 2005), provide holistic development of the student.

Peer counseling is an integral role for RAs (Blimling, 2010; Reingle et al., 2010), as RAs often respond to severe mental health concerns including suicidal ideation, gender identity and homophobia; sexual assault and misconduct; eating disorders; anxiety; and stress (Owens, 2011; Palandino et al., 2005; Reingle et al., 2010). Although RAs are not certified to provide professional mental health therapy or perform psychological assessments, RAs may be considered peer counselors (Lynch, 2019; Paladino et al., 2005). Peer counselors provide interactions in which empathy and acceptance are employed in an endeavor to help others (Blimling, 2010).

Effective peer counseling, according to Blimling (2003) involves a five-step model: (1) pre-counseling; (2) listening; (3) problem identification and analysis; (4) resolution; and (5) follow-up. During the pre-counseling stage, the student approaches the RA seeking assistance, or the RA approaches the student based on a referral by an exterior source. This stage is integral in

the development of trust and support for further steps to be successful. The listening stage requires active listening by the RA. This also includes the utilization of micro-counseling skills such as clarifying questions; paraphrasing and confirmation of meaning and understanding; and empathy. The listening stage continues the development of trust and rapport and provides the RA with the necessary information for the problem identification step. During the problem identification stage, the RA and student begin to identify solutions to overcome the identified problem. These potential solutions are assessed to ensure the options are ideal and realistic. The resolution stage involves the development of an action plan for resolving the issue. This plan would include the potential solutions identified within the problem identification step. The final step in this process is follow-up. Unlike other steps, this step is a continuous step in which the RA expresses continued interest and investment in the well-being of the student. As peer counselors, RAs are expected to provide support to individuals experiencing trauma; however, they often are not provided the training to adequately support these students while mitigating the risks of STS (Lynch, 2019).

RA Attrition. Student employment has a lasting impact on the success of college students in future employment; however, the risk of attrition often limits a student's experiences and potentially impacts their future employment. In a study by Hart Research Associates (2015) on behalf of the Association of American Colleges and Universities, employers value employees who have relevant, real-world experiences while they are enrolled in college. Though some believe employment while pursuing a college education may have negative effects on a student's academic performance, Kuh et al. (2006) found that students who worked on campus reported similar grades as those who are not employed, and higher grades than those who worked off campus. Furthermore, Kuh et al. (2006) found that students working in positions in their

academic field of study had a more positive experience with securing post-college employment. In 2008, Kuh identified "high-impact practices" as a method of increasing student retention and engagement. Though not initially identified as a high-impact practice, student employment has been identified as a potential program that may share similar characteristics as a high-impact practice (Rinto et al., 2017). There are five characteristics that are imperative for experiences to be considered high impact: (1) time and effort; (2) faculty and peer interaction; (3) diversity; (4) formal and informal feedback; (5) integration, synthesis, and application; and (6) connections.

According to Kuh (2008) regarding time and effort, high-impact practices require students to "devote considerable time and effort to purposeful tasks" (p. 14). For student employment, this suggests that students should be engaged in work that is related to the mission of the office in which they are employed, receive training related to their position, and challenged to reflect on their future goals and professional development (Rinto et al., 2017). Kuh (2008) asserted that effective practices should involve contact with faculty and other students. To satisfy this characteristic, student employees are supervised by faculty or staff within their office, provided opportunities to engage with other professional staff members, and work alongside other students (Rinto et al., 2017). High-impact practices should also focus on integrating different perspectives to holistically develop the involved students (Kuh, 2008). Through the recruitment of diverse student- and full-time-employees, student employment programs foster opportunities for students to interact with individuals who have different experiences than themselves (Rinto et al., 2017). Kuh (2008) asserts that all high-impact activities involve continuous feedback by supervisors and peers. Formal feedback for student employment programs may include annual performance evaluations, and informal feedback occurs during the daily activities of the program (Kuh, 2008). Furthermore, Rinto et al. (2017) asserted that self-

reflective activities and opportunities to provide and receive feedback from peers are also integral in high-impact practices. For student employment to be considered high-impact, students must be able to relate their experiences within their role as a student employee to other endeavors including their academic pursuits and future career goals (Kuh, 2008). This is consistent with the results of the study by Hart Research Associates (2015) which found that employers prefer applicants who have relevant real-world experiences. Kuh (2008) also asserted that students must be able to connect their educational experiences to their communities while developing an understanding of their role(s) in society. Rinto et al. (2017) applied this characteristic to student employment providing opportunities for students to reflect on how their role impacts others and connecting their role to the broader mission of the university. Though not initially identified as a high-impact practice, student employment opportunities have the potential to have an impact on student success. However, STS and burnout may inhibit students from fully realizing the impact on their academic success.

STS

Coined by Figley (1995), STS is defined as "the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other…the stress resulting from helping or wanting to help a traumatized or suffering person" (p. 10). Individuals experiencing STS often exhibit symptoms similar to those experiencing PTSD (American Psychiatric Association, 2013). Although similar to PTSD, STS focuses on the individuals that respond to others in crisis. Salloum et al. (2015) clarified STS as "the experience of psychological distress and post-traumatic stress symptoms resulting from helping clients who have been exposed to trauma" (p. 55). Similarly, Connally (2012) defined this phenomenon as a negative result of the desire to help others. This section focuses on the phenomena of trauma and

STS to further understand the problem identified for this research study. To fully understand this phenomenon, it is imperative to explore the roles of therapeutic relationships, affected populations, and resiliency factors associated with STS.

Unlike most medical diagnoses, many psychological diagnoses rely upon personal remedies in lieu of chemical or medical remedies. Figley (1995) defined personal remedies as the "natural occurring social support of family, friends, and acquaintances, and of professionals who care" (p. 7). Although these forms of support are meant to improve the well-being of the individual experiencing trauma, there exists a countertransference of trauma between the two individuals; as a friend, therapist, or family member learns of the individual's experiences, they often absorb aspects of the trauma that were not previously identified within the individual. Wall and Wheeler (1996), as well as Lambert and Barley (2001), asserted that the therapeutic relationship has an impact on a client's outcome. Specifically, Lambert and Barley (2001) found that as much as 30% of the variance in a client's outcome is affected by the presence of a therapeutic relationship.

Burnout, Vicarious Trauma, and Compassion Fatigue

Burnout, vicarious trauma, and compassion fatigue have been interchangeable with the term "STS;" however, these terms are distinct forms of STS and have important differences among them.

Burnout. Coined by Freudenberger (1974), burnout is defined as the physical, emotional, and psychological exhaustion resulting from exposure to populations that are suffering. Maslach (1998) identified three domains related to burnout: emotional exhaustion, depersonalization, and reduced sense of personal accomplishment. Emotional exhaustion occurs when an individual's emotional needs are depleted; regarding burnout, emotional resources are depleted based on the

needs of an individual's clients (Maslach, 1998). Depersonalization involves the negative or cynical response to others and their situations (Maslach, 1998). Reduction in personal accomplishment occurs when an individual feels as though they are not having an impact in their work or relationships with others (Maslach, 1998). Galek et al. (2011) defined burnout more generally as "the confluence of interpersonal and institutional sources of occupational stress" (p. 634). Furthermore, Galek et al. (2011) identified burnout as an outcome of a difficult work environment. In a study of 83 nurses, Munnangi et al. (2018) found significant negative correlations between burnout and personal accomplishment (r = -.233; p < .05), job satisfaction (r = -.335; p < .05), and effective supervision (r = -.277; p < .05). This is consistent across other professions including mental health professionals (e.g., Devilly et al., 2009), forensic interviewers (e.g., Perron & Hiltz, 2006), and teachers (e.g., Christian-Brandt et al., 2020). Though burnout is the result of prolonged work in difficult conditions (e.g., lack of supervisory support, excessive workload), STS is the result of prolonged exposure to individuals suffering from traumatic events (Figley, 2002).

Vicarious Trauma. Vicarious trauma involves the "process of [cognitive] change resulting from empathic engagement with trauma survivors" (Pearlman, 1999, p. 52). These changes often involve changes in one's views of themselves, their sense of safety and trust; and changes in spiritual beliefs (Pearlman, 1999). Saakvitne and Pearlman (1996) asserted that these changes are consequences of cumulative experiences, rather than the effect of one client. In contrast to STS, vicarious traumatization focuses on the internal, cognitive changes rather than the behavior or emotional changes. In a study of therapist trainees, adaptive coping mechanisms (F(10, 232) = 2.10, p < .001) and trauma-specific training (F(10, 232) = 3.58, p < .001) had a

significant effect on levels of vicarious trauma (Adams & Riggs, 2008). These results are consistent with prior studies on vicarious trauma (e.g., Romans et al., 1999; Silverstein, 1996).

Compassion Fatigue. According to Adams et al. (2006), compassion fatigue, though often identified as a combination of STS and burnout, involves the overall emotional and physical fatigue that is experienced due to the chronic use of empathy. Unlike vicarious traumatization, compassion fatigue is not a cumulative experience, instead the result of a single exposure to trauma (Adams et al., 2006). Individuals often experience compassion fatigue without experiencing STS or burnout (Adams et al., 2006). Furthermore, compassion fatigue may lead to burnout or STS. In fact, compassion fatigue is considered the emotional and physical fatigue of working with those who are suffering (Newell & MacNeil, 2010). Duarte and Pinto-Gouveia (2016) found a correlation between empathy-based guilt and burnout and compassion fatigue which was consistent with prior research (e.g., Figley, 1995; Jenkins & Baird, 2002).

Resiliency Factors for STS

In consideration of the constructivist self-development theor*y*, a person's ability to respond to a traumatic event or crisis is based on their life experiences and perceived realities (McCann & Pearlman, 1992). As such, there are resiliency factors when navigating STS. This section outlines common resiliency factors that have been identified in prior research.

Risk-based approaches to concerns are often used in reducing infectious diseases; however, mental health clinicians have shifted to focus on resilience factors (Rutter, 1993). Resiliency focuses on the utilization of an individual's internal resources to cope with and survive difficult situations (Ungar, 2008). According to Yigit and Tatch (2017), resiliency is built through situations including underprivileged upbringing, a person's ability to effectively respond to stress, or the ability to recover from traumatic experiences.

When individuals experience some form of crisis or stress, they often turn to a coping mechanism, which may be positive (e.g., mindfulness exercises) or maladaptive (e.g., substance abuse). Though it may be assumed that positive coping mechanisms improve mental health, Thompson et al. (2014) studied the impact of coping mechanisms on compassion fatigue within 213 mental health counselors. Through multiple regression analysis, Thompson and associates identified mindfulness exercises as a negative predictor of compassion fatigue, $\beta = -.299$, $p < .001$, but maladaptive coping mechanisms (e.g., self-distraction, substance use, self-blame) increased levels of compassion fatigue, $\beta = .217$, $p = .003$. These results suggest that individuals at risk for STS should employ mindfulness exercises to mitigate the effects of STS. In an article published the same year, Bourke and Craun (2014) studied STS in Internet Crimes Against Children Task Force personnel and the relation of coping mechanisms and work satisfaction on STS. Bourke and Craun utilized the STS scale developed by Bride et al. (2004) and obtained data from 600 participants. Using a multivariate regression, Bourke and Craun (2014) identified a significant positive correlation in STS levels and tobacco use, $\beta = .12$, $p < 0.001$, and alcohol use, $\beta = .22$, $p < 0.001$. These results were consistent with the results regarding maladaptive coping mechanisms by Thompson et al. Furthermore, Bourke and Craun (2014) found a significant negative correlation between STS levels and supervisory support, $\beta = -.19$, $p < .001$, and coworker support, $\beta = -.09$, $p = .02$.

Resiliency factors have also been studied in medical personnel, trauma workers, and child welfare workers. Crumpei and Dafinoiu (2012) studied empathy and compassion satisfaction in 77 medical workers in Romania—35 physicians and 42 nurses. Using correlation analysis, Crumpei and Dafinoiu did not find a significant relationship between empathy and STS; however, a significant positive correlation was identified between compassion and STS, $r(76) =$

.511, $p < .01$. These results are inconsistent with the results previously obtained by MacRitchie and Leibowitz (2010) who studied 64 trauma workers in South Africa. Using Pearson's correlation, MacRitchie and Leibowitz identified a significant positive relationship between empathy and STS, $r(63) = .33$, $p < .005$. Furthermore, MacRitchie and Leibowitz found a moderately negative, significant relationship between social support and STS, $r(63) = - .36$, $p < .05$. Salloum and colleagues (2015) focused on STS and compassion satisfaction in 104 child welfare workers. Through Pearson's correlation analysis, Salloum et al. (2015) found a significant, positive correlation between trauma-informed self-care and compassion satisfaction, $r(103) = .35$, $p < .001$, and significant negative correlations between trauma-informed self-care and burnout, $r(103) = -.42$ $p < .001$, and STS, $r(104) = -.30$, $p = .002$. In summary, these results suggest empathy may increase levels of STS. Furthermore, individuals who have supportive social groups (e.g., friends or family), experience compassion satisfaction in their professional role; and utilize trauma-informed self-care may have decreased levels of STS in comparison to others.

Similar to the emotional characteristics identified, identity-based characteristics can also impact STS. Several researchers have been unable to identify a correlation between gender identity and STS (Paladino et al., 2005). Salloum et al. (2015) were able to identify a significant correlation between gender (women) and compassion satisfaction, $t(102) = -2.11$, $p = .038$. Furthermore, significant positive correlations were identified between older age and levels of burnout, $r(104) = -.24$, $p = .014$, and STS, $r(104) = -.24$, $p = .016$; however, there was not a significant relationship identified between age and compassion satisfaction, $r(104) = .18$, $p = .072$. Unlike gender and age, race has not been identified as a characteristic that impacts STS

(Day et al., 2017). In summary, research suggests that gender and age may have an impact on STS, but race has not been identified as having an impact on STS.

Along with internal characteristics, external factors (e.g., social support systems, working conditions, types of trauma when responding, residence hall configuration) also impact STS. Several researchers have found that a supportive work and social environments have a negative correlation with STS (Boscarino et al., 2004; MacRitchie & Leibowitz, 2010; Thompson, et al., 2014). Boscarino et al. (2004) identified supportive work environment as a work environment in which the supervisor promotes self-care, and the employees genuinely care about the well-being of their colleagues. Using a sample of 817 clinical mental health nurses, Edwards et al. (2006) utilized the Maslach Burnout Inventory to measure the effects of supervision on burnout. Due to the use of nonparametric data, comparisons were made using a Mann-Whitney *U* test. Edwards et al. (2008) found a significant difference in burnout among nurses with experience with a supportive clinical supervisor ($M = 5.3$) and those who did not ($M = 8.4$; $z = -2.935$, $p = .003$). In summary, external factors influence an individual's ability to navigate STS. These external factors may include supportive work and social environments as well as supportive supervision.

Another external resiliency factor impacting STS is job satisfaction. Job satisfaction, as defined by Tarcan et al. (2017), is the attitude that an individual has about their job and occupational outlook. In a hierarchical regression analysis of job satisfaction and STS of 216 substance abuse counselors, Bride and Kintzle (2011) found STS was a significant predictor of job satisfaction ($\beta = -.020$, $p = .007$); as STS levels increase, job satisfaction decreases. The inverse relationship between job satisfaction and burnout has been extensively studied by others (e.g., Edwards et al., 2006; Salloum et al., 2015).

Similarly, job autonomy may impact STS, though indirectly through compassion satisfaction. Bae et al. (2019) found a significant positive association between higher work autonomy and compassion satisfaction, $r = .335$, $p < .01$, and a significant, negative association of compassion satisfaction with work interferences in an individual's personal life, $r = -.254$, $p < .01$. Kim and Stoner (2008) studied the role of autonomy in burnout among 346 social workers in California. Kim and Stoner found that job autonomy had a significant, negative association with burnout and job turnover, ($\beta = -.19$, $p < .05$). These results are consistent with studies in other populations including physicians (Sharon et al., 2006), K–12 teachers (Fernet et al., 2012), and psychiatric nurses (Madathil et al., 2014). Examples of these factors include coping mechanisms, compassion satisfaction, age, gender, and job satisfaction. Finally, there may be factors related to the RA position that impact levels of STS. When RAs respond to students in crisis, the type of trauma may impact the levels of STS. Lynch (2017) identified suicidal ideation as having the most significant impact on STS in RAs, $t(167) = -4.57$, $p = .003$, $\eta^2 = .10$, and this was followed by death of a loved one, $t(174) = -3.98$, $p = .003$ $\eta^2 = .06$; severe mental health issues, $t(185) = -3.50$, $p = .003$ $\eta^2 = .06$; and eating disorders, $t(47) = -3.25$, $p = .003$ $\eta^2 = .05$. Furthermore, Lynch (2019) identified suicidal ideation ($n = 90$, 43.3%), death of a loved one ($n = 118$, 56.7%), and severe mental health issues ($n = 75$, 36.1%) as the most frequently occurring types of trauma within the same sample. These results suggest that RAs are often responding to crises that have the highest potential of increasing STS levels. In conclusion, there are numerous emotional, identity-based, and external factors impacting levels of STS, and although, STS has been extensively studied in other trauma-related positions, Lynch (2017, 2019) expanded the literature to explore the role of the RA as it relates to STS. This study attempts to further connect the role of the RA to STS.

Summary

Using McCann and Pearlman's (1992) constructivist self-development theory, this literature review examined STS as it relates to the role of RAs. With the increase in mental health cases in college students, colleges and universities have been forced to expand their mental health-related programs and services to address the growing needs of their students (Stolzenberg et al., 2020). Specifically, Silverman and Glick (2010) identified nine common crisis situations college students experience, and in consideration of the location of the study and common crisis situations, three were identified: suicidal ideation and behavior, mental health, and sexual abuse. According to the Center for Collegiate Mental Health (2020), students experiencing suicidal ideation has increased by 6.9%, consistent with the Center for Disease Control (2021) identifying suicide as the second leading cause of death in adolescents. Similar to suicidal behavior and ideation, between 46% and 67.4% of college students reported some form of mental health concern (ACHA, 2020). Finally, 3.5% of men and 12.3% of women report some form of sexual abuse while enrolled in college (ACHA, 2020).

With the increasing prevalence of mental health concerns, college students are seeking assistance through various individuals including faculty, staff, and RAs. The RA position, though initially identified as a policy enforcement role, has been continuously expanded to include the roles of a peer counselor and a peer educator (Blimling, 2010). Through this role, RAs are being exposed to different forms of trauma including suicidal ideation, mental health concerns, and sexual assault. Through this exposure to trauma, RAs are susceptible to STS, a form of PTSD, which often leads to decreased levels of job satisfaction and burnout. Though STS is a relatively new area of study, scholarship suggests that there are numerous factors contributing to levels of STS including compassion satisfaction, age, gender, and work environment. Although a positive

work environment and compassion satisfaction may decrease STS levels, the younger age of college students and gender (women) may have positive effects on STS levels.

Chapter III

Method

While it has been established that individuals in helping capacities (e.g., social workers, nurses, and police officers) are susceptible to the effects of STS, this study attempts to expand the current literature to explore STS in RAs at a public, 4-year university in Tennessee. Specifically, this study attempts to identify any resiliency factors that may influence an RA's ability to navigate the stressors related to their role as a peer support. This chapter states the purpose, research questions, context, and methods employed within this study. This exploration is followed by a description of the participants for this study as well as a discussion of the ethical considerations stemming from the necessity of participants being required to recall potentially traumatic memories. The purposes of this study were to explore (a) the prevalence of STS in RAs at a 4-year public university in the southeastern United States, (b) the personal and institutional supports and barriers that impact RAs' responses to this STS, and (c) the roles STS plays in RA job satisfaction and risk of attrition. This study focused on the following research questions:

1. To what degree do RAs experience STS?
2. What supports and barriers do RAs identify as having influence on how they respond to STS?
3. To what degree are STS and job satisfaction predictors of risk of attrition in RAs?

Context of the Study

The context of this study was the housing department in a public university within a suburban area of the southeastern United States. The university's enrollment is approximately 11,000 students. This university serves undergraduate and graduate students, and approximately

1,800 students reside within university-owned, on-campus housing. First-year students living more than 50 miles from the university's campus are required to live on campus. The housing portfolio includes nine traditional residence halls and three apartment complexes. Of these apartment complexes, one is dedicated to non-traditional student and family housing. Non-traditional students, for the department, are defined as any student over the age of 21 or living with a dependent or spouse.

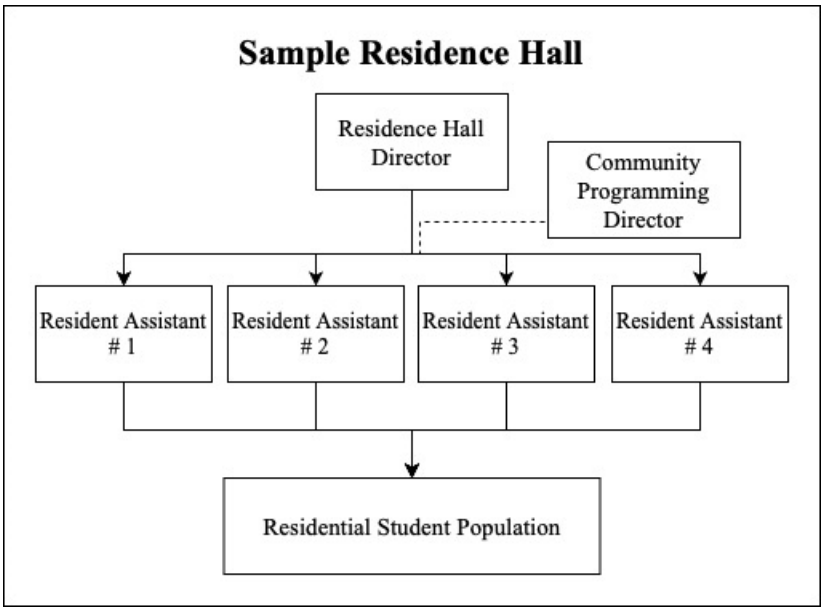
The Department of Housing/Residence Life employs 12 full-time staff members and 56 student employees. Of these 56 student employees, nine are residence hall directors, two are community programming directors, and 45 are RAs. Residence hall directors provide direct oversight of each residence hall, and they are responsible for the supervision of four to 10 RAs. Unlike all other residence life programs in Tennessee, this department does not require residence hall directors to possess a bachelor's or master's degree. In fact, most residence hall directors employed during this study are undergraduate students. Community programming directors provide educational programming for residential students as well as serve as a resource for RAs in developing their programmatic initiatives. RAs are full-time students, and they are employed to provide support for other residential students as they navigate their collegiate experience. RAs provide educational programming to complement the academic curriculum as well as provide support for crisis situations. RAs are aware of campus resources, and they often make referrals to campus resources (e.g., tutoring services or counseling services) based on the needs of the students.

An example of a residence hall supervision structure is provided in Figure 3.1. Both residence hall directors and community programming directors have at least 1 year of experience as an RA. All student staff positions are live-in positions, meaning the residence hall directors,

community programming directors, and RAs live within the residence hall(s) they supervise and support. The focus of this study is student staff—including residence hall directors, community programming directors, and RAs—who have responded to residential students in crisis. Specifically, these student staff may exhibit or be experiencing symptoms of STS due to their response to individuals in crisis.

Figure 3.1

Sample Residence Hall Organizational Chart



Note. Figure 1 provides a graphic representation of the staff configuration for a sample residence hall. Each hall consists of multiple RAs that are supervised by a residence hall director. Each hall also has a designated community programming director that provides programmatic direction for educational initiatives.

Research Design

Mixed methods research involves the integration of quantitative and qualitative data to make interpretations and understand the defined research problem (Creswell, 2014). The underlying principle for mixed methods is that neither quantitative nor qualitative methods are

adequate by themselves to understand the phenomenon of interest. The design of a mixed methods study requires focus on three issues: priority, implementation, and integration (Creswell, 2014). Priority refers to which method—quantitative or qualitative—is given more emphasis in the study. Implementation refers to whether the data collection and analyses occur chronologically or concurrently. Integration involves the phase in which the synthesis of quantitative and qualitative data occurs.

For this study, an explanatory sequential design was chosen. According to Creswell (2014), explanatory sequential research involves conducting a quantitative study of the phenomenon followed by a qualitative approach to explain the quantitative results. During the quantitative phase of this study, the researcher collected and analyzed data from RAs regarding their level of STS, STS self-efficacy, job satisfaction, and risk of attrition. Following the collection and analysis of the quantitative data, the qualitative phase was collected through individual phenomenological interviews. Participants were selected for these phenomenological interviews based on their responses during the quantitative phase of the study.

Participants

To explore the experiences of STS in U.S. RAs, participants were chosen based on criterion-based selection (Merriam, 2009). To participate in the study, participants must have met both of the following criteria:

3. Be employed as an RA within the housing department, and
4. Have supported a student through a traumatic life event while working as an RA.

There are currently 47 RAs within the research setting for this study. Potential participants range in age from 19 to 24, with a mean age of 21.0 (SD = 1.1). Resident assistants within the population have experience as an RA ranging from 0 to 4 years, with a mean

experience of 1.4 years. Most of the population identify as female (68.09%) with 31.91% identifying as male. Most of the population identify as Caucasian (51.06%); 36.2% as Black or African American, 6.38% as Hispanic, 4.26% as multiracial, and 2.13% did not specify a race. Regarding student classification, most students are juniors (31.91%), 29.79% are sophomores, 23.40% are seniors, 12.77% are freshmen, and 2.13% are graduate students.

Measures and Instrumentation

This section describes the surveys and semistructured interviews that were used for this study. Appendix A provides a research matrix outlining the research questions, variables and constructs, data collection methods, and the data analysis methods.

STS in RAs Scale

Participants were asked to complete a researcher-created STS in RAs scale. This scale was developed based on the STS scale developed by Bride et al. (2004) and the Job-Related Demands Scale developed by Maran et al. (2020). This instrument also included demographic questions to measure RA-related experiences. The aim of this scale was to provide the quantitative data to answer Research Questions 1–3 as well as identify individuals who meet the selection criteria for the qualitative portion of the study. This instrument is provided in Appendix B.

STS Scale. Developed by Bride et al. in 2004, the STS Scale is a 17-item instrument that is designed to assess the frequency of intrusion, avoidance, and arousal symptoms associated with STS. The scale is divided into three subscales: Intrusion, Avoidance, and Arousal. An example of an intrusion statement is “my heart started pounding when I thought about my work with students.” An example of an avoidance statement is “I avoided people, places, or things that

remind me of my work with clients." An example of an arousal statement is "I was easily annoyed."

Respondents are asked to indicate the frequency at which each item was true in the past seven days using a five-choice, Likert-type response (i.e., "never" to "very often"). According to Bride et al. (2004), the STS Scale has an overall coefficient alpha of 0.94, and the intrusion, avoidance, and arousal subscales have alphas of 0.83, 0.89, and 0.85, respectively. Although this instrument was designed for mental health clinicians, the term "client" was exchanged for "student" throughout the instrument.

Job-Related Demands Instrument. The Copenhagen Psychosocial Questionnaire was developed by Pejtersen et al. (2010) to measure positive and negative emotions at work, work satisfaction, burnout, workload, cognitive load, emotive dissonance, work-family conflict, job autonomy, organizational support, role clarity, and family support. An example of a workload statement is "Do you get behind with your work?" An example of an item within the work-family conflict subscale is "Do you feel that your work drains so much of your energy that it has a negative effect on your private life?" An example of an organizational support item is "How often is your supervisor willing to listen to your problems at work?" Respondents are asked to use a Likert-type scale to report the frequency at which each statement is true. According to Pejtersen et al. (2010), each subscale had a Cronbach's alpha ranging from 0.50 to 0.80. The average Cronbach's alpha for the Copenhagen Psychosocial Questionnaire was 0.769 (*SD* = 0.084).

Types of Trauma. Participants were asked to report the types of trauma their residents have experienced. This data were collected utilizing the Brief Trauma Questionnaire developed and validated by Schnurr et al. (1999) for the National Center for PTSD. A sample question is

"Has a resident ever shared their experiences of serving in a war zone, or in a noncombat job that exposed them to war-related casualties?"

Job Satisfaction and Attrition. Participants were asked to report their current job satisfaction as well as their intentions for employment the following academic year. An example question regarding job satisfaction is "To what degree do you find reward in your role as an RA?" An example question regarding employment intentions is "Are you planning to return as an RA for the 2022-2023 academic year?" If students answered "no," they were asked to respond to a Likert-type question, "To what degree has exposure to trauma impacted your decision?"

Demographics Survey. In the demographics portion of the survey, participants were asked to report their length of tenure as an RA, the number of students within their residence hall floor community, and the number and type of RA trainings they have attended. Participants were asked to report if their program of study is in a helping (e.g., education, psychology) or non-helping (e.g., mathematics, business) profession. Finally, participants were asked, using a Likert-type scale, to report their likelihood of returning as an RA. Participants were asked to elaborate on their response by indicating factors impacting their decision to not return as an RA. This information was referenced in the individual phenomenological interviews.

Individual Phenomenological Interviews

Individual phenomenological interviews were conducted to answer the research questions. For RQ 1, interviews were used to explore the participants' experiences with STS as well as STS self-efficacy. Interviews were also used for RQ 2 to explore any personal and institutional supports and barriers that had an influence on their experience with STS self-efficacy. Finally, the phenomenological interviews were used to understand the role STS has on job satisfaction and risk of attrition. Roulston (2010) recommends open and semistructured

interviews for phenomenological studies. According to Roulston (2010), phenomenological interviews "generate detailed and in-depth descriptions of human experiences as well as the participants' responses to the phenomenon of investigation" (p. 17). Furthermore, Roulston (2010) asserts that interviews must take a "neutral but interested stance…and the interviewer's role is to be a student of the interviewee, learning as much about the topic of inquiry as possible through sensitive questioning" (p. 17). The goal of the interview, according to Padilla-Diaz (2015) was "to listen carefully, follow up on participant's responses without interrupting the story flow to gain specific details of the participant's experience" (p. 17).

This study utilized one 30- to 60-minute semistructured interview with each participant. The interviewer attempted to build rapport with the individual and establish an understanding of their experience (Roulston, 2010). The interviewer also asked participants to reflect on any factors that impacted their experiences (Bevan, 2014). A sample question to answer RQ 1 is "What STS symptoms did you experience related to helping a student through a traumatic event?" A sample question to answer RQ 2 is "What personal barriers are important in dealing with residents experiencing trauma and the aftermath in life, such as STS?" A sample question to answer RQ3 is "How did STS play a role in your decision to return or not return as an RA, if at all?" A proposed interview protocol is provided in Appendix C, and the informed consent document is provided in Appendix D. A pilot study was conducted to identify any practical issues with the interview protocol and study design (Van Teijlingen & Hundley, 2002). Participants for the pilot study included two former RAs. Pilot participants were asked to respond to each question as if they were participating in the full-scale study. Pilot interviews were recorded and reviewed. Based on the pilot study, adjustments were made to the study to

improve effectiveness. Appendix E provides the Institutional Review Board approval for this study.

Procedure

Participant Sampling and Recruitment

Participants for the quantitative facet of this study were recruited using the current employment list within the housing department at the research setting. Potential participants received the recruitment email and consent form through their email address on file with the university affiliated with this study. See Appendix F for the sample recruitment email and consent form. The researcher also utilized time during the annual staff training workshop to answer any questions that potential participants may have regarding the study.

According to the original study design, participants for the individual, phenomenological interviews would have been selected using extreme case sampling. Extreme case sampling "focuses on cases that are rich in information because they are unusual in some way" (Patton, 1999, p. 169). This form of sampling allows the researcher to intensively study fewer cases to garner more information about the phenomenon of interest. Furthermore, due to the nature of the topic and the design of the study, extreme case sampling was expected to provide relevant data to support the research questions. Due to the relatively small population of interest, all RAs interested in participating in the phenomenological interviews were chosen to participate.

Although qualitative research designs often involve samples ranging from one to every individual in the population (McNabb & David, 2002), the goal was to have 10 interview participants; however, five students were comfortable completing the interviews. Boyd (2001) and Creswell (2014) suggested that research saturation occurs with two to 10 participants within a phenomenological study. Saturation, according to Saunders et al. (2018), occurs when data has

been collected and analyzed to the point at which further data collection is unnecessary or redundant. Following the completion of the five interviews, it was determined that information gleaned from the interviews were often redundant, specifically as it related to personal and institutional supports and barriers. Based on Saunders et al. (2018), saturation occurs when new data provides redundant information free of new information.

Data Collection

Survey

The hyperlink for the questionnaire, housed in Qualtrics, was included in the recruitment email sent to all RAs employed by the housing department. Participants had 14 days to complete the survey after the initial email is sent. The survey took approximately 15 minutes to complete. Reminder emails were be sent on Day 5, Day 10, and Day 14. After the survey window closed, responses were downloaded from Qualtrics.

Interviews

Interview participants were contacted using the information they provided in the questionnaire. The semistructured interviews lasted approximately 30–60 minutes, and interviews were conducted, recorded, and transcribed using videoconferencing technology (i.e., Zoom). The interviewer also took handwritten notes of important words or phrases during the interview as well. All audio recordings, transcripts, and notes were kept confidential between the researcher, the participant, and the researcher's advisor, and all related materials were stored in a locked filing cabinet within the researcher's office. Transcripts from the interviews were reviewed by the researcher to make any manual corrections.

Data Analysis

Quantitative Analysis

Following completion of the quantitative data collection, data were analyzed to answer the quantitative portions of the research questions.

Levels of STS and Secondary Trauma Self-Efficacy. The first research question focuses on the levels of STS in RAs. The STS in RAs Scale measured the participants' levels of STS. Data were analyzed using a hierarchical multiple regression with years of RA experience, number of RA trainings, and incidences of trauma as the independent variables and STS as the dependent variable.

Support Mechanisms and Barriers. The second research question attempted to identify any barriers and support mechanisms on the personal and institutional level that have an impact on an RA's response to STS. Data was collected through the STS in RAs scale, and the results were gleaned from a hierarchical multiple regression.

Impacts on Job Satisfaction and Attrition. The final research question in this study attempted to identify any relationships between STS, job satisfaction, and risk of attrition. Similar to the other inquiries, data was collected through the STS in RAs scale. Students were asked to report their intentions for employment the following academic year. A multiple regression analysis was conducted.

Qualitative Analysis

Transcripts from the interviews were analyzed using thematic analysis. Braun and Clarke (2006) outlined a six-phase process for conducting thematic analysis: familiarization, initial coding, thematic coding, coding review, definition and clarification, and report development. The first phase of thematic analysis involves the researcher familiarizing themself with the

collected data (Braun & Clarke, 2006). This was completed by reading the data multiple times followed by identifying patterns and meanings. The initial coding phase of the process involved identifying major codes exhibited within the data (Braun & Clarke, 2006). This was completed by reviewing data to identify major themes that are defined as "meaningful and manageable chunks of text, such as passages, quotations, single words" (Attride-Stirling, 2001, p. 391).

Braun and Clarke (2006) assert that thematic coding involves "searching for themes, collating codes into potential themes, gathering all data relevant to each potential theme" (p. 87). In this phase, data were sorted into the themes identified in the initial coding of the process. "Reviewing themes, checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis" (Braun & Clarke, 2006, 87). The first step of the coding review process involves reading through the codes for each theme to determine if a coherent pattern is developed (Braun & Clarke, 2006). If a coherent pattern exists, the entire data set was reviewed to ensure the themes fit in relation to the data. This also allowed the researcher to identify any additional data that needs to be coded (Braun & Clarke, 2006).

Braun and Clarke (2006) asserted that the definition and clarification step involves "defining and naming themes, ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definition and names for each theme" (p. 87). This step allowed the researcher to clearly define the themes including identifying any limitations or exclusions to the themes (Braun & Clarke, 2006). To accomplish this step, the researcher focused on identifying each theme, describing the essence of the theme, and determining what aspect of the data and research questions the theme fits under (Braun & Clarke, 2006). The report development step is the final opportunity for analysis. During the development of the report, clear examples should be extracted and related to the research questions and

supporting literature (Braun & Clarke, 2006). This report should go beyond a description by connecting the data to the research questions.

Integration of Results

According to Creswell and Plano Clark (2017), integration of results involves the connection of the results from the initial phase of data collection (e.g., the quantitative results) with those from the follow up phase of data collection (e.g., the qualitative results). The quantitative results provide an understanding of the phenomenon of interest (i.e., STS) and the qualitative results integrate the quantitative results with the lived experiences of the individuals (Creswell & Plano Clark, 2017). There are three common designs of data integration in mixed methods research: convergent design, explanatory sequential design, and exploratory sequential design. This study utilized an explanatory sequential design.

According to Creswell and Plano Clark (2017), explanatory sequential integration involves the use of qualitative results to further explain the quantitative results (Creswell & Plano Clark, 2017). An explanatory sequential design, therefore, promotes a more thorough understanding of the phenomenon. Within the present study, the quantitative results were expected to identify any linkages between STS and other variables; however, the qualitative results provided the nuances and context surrounding each of these interactions. By integrating the quantitative and qualitative results of this study, it was expected that the researcher would gain a greater understanding of the participants points of view when it comes to STS (Creswell & Plano Clark, 2017).

Trustworthiness

Although the purposes of qualitative and quantitative research are different, one critique of qualitative research is the trustworthiness of the findings without empirical methodologies to

support the results (Merriam, 2009; Moustakas, 1994). The qualitative facet of this study aims to describe the STS phenomenon, while the quantitative facet aims to quantify the phenomenon. To preserve the integrity of qualitative research, Guba (1981) recommends four constructs to corroborate the trustworthiness of the investigation: credibility, transferability, dependability, and confirmability.

Credibility

Similar to the internal validity of quantitative research, credibility focuses on the believability of the research by the reader (Guba, 1981). There are several methods of increasing credibility including triangulation, using established research methods, iterative questioning, peer scrutiny, researcher reflective commentary, and contextualizing with prior literature (Shenton, 2004). This study utilized triangulation, reflective commentary, and the contextualization with prior research. This study used data and method triangulation: quantitative survey data were triangulated with qualitative interview data. Reflective commentary included a researcher reflexivity statement and incorporation of reflexive statements based on field notes kept recording the researcher's thoughts, feelings, and connections (Merriam, 2009). Contextualization with prior research occurred through the thematic analysis of the phenomenological interviews. Thematic analysis allowed the researcher to utilize themes identified by relevant literature to guide the analysis of the current study (Braun & Clarke, 2012).

Transferability

Transferability involves the generalizability of the topic—the degree to which the results of the study may be transferred to other contexts (Guba, 1981). Transferability was supported by using rich, thick descriptions of the participants, context, and results (Creswell et al., 2007).

Thorough descriptions may help readers conceptualize the study findings within their own contexts and environments.

Dependability

Similar to reliability in quantitative research, dependability focuses on the degree to which the results of the study may be replicated (Guba, 1981). To bolster dependability, thorough descriptions of the methodology are provided. Furthermore, Guba (1981) recommends the use of a widely accepted methodology to improve dependability; thus, phenomenology is used for the qualitative facet of this study.

Confirmability

Confirmability refers to the degree to which the results may be confirmed by others (Guba, 1981). Guba (1981) recommends several methods of improving confirmability, and this study used the following methods: peer scrutiny, reporting negative instances, and the triangulation of data. All materials related to this study, including field notes and transcripts, were shared with the dissertation chair, who was asked to review the conclusions to support confirmability. Furthermore, all data were reported including instances in which the data contradict prior observations. Finally, the results of the qualitative portion of this study were triangulated using the results from the quantitative facet of this study.

Researcher Reflexivity

Similar to the phenomenological method described by Moustakas (1994), a researcher's experiences with the phenomenon of interest have an impact on the outcomes of the study. To avoid unintentional bias and preserve the essence of the study, it is imperative to bracket the researcher's own experiences and interests with STS (Moustakas, 1994). This section outlines

the researcher's experiences with trauma and STS while employed in various student housing-related roles.

I became an RA in 2010 at a 4-year, public university. I was an RA for 1 year and then transitioned into a community programming director position the following year. During March 2012, an interim residence hall director position became vacant after the residence hall director resigned due to mental health concerns. I was asked to take an interim residence hall director position within a large, apartment-style community. Through my experience as the interim hall director, I began to see the impact the residence hall director's trauma had on the RAs and residents within that community. Though at the time I was unable to define this phenomenon as STS, I felt obligated to assist the RAs in obtaining the help they needed to navigate the trauma experienced by their residence hall director.

I remained a residence hall director throughout my undergraduate career and, following graduation, I accepted a position as a professional hall director at a regional, 4-year university in southcentral Kentucky. I remained a residence hall director for four years while pursuing a master's degree in student affairs. During my time as a hall director, I supported students through various traumatic incidents including acts of sexual violence, severe mental health issues, attempted suicide, and completed suicide.

Dealing with these incidents had a lasting impact on me, as I found myself becoming more withdrawn and overwhelmed. Although student staff and professional staff receive annual training on mental health, these sessions focused on assisting the student experiencing trauma, but the training opportunities did not address the mental health and self-care of the staff. Through this realization and my experiences with helping students through trauma, I became interested in

how to better support and educate student staff in ways to maintain their mental health while supporting students through their experiences with trauma.

I am currently employed by the housing department that provides the context for this study. In 2018, I became the Assistant Director of Residence Life and was responsible for the indirect supervision of the student staff, including RAs. Through that role, I became interested in the lived experiences of RAs, as the department experienced a significant rate of annual staff turnover. In 2020, I became the Functional Support Specialist and was responsible for housing operations procedures as well as any technology-based initiatives for the department. In my current role, I do not have a supervisory relationship with any RAs or potential participants. During my tenure as the Functional Support Specialist, we have experienced a 100% turnover in RAs since serving in the role of Assistant Director of Residence Life so none of the RAs that I once indirectly supervised are potential participants.

Ethical Statement

Due to the nature of this study and the phenomenon of interest, there are concerns of the psychological well-being of the participants. As this study requires participants to reflect on their experiences with trauma and STS, care must be made to mitigate the risks of resurfacing traumatic stress. This was accomplished by ensuring prospective participants understand what is being asked of them, should they choose to participate, including being made aware of psychological risks that may be associated with participation.

Conducting research on trauma requires ethical considerations to avoid retraumatization or risk of further harm to participants. Though some evidence suggests that some participants may experience embarrassment or distress when asked sensitive questions about trauma (e.g., Black et al., 2006; Edwards et al., 2009; Langhinrichsen-Rohling et al., 2006), generally,

participants do not report any negative consequences of participation in trauma-based research (e.g., Edwards et al., 2009; Jorm et al., 2007; Widom & Czaja, 2006). Furthermore, trauma survivors have reported the benefits of involvement in trauma-based research often outweighs the risks (Edwards et al., 2009). Although researchers mitigate the negative effects of trauma-informed informed research, considerations must be made to promote the safety and well-being of the participants for this study. The Center for Victim Research identified several trauma-informed research strategies that were incorporated in this study: safety, trustworthiness, peer support, and empowerment (Murray, 2016).

Safety

First, to promote the safety of the participants several methods were utilized including the design of the interviews, the physical setting of the interviews, and the availability of resources for participants. To minimize the risk of re-traumatization, Goodwin and Tiderington (2020) recommend researchers only gather the minimum amount of information needed for research purposes when exploring potentially traumatic experiences. Though this study asks participants about their reactions to trauma, questions were intentionally designed to avoid asking about aversive details or experiences related to the traumatic event(s). To further promote the safety of the participants, the interviews related to this study was conducted via Zoom, and participants were encouraged to join the interview from a location that is comfortable for them. Furthermore, space was designated in another residence hall if a participant does not have access to a private space in their residence hall. Finally, resources were provided to individuals regarding local, regional, and national mental health resources in the event recruitment for participation or participation in the study causes emotional distress. An example of the mental health resources handout is provided in Appendix G.

Trustworthiness

People with history of trauma may feel mistrust with others (Goodwin & Tiderington, 2020). To promote trust and transparency, the researcher explicitly described each step of the research process, and participants were provided an overview of the topics to be discussed in the interview when they schedule their interview. Finally, participants were frequently reminded of the confidentiality practices related to this study. Any data and results were stored on a local hard drive and locked in a filing cabinet within a locked office on campus. Only the researcher had access to the hard drive and locked filing cabinet at any point. Furthermore, the principal investigator's contact information was provided to participants at every step of the research process, and participants were encouraged to contact the researcher with any questions.

Peer Support

Although the researcher of this study is neither a peer nor a therapist, researchers of trauma have an ethical obligation to minimize risks of involvement while providing support (Goodwin & Tiderington, 2020). For this study, peer support was addressed through the provision of resources related to trauma and mental health care. These resources were provided at multiple points in the research study including being attached to the recruitment email(s), provided to survey participants, and discussed during the phenomenological interviews.

Empowerment

Goodwin and Tiderington (2020) assert "when trauma survivors are respected as autonomous agents and feel that their voices matter, they may be more likely to share honestly and invest in the study" (p. 7). For this study, participants were empowered by utilizing semistructured interviews and ensuring participants are prepared for each step of the study. Specifically, the researcher explicitly described each step of the research process, and

participants were provided an overview of the topics to be discussed in the interview when they scheduled their interview. Furthermore, questions were developed utilizing trauma-informed language to prevent re-traumatization.

Chapter IV

Findings

This mixed methods study utilized an explanatory sequential design (Creswell, 2014) to investigate the research questions and the problem of practice. The STS in RAs scale, a Likert-type questionnaire, was used to determine the prevalence of STS in RAs and to inform each of the research questions. The questionnaire responses were analyzed using descriptive and inferential statistics, and the questionnaires were used to recruit volunteers for the qualitative interviews. The interviews were analyzed using theoretical thematic analysis (Braun & Clarke, 2006) and findings are presented using direct quotes from the participants. To maintain confidentiality, participants of the interview portion of this study are identified using pseudonyms: Lynn, Nicole, Wayne, James, and Ashli. This chapter presents the findings of the data and are organized by research question.

Degree of STS in RAs (RQ1)

The first research question examined the extent to which RAs experienced STS within the research setting. Questionnaire and interview responses were analyzed to answer this question. Quantitative data are presented first, then these data are triangulated using qualitative results. Finally, a summary is provided for the research question.

In quantifying trauma and STS, participants were asked to report their number of semesters of experience as an RA, the types of trauma incidents that has been reported to them, and the number of their RA training experiences. RAs, on average, had 2.1 semesters of experience (SD = 1.6) and had responded to 3.0 (SD = 2.1) types of traumatic incidents. Training experiences were broken down into onsite training, online training, RA class during the RA hiring process, inservice training, and staff development exercises. On average, RAs participated

in 25.2 (*SD* = 14.8) training experiences with most coming from staff development exercises, 10.4 (*SD* = 6.9), followed by on-site training, 7.0 (*SD* = 7.1). Level of STS was based on their responses from the STS scale, and participants reported an average score of 40.6 (*SD* = 23.0). It is important to note that, according to Bride et al. (2004), a score of 40.6 on the STS scale indicates moderate-to-severe STS. These results are also presented in Table 4.1.

Table 4.1

*Questionnaire Responses Based on RAs' Experiences (*N = *21)*

Factor	*M*	*SD*
Semesters of RA Experience	2.1	1.6
Types of Trauma	3.0	2.1
Total Training Experiences	25.2	14.8
On-Site Training Experiences	7.0	7.1
Online Training Experiences	2.9	3.0
RA Class during RA Hiring Process	1.0	0.0
Inservice Training	4.0	2.8
Staff Development Exercises	10.4	6.9
Secondary Traumatic Stress	40.6	23.0

A hierarchical multiple regression analysis using three models examined the relationship between level of STS and the following factors as independent variables: semesters of RA experience, types of trauma, and training experiences. See Table 4.2 for full details on each regression model.

Prior to the analysis, evaluations of each of the assumptions associated with a hierarchical multiple regression were conducted. The dependent variable of interest was continuous, and there were at least two continuous independent variables. There was linearity, as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.68. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus

unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1 (Menard, 1995). Furthermore, multicollinearity was assessed by checking each variance inflation factor. As no variance inflation factors were greater than 10, there was no evidence of multicollinearity (Myers, 1990). There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by *Q-Q* plot.

Table 4.2

Hierarchical Multiple Regression Predicting STS Levels from Semesters of Experience, Types of Trauma, and Training Experiences

	Secondary Traumatic Stress					
	Model 1		Model 2		Model 3	
Variable	*B*	β	*B*	β	*B*	β
Constant	39.32**		23.36*		1.70	
Semesters of Experience	0.58	.04	-2.01	-.14	-0.15	-.01
Types of Trauma			7.06*	.65	0.34	.03
Training					1.52**	.98
R^2	.00		.40		.99	
F	0.03		5.97*		453.16**	
ΔR^2	.00		.40		.59	
ΔF	0.03		11.89*		810.74**	

Note. $N = 21$.

*$p < .05$, **$p < .001$.

The independent factor in the first model was semesters of experience as an RA. In the model below, the level of STS increased as semesters of experience increased; however, the results were not statistically significant, $F(1, 19) = 0.03$, $p = .865$. Model 2 added incidences of trauma in the prediction of STS levels, and this model led to a statistically insignificant increase

in R^2 of .40, $F(2, 18) = 5.97$, $p = .010$. The full model of semesters of experience, incidences of trauma, and training experiences to predict STS levels was statistically significant, $R^2 = .99$, $F(1, 17) = 453.16$, $p < .001$; adj. $R^2 = .99$. The proposed model equation for predicting STS levels is presented below where *S* represents semesters of experience, *I* represents types of trauma, and *T* represents training:

$$\hat{Y}_I = 1.696 - 0.147S + 0.336I + 1.515T$$

STS is an Unfamiliar Concept: Defining STS

During the interviews, participants were first asked to define trauma and STS. Lynn provided a definition similar the definition of this study, and she attributed that to her training within her social work coursework. According to Lynn, trauma is "strong impacts on your functioning both socially and psychologically after being exposed to a traumatic event such as a sexual assault." Instead of defining trauma, other participants described instances of trauma including sexual assault, suicidal ideation, and death of a family member or friend.

Based on these lists, the following themes emerged: psychological trauma, physical trauma, historical trauma, and identity-based trauma. An item was coded as psychological trauma if it referred to any instance that may cause psychological harm to the individual. Examples of psychological trauma include bullying, suicidal ideation, psychological domestic violence, or the mental health aspects related to the loss of a pregnancy. Physical trauma codes included any trauma that causes physical harm to an individual. These examples included physical domestic violence, car accidents, sexual assault, or physical altercations. Historical trauma involved any trauma that occurred in the past. Most participants identified child abuse or child sexual assault; however, Lynn mentioned the loss of a parent as a child and being in a car accident as a child. The final theme to emerge was identity-based trauma. An item was coded as

identity-based trauma if it involved any trauma that is based on one's identity (e.g., race, gender, sexual orientation). Examples of identity-based trauma included racism, body shaming, and an unwelcoming response when an individual comes out as non-heterosexual. Table 4.3 provides the themes identified within the definitions of trauma and sample statements.

Table 4.3

Participants' Definitions of Trauma

Theme	Description	Sample Statements
Psychological Trauma	Trauma that caused psychological harm to the individual	"bullying"; "suicidal ideation"; "domestic violence"; "loss of a pregnancy"
Physical Trauma	Trauma that caused physical harm to the individual	"domestic violence"; "sexual assault"; "beat up during a robbery"
Historical Trauma	Trauma that occurred in the past	"child abuse"; "sexual assault as a child"; "being in a car wreck as a kid"; "losing a parent as child"
Identity-Based Trauma	Trauma that occurs based on one's identity (e.g., race, gender)	"ill-received coming out"; "racism"; "image-issues"; "things that cause problems based on who you are as a person"

It is important to note that, when participants were asked to define STS, every participant stated that they had not heard of STS until this study. James and Ashli compared STS to burnout, explaining it as "when you have had your fill of dealing with other's problems until you quit" (Ashli) and "when your job gets to be too much, you realize you are spending more time thinking about your job when you shouldn't be" (James). Instead of defining STS, Nicole identified several symptoms of STS including avoidance, intrusive thoughts, and sleep deprivation by stating, "When I started having nightmares about the girl who tried to kill herself, I realized something was wrong. . . . I then caught myself avoiding her because I didn't want to feel obligated to help."

Trauma is Prevalent: Explaining the Frequency and Effects of Trauma

After the individuals defined trauma and STS, participants were asked how frequently the RAs helped residents through traumatic situations. All four interviewees responded with *multiple times per week* or *daily*. Lynn compared her experience to navigating a minefield: "Every time I walk down the hall, it seems like there is always someone sticking their head out the door asking, 'Can I talk to you about something?' It's like I live with land mines."

Furthermore, participants were asked to differentiate between the types of traumas—severe and less severe—to which they are exposed. Every individual listed suicidal ideation and sexual assault as severe types of traumas. Less severe types of traumas included familial issues (e.g., divorce of parents, unwelcomed response when coming out as non-heterosexual) and academic issues (e.g., failing a class for the first time or missing an assignment). When asked what types of traumas (i.e., severe versus less severe) RAs respond to the most, participants said severe trauma was reported more often. Wayne shared, "It honestly depends on the time of year. At first, freshmen feel like they have to report everything, but they eventually learn to deal with their own problems and only come to me when shit really hits the fan [the problem becomes too big to handle alone]." Nicole also shared that students report severe trauma: "Sometimes I wish they would tell me they failed a test instead of the fact that they were sexually assaulted. It would make my job a whole lot easier."

When participants reflected on the effects of these reported traumatic experiences on their mental and physical health, most stated that their physical health was not as affected as their mental health. In fact, Wayne shared that he has found himself going to the gym more because, "if I am working out, I am not as available, and residents are less likely to bother me or ask me for help. So, I guess you could say this is actually helping me get more fit." Lynn shared a

similar experience: “When residents want to talk, I ask them to go for a walk to get them out of that space. One resident walked with me for 45 minutes!”

Although physical health may not have been negatively influenced by trauma and STS, each participant identified several ways in which they were impacted. Nicole, for example, shared that her experiences with a resident unearthed some historical trauma that she had been repressing:

> When my resident—let’s call her Kate—came to me to tell me about a sexual assault, it honestly broke my heart because she remembered so many details. She could describe the posters hanging on the walls, and she remembered what color his underwear were. As she described her experience in vivid detail, …I began to cry. And we are trained not to cry, but I couldn’t help it. Seeing Kate relive those memories, remind[ed] me of a situation I had in high school. I thought I had tricked myself into forgetting it, but I didn’t. After Kate left, I called the RHD on duty [and] then I cried for hours without end, reliving Kate’s experience mixed with mine.

The other participants shared similar stories. James shared, “I have to guard my heart. I can’t get too deep in the resident’s problems, or everything turns to doom and gloom for me. But that’s where [my campus counselor helps me cope].” Four themes emerged when exploring the effects of STS on mental health: arousal, avoidance, intrusion, and negative cognition. These themes are consistent with the symptomology of post-traumatic stress and STS as defined by the DSM-5 (American Psychiatric Association, 2013).

Statements were coded as “arousal” if the RA described instances of irritability, self-destructive behavior, or sleep disturbance. For example, James shared a story in which he actively avoided a resident who shared several instances of trauma, because “if I see him, I am

immediately in a bad mood." Similarly, Nicole shared that she dreads her duty days, because she is afraid of what she is going to have to respond to. "I can't plan on doing any homework on duty nights. . . . There is always a resident with an issue."

Statements were coded as "avoidance" when the RA spoke of actively avoiding internal and external stimuli that evoked memories of trauma. For example, Nicole shared that she avoids going into a resident's former room, because it brings back memories of the night she was told about Kate's experience with sexual assault. James shared that he "looks the other way" when he sees a resident who has shared several instances of trauma, because he "can't take on any more problems [does not want to deal with another issue]."

Statements were coded as "intrusion" if the RA described instances of recurring, involuntary memories of trauma. Lynn and Nicole both shared that they have experienced nightmares related to different traumatic incidents. "There have been so many nights where I wake up in a panic, because the on-duty phone was ringing in my dream" (Lynn). "The nightmares get to me. Sometimes, I can't tell reality from a dream" (Nicole). James shared that he failed a quiz, because he "could not stop thinking about him [the resident] taking all of those pills."

Finally, statements were coded as "negative cognition" if they involved negative beliefs about oneself or others or is a persistent, negative emotional state. Lynn, who compared her community to landmines, questioned "why did I get stuck with the difficult floor?" Similarly, James—who reported one of the highest level of types of trauma—questioned "does something bad have to happen to everyone?" Table 4.4 provides a further breakdown of the types of effects on mental health as gleaned from the interviews and sample statements from the participants.

Table 4.4

Effects on Mental Health

Theme	Description	Sample Statements
Arousal	Irritability, self-destructive behavior, sleep disturbances	"If I see him, I am immediately in a bad mood"; "My duty days are the worst days"
Avoidance	Avoiding internal and external stimuli that bring back memories of trauma	"After Kate moved out, I couldn't go back in her room. It just brought back too many memories."; "I look the other way when I see a 'problem resident'"
Intrusion	Recurring, involuntary memories of the trauma	"Every time I go to the café, I think about my conversation with him"; "I failed a quiz, because I couldn't focus"; "The nightmares…"
Negative Cognition	Negative beliefs about oneself or others or a persistent, negative emotional state	"Does something bad have to happen to everyone?"; "Why did I get stuck with the difficult floor?"

Summary

The first research question focuses on the extent to which RAs experienced STS within the research setting. On average, the participants of this study reported moderate-to-severe levels of STS. Furthermore, a multiple regression analysis found that a model containing semester of experience, types of trauma, and amount of training as an RA predicted levels of STS at a statistically significant level, $p < .001$. Semesters of experience was the only factor to have an inverse relationship with STS. Furthermore, training was the only statistically significant predictive factor for STS. This may be attributed to more experience with trauma, thus lessening the effects, or the development of a stronger support system, which was explored in Research Question 2 of this study.

The qualitative results further explain the quantitative results of this study. Specifically, types of trauma had a positive relationship with level of STS, which was supported by the experiences of the participants. In defining trauma, the interview participants identified four themes associated with trauma: psychological trauma, physical trauma, historical trauma, and

identity-based trauma. In defining STS, participants often equated STS to burnout. Finally, the participants identified several effects of trauma that align with the symptomatic areas of STS: arousal, avoidance, intrusion, and negative cognition.

Personal and Institutional Supports and Barriers (RQ 2)

The second research question of this study focused on the supports and barriers that influence how RAs respond to STS. Questionnaire and interview responses were analyzed to answer this question. Quantitative data are presented first; then these data are triangulated using qualitative results. Finally, a summary is provided for the research question.

Participants were asked to complete the Copenhagen Psychosocial (Pejtersen et al., 2010) questionnaire portion of the STS in RAs survey, which consisted of demands at work, work organization and job contents, interpersonal relationships, leadership, work-individual interface, and social capital. Demands at work focused on quantitative (e.g., workload level) and emotional demands (e.g., demand for hiding emotions while at work) as well as work pace. Work organization and job contents focused on how an individual completes their work as well as the degree of responsibility for the individual. Interpersonal relationships focused on an individual's relationship with coworkers, and leadership focused on the quality of supervision and the institutional leadership profile. Work-individual interface focused trust and social support, and social capital focused on the degree to which an individual's life is affected by their work.

Level of STS was based on their responses within the STS scale. The highest scores were exhibited in organization and job contents with a mean score of 70.3 (SD = 6.9), interpersonal relationships and leadership with mean score of 62.7 (SD = 6.6), and STS with a mean score of 40.6 (SD = 23.0). The mean results are presented in Table 4.5.

Table 4.5

*Questionnaire Responses of Supports and Barriers (*N = *21)*

Factor	*M*	*SD*
Demands at Work	37.0	2.7
Organization and Job Contents	70.3	6.9
Interpersonal Relationships and Leadership	62.7	6.6
Work-Individual Interface	25.2	3.3
Social Capital	5.5	1.7
Secondary Traumatic Stress	40.6	23.0

A multiple regression analysis examined the relationship between level of STS and the following factors as independent variables: demands at work, organization job and contents, interpersonal relationships and leadership, work-individual interface, and social capital. See Table 4.6 for full details on each regression model.

Prior to the analysis, evaluations of each of the assumptions associated with a multiple regression were conducted. The dependent variable of interest was continuous, and there were at least two continuous, independent variables. There was linearity, as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.63. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. There were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and values for Cook's distance above 1. The assumption of normality was met, as assessed by *Q-Q* plot.

Table 4.6

Hierarchical Regression Predicting STS Levels From Supports and Barriers

Variable	*B*	95% CI	β	*t*	*p*
Constant	-231.66	[-522.32, 59.00]		-1.699	.110
Demands at Work	2.43	[-2.64, 7.49]	.28	1.022	.297
Work Organization/Job Contents	0.95	[-0.93, 2.83]	.88	1.081	.297
Interpersonal Relationships and Leadership	1.13	[-1.32, 3.58]	.32	0.984	.341
Work-Individual Interface	0.97	[-5.20, 7.13]	.14	0.335	.743
Social Capital	3.67	[-7.53, 14.87]	.27	0.698	.496

Note. $N = 21$. CI = Confidence Interval for *B*.

The model included demands at work, work organization and job contents, interpersonal relationships and leadership, work-individual interface, and social capital as independent factors. Though this model failed to produce statistically significant predictors of STS, $F(5, 15) = 1.12$, $p = .392$, the proposed model equation is presented below where *D* represents demands at work, *O* represents work organization and job contents, *I* represents interpersonal relationships and leadership, *W* represents work-individual interface, and *S* represents social capital:

$$\hat{Y}_2 = -231.66 + 2.43D + 0.95O + 1.13I + 0.97W + 3.67S$$

Although the quantitative analysis of this research question failed to produce statistically significant predictors of STS, interview participants identified several personal and institutional supports and barriers that affected them as they navigated STS.

Knowing What You Can Control: Personal Supports

When participants shared their thoughts about personal supports or resiliency factors, every participant mentioned the use of social and familial supports (See Table 4.7). Ashli, for example, described her relationship with her friend, Penny:

> Penny is pretty much my own [personal] RA. Anytime something bad happens, she is always there to listen to my story, and I know I can trust her not to repeat anything. Penny challenges me, though, because I like to get into the mindset of "if I had been there, it wouldn't have happened." Penny shuts that [self-blame] down like that {snaps fingers}.

Along with social and familial supports, participants identified the need for positive self-talk. Similar to Ashli, Lynn shared she struggles with self-blame but Lynn shared a tactic she uses instead of just relying on others:

> Each week, I write a positive statement about myself on a Post-It note and I stick it in my planner. If I am ever having a rough day, I flip back through my planner and read each note. Sometimes, you just need that reminder that you are doing a great job. I can't take credit for that. My mom gave me the idea.

Although James was very quick to explain his reliance on other members of his fraternity, he described his views of the job as more stoic than others, stating "*que sera, sera* [what will be, will be]. . . . I can't get too caught up in what is going on, or I will start hyper-analyzing everything I do. It's sad to say, but life is fucked up—some things [stressful situations] are unavoidable" (James). Similarly, Lynn recognized that her residents experienced problems that were often out of her control. "I can't protect everyone, but I can help them."

Table 4.7

Personal Resiliency Factors Influencing STS

Theme	Description	Sample Statements
Positive Self-Talk	Viewing oneself in a positive light	"I just tell myself, 'I am doing a great job'"; "I was able to get them the help they needed"
Social and Familial Supports	Using friends and family as sounding boards and sources of support	"If it weren't for my mom, I would have already quit"; "My best friend has an open-door policy at her apartment any time I need to get away"
Locus of Control	Recognition that the individual has certain things within or outside of their control	"I can't protect everyone, but I can help them"; "Some things are just beyond my control"

Don't Get in Your Head: Personal Barriers

When participants reflected on their personal barriers when responding to STS, negative self-talk was one of the first factors every participant mentioned. "If you get up in your head, you will immediately screw yourself up" by not recognizing what is in your control and what is not (Nicole). Most of the other barriers were related to having a lack of one or more of the previously identified personal supports (e.g., lack of social or familial support). "For me, I struggle, because I don't have a close relationship with my parents. I rely on my friends more than I probably should, and sometimes they can't give me the support I need" (Lynn).

Another major barrier was alcohol use. Instead of seeking support through other means, some participants shared their dependence on substances for support. Specifically, James shared he uses alcohol as a method of avoiding his mental health concerns in response to trauma. Although James recognized the short-term benefits of alcohol use (e.g., avoidance of issue, relaxation, ease in coping), he also recognized there are some long-term negative implications:

> I had a student knock on my door on a Monday morning and confide in me that they were thinking about killing themselves. After getting them connected to a counselor and [the]

> campus police, I really needed a beer. A good beer always helps me relax, but I forgot I had a lab practical later that day. I had already decided I was going to skip classes and hang with some buddies, but I completely forgot about the lab practical. . . . Needless to say, I almost failed that class.

Ashli and Lynn also mentioned alcohol as a barrier. "I lean on a good glass of wine to get me through some days" (Ashli). Lynn went so far to say that alcohol was a "slippery slope that I don't want to go down."

Another barrier identified by participants is the limited training they receive for traumatic experiences. Specifically, participants shared that RAs are not exposed to the level of training necessary to adequately respond to trauma. "We spend days talking about writing [incident reports] but spend 30 minutes—maybe—talking about mental health" (James). Lynn stated that "[mental health] training is not prioritized." Ashli confirmed this by saying that the RA training program "spent too much time talking about the easy stuff [educational programming and building community] instead of focusing on real-life issues [responding to trauma]." It is important to note that the interview participants reported, on average, to have participated in 26.1 (*SD* = 7.7) training experiences during their tenure as an RA, but their concerns for limited training are based on the content of the training instead of the frequency of training.

In sum, there were four personal barriers identified from the participants: negative self-talk, alcohol use, lack of social and familial support, and limited training on mental health response. A complete list of themes associated with personal barriers is presented in Table 4.8.

Table 4.8

Personal Barriers Influencing STS

Theme	Description	Sample Statements
Negative Self-Talk	Viewing oneself in a negative light	"It's all your fault"; "If you had just been there…"; "This is your first time being an RA, you aren't ready for this"
Alcohol Use	Using alcohol as a coping mechanism	"slippery slope"; "a good beer helps me relax…but I forgot…"; "drinking too much"
Lack of Social or Familial Support	Unable to use friends and family as sounding boards and sources of support	"I am not close to my mom"; "All of my friends are RAs. They get it, but it just turns into a gripe fest"
Limited Training	Individuals are not exposed to the level of training necessary to adequately respond to trauma.	"They don't teach you this in RA class"; "new territory"; "not in a textbook"

There Is More Than Counseling: Institutional Supports

Following an exploration of the personal supports and barriers, the focus shifted to institutional supports that helped RAs navigate STS and traumatic crises. When speaking about institutional supports, the first-mentioned support for every participant was the counseling center. This is a central part of their training as resident assistants, so it was expected that this be the first response. It is important to note though, three of the participants mentioned having ongoing appointments with a campus counselor.

> My first year as an RA, I invited [Amy] to help with a mental health program, and I built a strong connection with her. When I had a tough situation with a resident, I reached out to Amy, and she was quick to set up an appointment. I have been attending weekly or bi-weekly ever since. We just have a vibe—she understands my role, and she is always willing to talk through my residents' problems with me (Ashli).

Other supports that were mentioned included campus involvement, their supervisor, and campus programming related to mental health. Table 4.9 provides a description of the themes related to institutional supports.

Table 4.9

Institutional Supports Influencing STS

Theme	Description	Sample Statements
Campus Counseling Centers	Availability of trained clinicians for college students	"counseling services"; "let's talk sessions with [Amy]"; "free counseling"
Campus Involvement	Participation in university-sponsored organizations	"my fraternity"; "going to the honors commons"; "the programming board"
Supervisor	Intentional supervision that goes beyond job performance	"[Supervisor]"; "my area coordinator"; "he's more than a boss"
Mental Health Campus Programming	Activities and events related to mental health awareness	"upstander training"; "the T-shirt Project"; "[mental health awareness organization]"

Another theme to emerge was campus involvement, which was defined as participation in university-sponsored organizations. James shared campus involvement was "critical" for him. "If I didn't have my fraternity brothers, I don't know that I would be able to keep on [continue to be an RA and respond to crises]." Lynn shared that she was involved with a student-interest organization. "They give me a break from the drama [crises]. At the meetings, I am just [Lynn]—not RA [Lynn]."

Strong (i.e., competent and caring) supervision was mentioned as a form of support for these students. Nicole described her supervisor as "a strong role model and source of support." She also noted that her supervisor understood what they were going through as RAs, as he was "not that far removed from what we are doing," meaning that he had been in the RA role recently. Furthermore, she shared that her supervisor makes himself available. "Sometimes that just involves me crying in his office, but he somehow makes me feel better." James shared a

similar experience. “I am not in his area of campus anymore, but he always checks on me. There have been so many times that . . . he meets me on the intramural field just to get me out of the building [so I can take a break from the chaos].”

Campus programming related to mental health was the last theme that emerged from these responses. Wayne identified the influence of mental health programming such as upstander training, a mental health and sexual assault training program designed to promote bystander intervention. “Through upstander intervention training, I gained the confidence to step in and help instead of just keeping my head down [ignoring a traumatic event or concerning situation]” (Wayne). James shared his experience, as he is heavily involved in a student-led mental health awareness organization:

> Being an ambassador for [mental health awareness organization] has pushed me to think outside of the box when it comes to my mental health. I frequently ask myself, “Am I in a good spot, or do I need to get some help?” Sometimes, it’s “yes” and sometimes it is “no,” but I wouldn’t ask that question if it weren’t for [mental health awareness organization].

Nicole had a similar view on mental health awareness organizations. She described a time where a passive program was being held on campus with t-shirts outlining different vignettes related to sexual assault. A passive program may be an art exhibit or bulletin board in which students do not actively engage in an activity beyond reflecting on the content of the exhibit. In this instance, there were t-shirts were being temporarily displayed in a common area on campus.

> I saw a t-shirt that made me wonder, “did Kate make this shirt, because it’s literally the story she told me a few weeks ago.” It freaked me out. I didn’t know what to do, but I

found that seeing that story in this light [setting] made me realize, "this person got the help she needs and now she is helping others." It's really empowering.

Inability to Get Away: Institutional Barriers

Similar to personal barriers, interview participants identified the absence of the institutional supports as institutional barriers (e.g., poor supervision). There were several new institutional barriers identified, and they are defined in Table 4.10. The barriers include the RA position, lack of supervision, and limited available counselors.

Table 4.10

Institutional Barriers Influencing STS

Theme	Description	Sample Statements
The RA Role	The work requirements related to serving as an RA including on-call schedules and living where they work	"being on call several days a week"; "I am always on duty"; "I can't get away from them"; "they are always looking for me"
Lack of Supervision	Supervision that fails to go beyond job performance	"if you follow the manual you won't get fired"; "Suck it up, buttercup"
Limited Available Counselors	Counselors are unavailable due to limited staffing and frequent turnover.	"three weeks to schedule an appointment"; "there's only one counselor"; "they are short-staffed"

The responsibilities related to the RA role was one of the most frequently mentioned barriers. RAs are required to serve in an on-call capacity weekly for their residence hall, and they have one weekend of on-call duty per month. Participants explained that "You only ever get like 3–4 days off before it's your turn to be on duty again. That's not enough time" (James) and "After Kate's situation, I had two more duty nights that week. I was spent [exhausted]" (Nicole). The on-call schedule was not the only factor that emerged within this theme. The requirement for RAs to live on the floor with their residents also was frequently mentioned. James stated, "I can't get away from them. Sometimes, I just want to scream, 'I have my own fucking problems to deal

with!'" Nicole shared that the pressure to be available for her residents often keeps her from getting away from the building when she knows she needs a break: "I am scared to leave. What if someone needs me? It feels selfish to run away every time I need a break" (Nicole).

Although supervision was mentioned as an institutional support, lack of supervision was identified as a barrier. Ashli shared, "I had a supervisor that did not care what was going on. She told me one time to just 'suck it up, buttercup'. That hurt, and I lost a lot of respect for her." Similarly, Wayne shared his frustrations about his RHD:

> Some hall directors make it a priority to discuss recent situations to help us do better next time. [My hall director] doesn't care. He always says, 'if you did what is in the manual, you aren't going to get fired'. {voice raises to yelling} That doesn't help me!

Finally, the last theme was the unavailability of counselors. Within this research setting, the counseling center has recently lost several licensed clinicians. At the time of the interviews, there was only one licensed clinician employed by the university. "If you want to go to counseling, you better plan it 3 weeks out. They can't get you in any earlier" (James). "I feel bad for [counselor]. She is always responding to crises, and she doesn't have time to actually help the students that need help."

Summary

This research question attempted to identify personal and institutional supports and barriers that influence levels of STS in resident assistants. The quantitative analysis related to this research question failed to provide statistically significant results; however, the qualitative portion of this study identified several personal and institutional supports and barriers. Examples of personal supports included positive self-talk, social and familial supports, and an understanding of one's locus of control. Examples of personal barriers included negative self-

talk, lack of social and familial support, alcohol use, and limited training. Institutional supports focused predominantly on campus counseling centers; however, other institutional supports included campus organizations, strong supervision, and mental health-related campus programming. Institutional barriers predominantly focused on the RA role with other topics included lack of strong supervision and limited available counselors.

STS and Job Satisfaction as Predictors of Attrition (RQ 3)

The third research question of this study focused on the influence of STS and job satisfaction on attrition in RAs. Questionnaire and interview responses were analyzed to answer this question. Quantitative data are presented first, then these data are triangulated using qualitative results. Finally, a summary is provided for the research question.

Participants were asked to report their level of satisfaction within their role as an RA, as well as their intentions for returning as an RA for the upcoming year. Level of STS was based on their responses within the STS scale. The mean results are presented in Table 4.11.

Table 4.11

*Responses of Job Satisfaction, STS, and Attrition (*N = *21)*

Factor	*M*	*SD*
Job Satisfaction	4.2	0.6
Intentions for Upcoming Year	4.1	1.1
Secondary Traumatic Stress	40.6	23.0

The average score for job satisfaction was 4.2, which suggests that, on average, participants found their job to be *rewarding* to *very rewarding*. Furthermore, only two participants reported their score being *less than rewarding*. Similarly, a mean score of 4.1 (*SD* = 1.1) for intentions for the upcoming year suggests that, on average, participants are likely to return for the upcoming year.

Prior to the multiple regression analysis, all assumptions were assessed. There was linearity, as assessed by partial regression plots and a plot of studentized residuals against the predicted values. There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.63. There was homoscedasticity, as assessed by visual inspection of a plot of studentized residuals versus unstandardized predicted values. There was no evidence of multicollinearity, as assessed by tolerance values greater than 0.1. Furthermore, there were no studentized deleted residuals greater than ±3 standard deviations, no leverage values greater than 0.2, and no values for Cook's distance above 1. The assumption of normality was met, as assessed by a *Q*-*Q* Plot. Thus, all assumptions for a multiple regression were met.

A multiple regression analysis was conducted. The independent variables of interest were level of job satisfaction and level of STS. Both variables were continuous variables. The dependent variable was the intention to return as an RA. The multiple regression model was statistically significant in predicting an RA's intentions to return when considering job satisfaction and level of STS, $F(2, 18) = 5.18$, $p = .017$, adj. $R^2 = .30$. Although job satisfaction was statistically significant at $p = .013$, level of STS was not statistically significant. Regression coefficients and standard errors may be found in Table 4.12. Based upon the results of this model, intention to return may be predicted using the following equation with *J* representing job satisfaction and *S* representing STS:

$$\hat{Y}_3 = -0.52 + 0.99J - 0.01S$$

Table 4.12

Regression for Intentions to Return from Job Satisfaction and STS

Variable	*B*	95% CI	β	*t*	*p*
Constant	-0.52	[-3.69, 2.65]		-0.35	.734
Job Satisfaction	0.99**	[0.24, 1.74]	.52	2.76	.013
Secondary Traumatic Stress	-0.01	[-0.02, 0.03]	.88	1.25	.229

Note. $N = 21$. CI = Confidence Interval for *B*. $R^2 = 0.37$.

These results suggest that the likelihood of returning increases by 0.99 as job satisfaction increases. Regarding STS, likelihood of returning increases by 0.01 as STS levels increase.

To further understand the role of job satisfaction and STS on an RA's intentions to return for the upcoming year, each interview participant was asked to reflect on how STS played a role in their decision to return or not return as an RA. All participants stated that STS—or "burnout" as two participants called it—had some level of impact. Only James, however, stated that it was the deciding factor. Lynn explained, "Obviously, I am tired and I have had a lot happen this year, but I can't just quit. I love helping my residents even when it costs me dearly." Other interview participants shared that they often considered burnout when making plans for next year, but other reasons kept them from quitting. "I can't just quit. I don't have enough financial aid to cover my tuition, so the RA job helps pay the bills" (Nicole). "I wish I could just quit, but where would I live?" (Wayne). James shared a different perspective, "I am so fucking done. I can't entertain the idea of doing this again. This was too much."

Participants were asked how job satisfaction played a role in their intentions to return. Furthermore, they were asked which factor was more influential: STS or job satisfaction. As expected from the quantitative results, every participant except James said job satisfaction, or lack thereof, was more influential in their decision to return. James shared, "No matter how

much I love this job, I can't get past the year I have had. I am done. I can't do this all over again next year." Lynn was very passionate about helping her students, and it was evident that she leverages that passion to help her residents' trauma: "I remember being a freshman. I knew no one but my RA. That's why I want to help them." Lynn further shared that being an RA helps her be a better person by stating, "I am not a quitter. Besides, why should I quit something I love?" Others described job satisfaction as the "fuel that keeps you going" (Wayne) or "the reason I go back on call every day" (Ashli).

Summary

This research question focused on the influences of job satisfaction and STS on risk of attrition and intention to return as a resident assistant. As evidenced by the multiple regression analysis, job satisfaction was a statistically significant predictor of risk of attrition; however, STS was not a statistically significant predictor. These results were further affirmed by the qualitative results related to this question. Participants identified STS has having an influence, but the overall deciding factor was job satisfaction. Those with relatively high scores of job satisfaction (e.g., Lynn and Wayne) had a more positive outlook on their role as an RA thus planned to return as an RA. Those with a relatively low score on job satisfaction (e.g., James) did not plan to return as an RA.

Chapter V

Discussion and Recommendations

The purposes of this study were to explore (a) the prevalence of STS in RAs at a 4-year public university in the southeastern United States, (b) the personal and institutional supports and barriers that impact RAs' responses to this STS, and (c) the roles STS plays in RA job satisfaction and risk of attrition. This study focused on the following research questions:

1. To what degree do RAs experience STS?
2. What supports and barriers do RAs identify as having influence on how they respond to STS?
3. To what degree are STS and job satisfaction predictors of risk of attrition in RAs?

This chapter provides a discussion of the findings and limitations and delimitations of the study along with implications for future practice and research.

Discussion

Several findings emerged from this study. First, participants were able to define trauma and provide examples of trauma exemplified in their role as an RA. Second, although prevalent among RAs according to the scale used within this study, nearly all participants were unable to fully define STS due to lack of awareness of the phenomenon prior to this study. Third, there were factors within the role of an RA that influence STS levels. Next, there were several personal and institutional resiliency factors and barriers that influenced how participants responded to trauma within their role as an RA. Finally, job satisfaction, unlike STS, is a significant factor in predicting risk of attrition in RAs. Each finding is discussed below.

Defining Trauma Within the Residence Life Context

Interview participants identified four themes within their definitions of trauma: psychological trauma, physical trauma, historical trauma, and identity-based trauma. This is consistent with four of the nine types of trauma within college students identified by Silverman and Glick (2010). Furthermore, the most common types of trauma reported by students and mentioned in the interviews were suicidal ideation, mental health, and sexual abuse, which is consistent with data from the World Health Organization (Auerbach et al., 2018), the Center for Disease Control (2021), and others (e.g., Coulter & Rankin, 2020; Krebs et al., 2007; Tjaden & Thoennes, 1998).

In 2020, the American College Health Association found that most undergraduate students experienced some form of mental health crisis, and these rates continue to increase. The experiences of the participants are consistent with the results of the American College Health Association, as the RAs reported they assist a resident through a traumatic event *multiple times per week* or *daily*. It is also important to note when describing the effects of trauma, themes emerged such as the effects identified by the American Psychiatric Association (2013): arousal, avoidance, intrusion, and negative cognition of mood. Participants described instances of each including one individual who avoided going into a resident's former room assignment after a sexual assault due to the traumatic experience of hearing her story and the dredging up of memories of her own trauma.

Prevalence of STS in RAs

On average, participants reported moderate levels of STS, according to a scale developed by Bride et al. (2004). Individuals participating in the interview portion of this study identified several types of trauma that are consistent with the results by Silverman and Glick (2010).

Specifically, individuals identified physical or emotional trauma such as domestic or sexual violence; suicidal ideation and behavior; mental health concerns such as anxiety, depression, or psychosis; and academic crises.

Although participants indicated moderate levels of STS, they were unable to define STS. This seemed to be due to a lack of awareness of the phenomenon, however, not an absence of symptoms. In fact, every participant reported they had not heard of STS until this study. It is important to note that individuals were, however, able to contextualize STS within their role as an RA. For example, a participant called it "having your fill," or an overabundance of responding to crises. Another student described a reduction in their sense of accomplishment, which has been identified as a factor contributing to burnout (e.g., Galek et al., 2011; Maslach, 1998; Munnangi et al., 2018). Another participant was able to identify symptoms she had experienced including avoidance, intrusive thoughts, and sleep deprivation. These symptoms are consistent with the definition of STS developed by the American Psychiatric Association (2013).

Factors Influencing STS in RAs

This study found that semesters of experience, types of trauma, and amount of training significantly predicted levels of STS in resident assistants. Specifically, semesters of experience had an inverse relationship with STS levels, whereas all other factors had a positive relationship. Work experience negatively impacting levels of STS affirms results from those in other contextual settings, including counselors, social workers, and medical staff (e.g., Boscarino et al., 2004; Day et al, 2017; Lee et al., 2018; MacRitchie & Leibowitz, 2010). Similarly, a positive relationship between types of trauma and STS levels is consistent with studies in other contexts.

Although training has been identified as a significant factor in decreasing levels of STS in other contexts (e.g., Boscarino et al., 2004), this study identifies a significant positive correlation

with training and STS. This may be attributed to the overall quality of training RAs receive at this institution. Unlike mental health therapists and other licensed individuals, RAs often attend training in short increments of time by non-licensed higher education administrators, such as directors of residence life and residence hall directors. Furthermore, participants identified a gap in training related to responding to mental health crises as an RA.

Resiliency Factors and Barriers Influencing STS in RAs

The quantitative analysis related to resiliency factors and barriers failed to provide statistically significant results; however, the qualitative portion of this study identified several personal and institutional supports and barriers influencing how RAs respond to STS.

Personal Resiliency Factors

Yigit and Tatch (2017) defined resiliency as a person's ability to effectively respond to stress or the ability to recover from traumatic experiences. In regard to personal resiliency factors, interview participants identified factors that were arranged in three themes: positive self-talk, social and familial support, and locus of control. Positive self-talk involved the ability of an individual to view themselves in a positive manner. This is consistent with prior research, as Thompson et al. (2014) found that mindfulness and positive self-talk were negative predictors of compassion fatigue. Another emerging personal resiliency factor influencing STS in RAs includes social and familial support. Social and familial support has previously been studied by Salloum et al. (2015) as it relates to compassion satisfaction (i.e., a positive emotional reaction to helping others), and this study expands the importance of social and familial support to STS.

Another theme to emerge involved an individual's locus of control. Locus of control, defined by Rotter (1966), involves the extent to which an individual believes they have control over instances in their own life. This phenomenon was exemplified in the participants of this

study, as they often described their understanding of how they could not prevent a crisis, but they were able to help a student through the crisis. Similar to these personal resiliency factors, participants were also able to identify several personal barriers as well.

Personal Barriers

When identifying personal barriers, one of the most mentioned barriers were negative self-talk, which was defined in this study as viewing oneself in a negative light. This included self-blame and a heightened sense of responsibility for the outcomes of the crisis. This is consistent with the work of Thompson et al. (2014), who identified maladaptive coping mechanisms (e.g., self-blame) as a factor which increases levels of compassion fatigue.

Other barriers identified within this study involved alcohol use, a lack of social or familiar support, and limited training. One participant shared they rely on alcohol to avoid the emotions related to the experience of dealing with others' trauma. Bourke and Craun (2014) identified alcohol and tobacco use as a barrier in their study on STS in Internet Crimes Against Children Task Force personnel. It can be inferred that the absence of social and familial support was a barrier to overcoming STS as these factors were mentioned as a personal resiliency factor. This would affirm the work of Salloum et al. (2015) and MacRitchie and Leibowitz (2010) who identified social and familial supports as an influential factor in mitigating levels of STS. Finally, participants identified limited training opportunities as a barrier, which aligned with Salloum et al. (2015) who found that training on mindfulness and trauma-informed self-care have a negative correlation with burnout. In sum, four themes emerged regarding personal barriers: negative self-talk, alcohol use, lack of social or familial support, and limited training. Though personal resiliency factors and barriers play a role in the RAs responses to STS, there also existed institutional resiliency factors and barriers.

Institutional Support Factors

The first-mentioned support for every participant was the counseling center. This may be attributed to the training structure provided to RAs within the research context, as RAs are trained to utilize the counseling center as much as possible. Other factors included campus involvement, their supervisor, and mental health campus programming. Participants described how being involved in campus organizations (e.g., mental health awareness organizations, social clubs, Greek-lettered organizations) provided an outlet from the position, and it provided social support systems to promote their own self-care. This is consistent with the work conducted by others (e.g., MacRitchie & Leibowitz, 2010) involving the effects of social support systems on STS, burnout, and compassion fatigue.

Similarly, strong (i.e., competent and caring) supervision was identified as a support factor for RAs. This included availability of the supervisor for reflection and discussion after the event, as well as the ability for the supervisor to empathize with the individual's experiences as an RA. These results affirm the findings of Boscarino et al. (2014) on supportive work environments as well as Edwards et al. (2006) who measured effective supervision on burnout in nurses. Furthermore, Tarcan et al. (2017) identified a positive relationship between effective supervision and job satisfaction as well as an inverse relationship between job satisfaction and STS.

Campus mental health programming was another support factor identified within this study. Though, Bourdon et al. (2020) identified the prevalence of campus mental health programming, D'Amico et al. (2016) and Eisenberg et al. (2012) found that this programming was underutilized. Approximately 13% of students utilize campus mental health programming (Eisenberg et al., 2012); however, this study provided examples of RAs who found their use of

mental health programming beneficial in responding to STS. Furthermore, these participants found a benefit to this type of programming as it relates to STS. Although these institutional resiliency factors aided RAs as they responded to STS, barriers, on the institutional level, were identified that were a detriment to the RAs' responses to STS.

Institutional Barriers

Three institutional barriers emerged within this study: the RA role, a lack of strong supervision, and limited availability of counselors within the research setting. The RA role was a substantial barrier, as it was most frequently mentioned among the participants. As the RA role is an on-call role, participants shared they did not feel as though they could take time away from the role compared to other shift-based jobs. Similarly, participants recognized the difficulties of living in the same community as their residents. Several participants shared instances in which they avoided residents to avoid having to speak with them and respond to additional crises. Though this structure is consistent with similar roles within the United States (Paladino et al., 2005), this creates an environment that is not conducive for promoting the mental health of RAs.

Another barrier was a lack of strong supervision. As mentioned previously, those with strong supervisors found a source of support when dealing with trauma; however, there were some participants that did not have that type of supervision. Participants lacking strong supervision identified this as a barrier, as they did not feel as though they were operating within a supportive work environment. As mentioned previously, a supportive work environment has been found to decrease levels of burnout and STS (Boscarino et al., 2014).

Finally, the limited availability of counselors within this research setting was identified as a barrier. As counseling centers have been around since 1910 (Kraft, 2011), this study further affirms the need for counselors within the residence life program. In sum, three institutional

barriers were identified from this study: the RA role, the absence of strong supervision, and the limited availability of counselors within the research setting.

Job Satisfaction, STS, and Their Influence on Risk of Attrition

Through a multiple regression analysis, job satisfaction is a statistically significant predictor of risk of attrition; however, STS is not a statistically significant predictor. These results are further affirmed by the interview participants who mentioned STS as having an influence, but that the overall deciding factor was job satisfaction. Specifically, those with a more positive outlook on their role as an RA planned to return, while those with relatively low scores on job satisfaction did not plan to return as an RA. This study expands the work of Bride and Kintzle (2011) as well as others (e.g., Edwards et al., 2006; Salloum et al., 2015) by expanding the research on job satisfaction and STS to a new population, RAs.

Limitations

This study was not without its limitations. Limitations within a study are components that are beyond the control of the researcher, and they exist within every study (Marshall & Rossman, 2014). Limitations for this study include participant bias, the generalizability of the quantitative findings, and the impact of PTSD-related memory alteration on narratives.

Limitations specific to the quantitative facet of this study involve the propensity for low response rates. This was addressed by sending email reminders 5 and 10 days after sending the initial survey. Furthermore, this study relies on self-reported data, which is subject to participant bias. Participant bias occurs when participants respond in ways to meet the expectations of the researcher—participants do not behave normally, and instead behave in ways they think they are supposed to (Gove & Geerken, 1977). To reduce participant bias,

participants were informed that responses would be anonymous. Furthermore, survey data were triangulated using phenomenological interviews.

For the qualitative facet of this study, it is important to understand aspects of a phenomenological study. Phenomenological studies are concerned with describing a phenomenon within an identified population instead of operationalizing to other populations (Moustakas, 1994). Due to the qualitative nature and the individuality of the narratives, this study may not be generalized to larger populations; however, conclusions from this study may be transferred to other institutions with similar housing structures and stakeholders. This study may assist individuals in further understanding STS at the institution under study, but it is not intended to address STS in other helping professions or other institutions.

This study was conducted with a small population, approximately 45, so the potential participants for this study were limited. In total, 21 RAs participated in the quantitative portion of this study, and five students participated in the phenomenological interviews.

Finally, this study relies heavily on the short- and long-term memories of the participants. Memory alteration has been identified as a long-term symptom of PTSD due to the avoidance of associated stimuli (American Psychiatric Association, 2013). Individuals experiencing avoidance symptoms often report an inability to recall important aspects of the trauma (Samuelson, 2011). To minimize the effects of memory alteration, semistructured phenomenological interviews were used in lieu of structured interviews. By allowing the participant to control the narrative and the interview, memories often emerge unaltered, thus improving the narrative (Morse et al., 2012). Participants may still have felt hesitant, however, to share their experiences due to fear of negative emotions related to the traumatic event.

Delimitations

Delimitations of a study occur when limitations are set by the researcher to ensure achievement of the goals of the study (Theofanidis & Fountouki, 2018). For this study, there are several delimitations. First is the selection of participants based on their location of employment. The housing department is the same department where I am currently employed, although I have no supervisory relationships with any participants of the study. This population was chosen so that the findings of this study may be used to make recommendations to improve the RA program and better support current employees in responding to STS. Another delimitation is the exclusion of RAs who have been promoted to residence hall directors or community programming directors. These individuals are provided with additional training opportunities, and they often do not have direct contact with residents. Next, due to a small research population, the relationship of the researcher to the participants, and the sensitivity of the topic of interest, participant demographic information was not collected to preserve the integrity of the study. Finally, the problem of practice is a delimitation, as the researcher has worked with students who have experienced trauma as well as RAs who have experienced STS.

Implications for Practice and Research

The current study explored the prevalence of STS in RAs at a 4-year public university in the southeastern United States, the personal and institutional supports and barriers that impact RAs' responses to this STS, and the roles STS play in RA job satisfaction and risk of attrition. Based upon the findings of this study, the implications for practice include (a) expanded training to address responding to mental health crises as well as coping mechanisms for dealing with STS, (b) training supervisors in best practices of trauma-informed supervision, (c) expansion of counseling center support for residence life programs, and (d) developing protocols for early

detection of burnout and STS in RAs as well as interventions to prevent further burnout. Implications for future research include (a) addressing the lack of evidence surrounding resident assistants' mental health, (b) replicating the study in multiple settings with an expanded population of diverse genders, ages, and ethnicities, and (c) addressing the effects of campus educational programming on STS in RAs.

Implications for Practice

When examining the results of this study, participants identified a dearth of training experiences on mental health crisis response and coping mechanisms for dealing with STS. Due to the increasing rates of mental health crises on college campuses (Stolzenberg et al., 2020), administrators of residence life programs should dedicate adequate time in training to address mental health crises as well as methods of responding to STS after responding to residential crises.

Another implication for practice is to ensure supervisors within residence life programs are trained on trauma-informed supervision to better support RAs as they respond to mental health crises on campus. The findings of this study support this implication, as individuals who had strong supervisors identified this as a resiliency factor; those without strong supervisors identified their supervisor as a barrier to dealing with STS. Given that most supervisors within this setting are undergraduate students and that age may be a mitigating factor of STS (Salloum et al., 2015), existing training should be expanded to address trauma-informed and STS-informed supervisory practices to promote the well-being of the RAs and their supervisors. Furthermore, supervisors of RAs should participate in training on methods of identifying and addressing STS in their RAs (Boscarino et al., 2004). According to Berger and Quiros (2016), trauma-informed training should include methods related to empowerment, relationship building, and advocacy

for self-care. Empowerment includes the validation of the individual's experiences while also providing opportunities for professional development and reflection. Relationship building involves a supervisory environment in which all individuals feel emotionally safe and supported, and advocacy for self-care involves the provision of resources as well as the encouragement to practice self-care as needed by the individuals experiencing STS.

One of the most-mentioned support factors within the current study was the counseling center on campus; however, RAs recognized that the current state of the counseling center with limited employees served as a barrier to responding to STS. Due to these findings, it is imperative that residence life programs continue to integrate campus counseling centers into their crisis response and educational programming protocols. Furthermore, counseling centers should continue to advocate for the expansion of counseling staff to ensure adequate response of mental health concerns for all students. Furthermore, administrators should ensure that counseling centers are staffed appropriately, and counselors, who leave the center, should be replaced in a timely manner.

Based on the prevalence of symptomology yet relative unawareness of STS in RAs, residence life programs should implement early detection protocols for STS in RAs. These protocols should not only outline methods of identification of STS through self-ratings and supervisory reviews, but there should also be support mechanisms for RAs experiencing STS symptoms. Furthermore, these protocols should identify methods of promoting separation of RAs from their residential communities, as participants identified living their community as a barrier to overcoming STS.

Implications for Research

While conducting the literature review, there was a dearth of research on resident assistants and their experiences with mental health. Due to the increasing rates of mental health concerns in college students, compounded with the expectation of RAs to serve as peer counselors, opportunities exist for future research to explore mental health concerns in RAs. Furthermore, this study could be expanded to utilize in-depth interviews to identify effective coping mechanisms in resident assistants within a national population.

This study may also be replicated in settings that have more numerous types of trauma and in settings with more experienced RA. One opportunity for research involves the consideration of the types of trauma that RAs respond to and the implications of these types of traumas on STS levels. This study may also be replicated in populations of RAs that have more experience as an RA or those that possess bachelor's degrees or advanced training. Moving forward, additional research is needed on campus educational programming as it relates to STS. The current study identified educational programming as a resiliency factor, but there exists a dearth of research on this phenomenon. Specifically, in-depth interviews and quantitative data may be used to measure the effects of these programs on STS in RAs as well as other student leaders on college campuses.

This study failed to identify a relationship between STS and risk of attrition; however, prior research identifies a relationship between STS and job satisfaction, a significant predictor of risk of attrition in this study (Tarcan et al., 2007). Therefore, additional factors should be investigated as they relate to STS. Additional research should be conducted to understand the role of STS in risk of attrition and job satisfaction in resident assistants. Specifically, research should be conducted to understand if job satisfaction is a mediating variable between STS and

risk of attrition in RAs. Furthermore, this study only considered the job satisfaction and STS in the exploration of the risk of attrition. Other factors, such as race and ethnicity, have been identified as having implications on levels of STS (e.g., Salloum et al., 2015), so this study should be expanded to consider demographic factors and their roles on STS, job satisfaction, and risk of attrition.

Demographic data were not collected in an effort to protect the anonymity of the participants, and this study involved the low response rates within the small population of interest. As such, this study does not take into consideration the implications of identity-based factors on STS levels in RAs. Though research has been conducted on demographic factors (e.g., Salloum et al., 2015) and STS in other populations, research should be conducted on demographic factors to further expand current literature on RAs and mental health. Specifically, research should also be conducted to understand the role of these demographic and identity-based factors on job satisfaction and risk of attrition.

References

Adams, R. E., Boscarino, J. A., & Figley, C. R. (2006). Compassion fatigue and psychological distress among social workers: A validation study. *American Journal of Orthopsychiatry*, *76*(1), 103-108. https://doi.org/10.1037/002-9432.76.1.103

Adams, S. A., & Riggs, S. A. (2008). An exploratory study of vicarious trauma among therapist trainees. *Training and Education in Professional Psychology*, *2*(1), 26-34. https://doi.org/10.1037/1931-3918.2.1.26

American College Health Association. (1961). Recommended standards and practices for a college health program. *Journal of the American College Health Association*, *18*(1), 41-89.

American College Health Association. (2020). *Undergraduate Student Reference Group Executive Summary: Fall 2020.* https://www.acha.org/documents/ncha/NCHA-III_Fall_2020_Undergraduate_Reference_Group_Executive_Summary.pdf

American Psychiatric Association. (1980). *Diagnostic and statistical manual for mental disorders* (3rd ed.).

American Psychiatric Association. (2000). *Diagnostic and statistical manual for mental disorders* (4th ed., text rev.). https://doi.org/10.1176/appi.books.9780890423349

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 *et seq.* (1990). https://www.ada.gov/pubs/adastatute.htm

Artime, T. M., Buchholz, K. R., & Jakupcak, M. (2019). Mental health symptoms and treatment utilization among trauma-exposed college students. *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(3), 274-282. https://doi.org/10.1037/tra0000376

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative research*, *1*(3), 385-405. https://doi.org/10.1177/146879410100100307

Auerbach, R. P., Mortier, P., Bruffaerts, R., Alonso, J., Benjet, C., Cuijpers, P., Demyttenaere, K., Ebert, D. D., Green, J. G., Hasking, P., Murray, E., Nock, M. K., Pinder-Amaker, S., Sampson, N.A., Stein, D. J., Vilagut, G., Zaslavsky, A. M., & Kessler, R. C. (2018). The WHO world mental health surveys intervals international college student project: Prevalence and distribution of mental disorders. *Journal of Abnormal Psychology, 127*(7). 623-638. https://doi.org/10.1037/abn0000362

Bae, J., Jennings, P. F., Hardeman, C. P., Kim, E., Lee, M., Littleton, T., & Saasa, S. (2019). Compassion satisfaction among social work practitioners: The role of work-life balance. *Journal of Social Service Research*, *46*(3), 320-330. https://doi.org/10.1080/01488376.2019.1566195.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, *84*(2), 191-215. https://doi.org/10.1037/0033-295x.84.2.191

Barreira, P., & Snider, M. (2010). History of college counseling and mental health services and role of the community mental health model. In J. Kay & V. Schwartz (Eds.), *Mental Health Care in the College Community*. (21-31). Wiley & Sons, Ltd. https://doi.org/10.1002/9780470686836.ch2

Bean, R. C., Ong, C.W., Lee, J., & Twohig, M. P. (2017). *Acceptance and commitment therapy for PTSD and trauma: An empirical review*. Utah State University.

Benjet, C., Bromet, E, Karam, E. G., Kessler, R. C., McLaughlin, K. A., Ruscio, A. M., Shahly, V., Stein, D. J., Petukhova, M., Hill, E., Alonso, J., Atwoli, L., Bunting, B., Bruffaerts, R., Caldas-de-Almeida, J. M., de Girolamo, G., Florescu, S., Gureje, O., Huang, Y., . . . Koenen, K. C. (2016). The epidemiology of traumatic event exposure worldwide: Results from the World Mental Health Survey Consortium. *Psychological Medicine*, *46*(2), 327-343. https://doi.org/10.1017/S0022391715001981.

Berger, R., & Quiros, L. (2016). Best practices for training trauma-informed practitioners: Supervisors' voice. *Traumatology*, *22*(2), 145-154. https://doi.org/10.1037/trm0000076

Bernat, J. A., Ronfeldt, H. M., Calhoun, K. S., & Arias, I. (1998). Prevalence of traumatic events and peritraumatic predictors of posttraumatic stress symptoms in a nonclinical sample of college students. *Journal of Traumatic Stress, 11*(4), 645-664. https://doi.org/10.1023/A:1024485130934

Bevan, M. T. (2014). A method of phenomenological interviewing. *Qualitative health research*, *24*(1), 136-144. https://doi.org/10.1177/1049732313519710

Black, M. C., Kresnow, M. J., Simon, T. R., Arias, I., & Shelley, G. (2006). Telephone survey respondents' reactions to questions regarding interpersonal violence. *Violence and Victims*, *21*(4), 435-459. https://doi.org/10.1891/vivi.21.4.445

Blanchard, E. B., Rowell, D., Kuhn, E., Rogers, R., & Wittrock, D. (2005). Posttraumatic stress and depressive symptoms in college population one year after the September 11 attacks: The effect of proximity. *Behaviour Research and Therapy*, *43*(1), 143-150. https://doi.org/10.1016/j.brat.2003.12.004

Blimling, G. (2003). *The RA: Applications and strategies for working with college students in residence halls* (6th ed.). Kendall/Hunt.

Blimling, G.S. (2010). *The RA: Applications and strategies for working with college students in residence halls* (7th ed.). Kendall/Hunt.

Boscarino, J. A., Figley, C. R., & Adams, R. E. (2004). Compassion fatigue following the September 11 terrorist attacks: A study of secondary trauma among New York City social workers. *International Journal of Emergency Mental Health*, 6(2), 57-66. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2713725/

Bourdon, J. L., Moore, A. A., Long, E. C., Kendler, K. S., & Dick, D. M. (2020). The relationship between on-campus service utilization and common mental health concerns in undergraduate college students. *Psychological Services*, *17*(1), 118-136. https://doi.org/10.1037/ser0000296

Bourke, M. L., & Craun, S. W. (2014). Secondary traumatic stress among internet crimes against children task force personnel: Impact, risk factors, and coping strategies. *Sexual Abuse*, *26*(6), 586-609. https://doi.org/10.1177/1079063213509411

Boyd, C. O. (2001). Phenomenology the method. In P. L. Munhall (Ed.), *Nursing research: A qualitative perspective* (3rd ed., pp. 93-122). Jones & Bartlett Learning.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), *APA handbook of research methods in psychology, Vol. 2. Research designs: Quantitative, qualitative, neuropsychological, and biological* (pp. 57-71). American Psychological Association Press. https://doi.org/10.1037/13620-004

Bride, B. E. (2007). Prevalence of secondary traumatic stress among social workers. *Social work*, *52*(1), 63-70. https://doi.org/10.1093/sw/52.1.63

Bride, B. E., & Kintzle, S. (2011). Secondary traumatic stress, job satisfaction, and occupational commitment in substance abuse counselors. *Traumatology*, *17*(1), 22-28. https://doi.org/10.1177/1534765610395617

Bride, B. E., Robinson, M. M., Yegidis, B., & Figley, C. R. (2004). Development and validation of the Secondary Traumatic Stress Scale. *Research on Social Work Practice*, 14*,* 27-35. https://doi.org/10.1177/1049731503254106

Britt-Spells, A. M., Slebodnik, M., Sands, L. P., & Rollock, D. (2018). Effects of perceived discrimination on depressive symptoms among Black men residing in the United States: A meta-analysis. *American Journal of Men's Health*, *12*(1), 52-63. https://doi.org/10.1177/1557988315624509

Bruffaerts, R., Mortier, P., Auerbach, R. P., Alonso, J., Hermosillo De la Torre, A. E., Cuijpers, P., Demyttenaer, K., Ebert, D., Green, J. G., Hasking, P., Stein, D. J., Ennis, E., Nock, M. K., Pinder-Amaker, S., Sampson, N. A., Vilagut, G., Zaslavsky, A. M., & Kessler, R. C. (2019). Lifetime and 12-month treatment for mental disorders and suicidal thoughts and behaviors among first year college students. *International Journal of Methods in Psychiatric Research*, *28*(2), Article e1764. https://doi.org/10.1002/mpr.1764

Bryant-Davis, T. (2007). Healing requires recognition: The case for race-based traumatic stress. *The Counseling Psychologist, 35*(1), 135-143. https://doi.org/10.1177/0011000006295152

Bulhan, H. A. (1985). Black Americans and psychopathology: An overview of research and theory. *Psychotherapy: Theory, Research, Practice, Training, 22*(2), 370-378. https://doi.org/10.1037/h0085517

Canto, A. I., Swanbrow Becker, M., Cox, B. E., Hayden, S., & Osborn, D. (2017). College students in crisis: Prevention, identification, and response options for campus housing professionals. *Journal of College and University Student Housing*, *43*(2). 44-57. https://www.nxtbook.com/nxtbooks/acuho/journal_vol43no2/index.php#/p/6

Cantor, D., Fisher, B., Chibnall, S. H., Townsend, R., Lee, H., Thomas, G., Lee, H. (2015). *Report on the AAU campus climate survey on sexual assault and sexual misconduct*. The University of Virginia. *https://ira.virginia.edu/sites/ias.virginia.edu/files/University%20of%20Virginia_2015_climate_final_report.pdf*

Carter, R. T. (2007). Racism and psychological and emotional injury: Recognizing and assessing race-based traumatic stress. *The Counseling Psychologist*, *35*(1), 13-105. https://doi.org/10.1177/0011000006292033

Center for Collegiate Mental Health (2020). *Annual Report: 2020*. https://ccmh.psu.edu/assets/docs/2020%20CCMH%20Annual%20Report.pdf

Center for Disease Control (2021). Deaths and mortality. https://www.cdc.gov/nchs/fastats/deaths.htm

Chao, R. C. L. (2011). Managing stress and maintaining well-being: Social support, problem-focused coping, and avoidant coping. *Journal of Counseling and Development*, *89*(3), 338-348. https://doi.org/10.1002/j.1556-6678.2011.tb00098.x

Christian-Brandt, A. S., Santacrose, D. E., & Barnett, M. L. (2020). In the trauma-informed care trenches: Teacher compassion satisfaction, secondary traumatic stress, burnout, and intent to leave education within underserved elementary schools. *Child Abuse & Neglect*, *110*, Article e104437. https://doi.org/10.1016/j.chiabu.2020.104437

Conley, C. S., Hundert, C. G., Charles, J. L. K., Huguenel, B. M., Al-khouja, M., Qin, S., Paniagua, D., & Corrigan, P. W. (2020). Honest, open, proud-college: Effectiveness of a peer-led small-group intervention for reducing the stigma of mental illness. *Stigma and Health*, *5*(2), 168-178. https://doi.org/10.1037/sah0000185

Connally, D. (2012). The relationship between clinician sex, ethnicity, sexual identity and secondary traumatic stress. *Journal of Gay & Lesbian Mental Health, 16*(4), 306-321. https://doi.org/10.1080/19359705.2012.697002

Corrigan, P. W., & Penn, D. L. (1999). Lessons from social psychology on discrediting psychiatric stigma. *American Psychologist*, *54*(9), 765-776. https://doi.org/10.1037/0003-066x.54.9.765

Coulter, R. W., & Rankin, S. R. (2020). College sexual assault and campus climate for sexual- and gender-minority undergraduate students. *Journal of Interpersonal Violence*, *35*(5-6), 1351-1366. https://doi.org/10.1177/0886260517696870

Creswell, J. W. (2014). *A concise introduction to mixed methods research*. Sage.

Creswell, J. W., & Plano Clark, V. L. (2017). *Designing and conducting mixed methods research*. Sage.

Creswell, J. W., Hanson, W. E., Plano Clark, V. L., & Morales, A. (2007). Qualitative research designs: Selection and implementation. *The Counseling Psychologist*, *35*(2), 236-264. https://doi.org/10.1177/0011000006287390

Crumpei, I., & Dafinoiu, I. (2012). The relation of clinical empathy to secondary traumatic stress. *Procedia-Social and Behavioral Sciences*, *33*, 438-442. https://doi.org/10.1016/j.sbspro.2012.01.159

D'Amico, N., Mechling, B., Kemppainen, J., Ahem, N. R., & Lee, J. (2016). American college students' views of depression and utilization of on-campus counseling services. *Journal of American Psychiatric Nurses Association*, *22*(4), 302-311. https://doi.org/10.1177/1078390316648777

Davidson, J. R., & Foa, E. B. (1991). Diagnostic issues in posttraumatic stress disorder: Considerations for the DSM-IV. *Journal of Abnormal Psychology*, *100*(3), 346-355. https://doi.org/10.1037/0021-843x.100.3.346

Day, K. W., Lawson, G., & Burge, P. (2017). Clinicians' experiences of shared trauma after the shootings at Virginia Tech. *Journal of Counseling & Development*, *95*(3), 269-278. https://doi.org/10.1002/jcad.12141

Devilly, G. J., Wright, R., & Varker, T. (2009). Vicarious trauma, secondary traumatic stress or simply burnout? Effect of trauma therapy on mental health professionals. *Australian & New Zealand Journal of Psychiatry*, *43*(4), 373-385. https://doi.org/10.1080/00048670902721079

Diggs, G. A., Garrison-Wade, D. F., Estrada, D., & Galindo, R. (2009). Smiling faces and colored spaces: The experiences of faculty of color pursuing tenure in the academy. *The Urban Review*, *41*(4), 312-333. https://doi.org/10.1007/s11256-008-0113-y

Din-Dzietham, R., Nembhard, W. N., Collins, R., & Davis, S. K. (2004). Perceived stress following race-based discrimination at work is associated with hypertension in African

Americans, The metro Atlanta heart disease study, 1999-2001. *Social Science & Medicine*, *58*(3), 449-461. https://doi.org/10.1016/s0277-9536(03)00211-9

Duarte, J., & Pinto-Gouveia, J. (2016). Effectiveness of a mindfulness-based intervention on oncology nurses' burnout and compassion fatigue symptoms: A non-randomized study. *International Journal of Nursing Studies*, *64*, 98-107. https://doi.org/10.1016/j.ijnurstu.2016.10.002

Ebert, D. D., Buntrock, C., Mortier, P., Auerbach, R., Weisel, K. K., Kessler, R. C., Cuijpers, P., Green, J. G., Kiekens, G., Nock, M. K., Demyttenaere, K., & Bruffaerts, R. (2019). Prediction of major depressive disorder onset in college students. *Depression and Anxiety*, *36*(4), 294-304. https://doi.org/10.1002/da.22867

Edwards, D., Burnard, P., Hannigan, B., Cooper, L., Adams, J., Juggessur, T., Fothergil, A., Coyle, D. (2006). Clinical supervision and burnout: The influence of clinical supervision for community mental health nurses. *Journal of Clinical Nursing*, *15*(8), 1007-1015. https://doi.org/10.1111/j.1365-2702.2006.01370.x

Edwards, K. M., Kearns, M. C., Calhoun, K. S., & Gidycz, C. Z. (2009). College women's reaction to sexual assault research participation: Is it distressing? *Psychology of Women Quarterly*, *33*(2), 225-234. https://doi.org/10.1111/j.1471-6402.2009.01492.x

Eisenberg, D., Hunt, J., Speer, N., & Zivin, K. (2011). Mental health service utilization among college students in the United States. *The Journal of Nervous and Mental Disease*, (*1995*), 301-308. https://doi.org/10.1080/07448481.2010.546.461

Eisenberg, D., Speer, N., & Hunt, J. B. (2012). Attitudes and beliefs about treatment among college students with untreated mental health problems. *Psychiatric Services*, *63*(7), 711-713. https://doi.org/10.1176.appi.ps.201100250

Elwood, L. S., Mott, J., Lohr, J. M., & Galovski, T. E. (2011). Secondary trauma symptoms in clinicians: A critical review of the construct, specificity, and implications for trauma-focused treatment. *Clinical Psychology Review*, *31*(1), 25-36. https://doi.org/10.1016/j.cpr.2010.09.004

Fang, C. Y., & Myers, H. F. (2001). The effects of racial stressors and hostility on cardiovascular reactivity in African American and Caucasian men. *Health Psychology*, *20*(1), 64-70. https://doi.org/10.1037/0278-6133.20.1.64

Feagin, J. (2013). *Systemic racism: A theory of oppression.* Routledge. https://doi.org/10.4324/9781315880938

Fernet, C., Guay, F., Senécal, C., & Austin, S. (2012). Predicting intraindividual changes in teacher burnout: The role of perceived school environment and motivational factors. *Teaching and Teacher Education*, *28*(4), 514-525. https://doi.org/10.1016/j.tate.2011.11.013

Figley, C. R. (1995). Compassion fatigue: Toward a new understanding of the costs of caring. In B. H. Stamm (Ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators* (pp. 3-48). Sidran Press.

Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self-care. *Journal of Clinical Psychology*, *58*(11), 1433-1441. https://doi.org/10.1002/jclp.10090

Fisher, B. (2000). *The sexual victimization of college women.* U.S. Department of Justice.

Freudenberger, H. J. (1974). Staff burnout. *Journal of Social Issues, 30*(1), 159-165. https://doi.org/10.1111/j.1540-4560.1974.tb00706.x

Galek, K., Flannelly, K. J., Greene, P. B., & Kudler, T. (2011). Burnout, secondary traumatic stress, and social support. *Pastoral Psychology, 60*(5), 633-649. https://doi.org/10.1007/s11089-011-0346-7

Goldman-Mellor, S. J., Caspi, A., Harrington, H., Hogan, S., Nada-Raja, S., Poulton, R., & Moffitt, T. E. (2014). Suicide attempt in young people: A signal for long-term health care and social needs. *JAMA Psychiatry*, *71*(2), 119-127. https://doi.org/10.1001.jamapsychiatry.2013.2803

Goodwin, J., & Tiderington, E. (2020). Building trauma-informed research competencies in social work education. *Social Work Education*, *39*, 1-14. https://doi.org/10.1080/02615479.2020.1820977

Gove, W. R., & Geerken, M. P. (1977). Response bias in surveys of mental health: An empirical examination. *American Journal of Sociology*, *82*, 1289-1317. https://doi.org/10.1086/226466

Greinacher, A., Derezza-Greeven, C., Herzog, W., & Nikendei, C. (2019). Secondary traumatization in first responders: a systematic review. *European Journal of Psychotraumatology, 10*(1), Article e1562840. https://doi.org/10.1080/20008198.2018.1562840

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Technology Research and Development*, *29*(2), 75-91. https://doi.org/10.1007/bf02766777

Hanson, R. K. (1990). The psychological impact of sexual assault on women and children: A review. *Annals of Sex Research*, *3*(2), 187-232. https://doi.org/10.1007/bf00850870

Hardy, S. E., & Dodd, D. K. (1998). Burnout among university RAs as a function of gender and floor assignment. *Journal of College Student Development, 39*. 499-501.

Hart Research Associates (2015). *Falling short? College learning and career success*. https://www.aacu.org/sites/default/files/files/LEAP/2015employerstudentsurvey.pdf

Harvey, M. R. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress*, *9*(1), 3-23. https://doi.org/10.1002/jts.2490090103

Hefner, J., & Eisenberg, D. (2009). Social support and mental health among college students. *American Journal of Orthopsychiatry*, *79*(4), 491-499. https://doi.org/10.1037/a0016918

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377-391. https://doi.org/10.1002/jts.2490050305

Herman, S., Archambeau, O. G., Deliramich, A. N., Kim, B. S., Chiu, P. H., & Frueh, B. C. (2011). Depressive symptoms and mental health treatment in an ethnoracially diverse college student sample. *Journal of American College Health*, *59*(8), 715-720. https://doi.org/10.1080/07448481.2010.529625

Jeanne Clery Disclosure of Campus Security Policy and Campus Crime Statistics Act of 1990, 20 U. S. C. § 1092 (f) (2018). https://www2.ed.gov/admins/lead/safety/campus.html

Jenkins, S. R., & Baird, S. (2002). Secondary traumatic stress and vicarious trauma: A validation study. *Journal of Traumatic Stress*, *15*(5), 423-432. https://doi.org/10.1023/a:1020193526843

Jones, J. M. (1997). *Prejudice and racism*. McGraw-Hill Humanities, Social Sciences, & World Languages.

Jorm, A. F., Kelly, C. M., & Morgan, A. J. (2007). Participant distress in psychiatric research: A systematic review. *Psychological Medicine*, *37*(7), 917-926. https://doi.org/10.1017/S0033291706009779

Kim, H., & Stoner, M. (2008). Burnout and turnover intention among social workers: Effects of role stress, job autonomy, and social support. *Administration in Social Work*, *32*(3), 5-25. https://doi.org/10.1080/03643100801922357

Kirsch, D. J., Pinder-Amaker, S. L., Morse, C., Ellison, M. L., Doerfler, L. A., & Riba, M. B. (2014). Population-based initiatives in college mental health: Students helping students to overcome obstacles. *Current Psychiatry Reports*, *16*(12), 525-533. https://doi.org/10.1007/s11920-014-0525-1

Kitzrow, M. A. (2003). The mental health needs of today's college students: Challenges and recommendations. *Journal of Student Affairs Research and Practice, 41*(1), 167-181. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.930.8512&rep=rep1&type=pdf

Knipscheer, J., Sleijpen, M., Frank, L., de Graaf, R., Kleber, R., ten Have, M., & Dückers, M. (2020). Prevalence of potentially traumatic events, their life events, and subsequent reactions indicative for posttraumatic stress disorder in the Netherlands: A general population study based on the trauma screening questionnaire. *International Journal of Environmental Research and Public Health*, *17*(5), 1725-1740. https://doi.org/10.3390/ljerph17051725

Kraft, D. (2011). One hundred years of college mental health. *Journal of American College Health*, *59*(6), 477-481. https://doi.org/10.1080/07448481.2011.569964

Krebs, C. P., Lindquist, C. H., Warner, T. D., Fisher, B. S., & Martin, S. L. (2007). *The campus sexual assault (CSA) study*. National Institute of Justice. https://doi.org/10.1037/e423412008-001

Krebs, C. P., Lindquist, C. H., Warner, T. D., Fisher, B. S., & Martin, S. L. (2016). *Campus sexual assault (CSA) study, final report (2007).* National Institute of Justice. https://biblioteca.cejamericas.org/bitstream/handle/2015/439/Campus_Sexual_Assault.pdf?sequence=1&isAllowed=y

Kuh, G. D. (2008). *Excerpt from high-impact educational practices: What they are who has access to them, and why they matter.* Association of College and Universities. http://ueeval.ucr.edu/teaching_practices_inventory/Kuh_2008.pdf

Kuh, G. D., Kinzie, J., Cruce, T., Shoup, R., & Gonyea, R. M. (2006). Connecting the dots: Multi-faceted analyses of the relationship between student engagement results from the NSSE, and the institutional practices and conditions that foster student success. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.182.2871&rep=rep1&type=pdf

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357-361. https://doi.org/10.1037/0033-3204.38.4.357

Langhinrichsen-Rohling, J., Arata, C., O'Brien, N., Bowers, D., & Klibert, J. (2006). Sensitive research with adolescents: Just how upsetting are self-reporting surveys anyway? *Violence and Victims*, *21*(4), 425-444. https://doi.org/10.1891/0886-6708.21.4.425

Lattie, E. G., Adkins, E. C., Winquist, N., Stiles-Shields, C., Wafford, Q. E., & Graham, A. K. (2019). Digital mental health interventions for depression, anxiety, and enhancement of

psychological well-being among college students: A systematic review. *Journal of Medical Internet Research*, *21*(7), Article 312869. https://doi.org/10.2196/12869

Lee, D. L., & Ahn, S. (2011). Racial discrimination and Asian mental health: A meta-analysis. *The Counseling Psychologist*, *39*(3), 463-489. https://doi.org/10.1177/0011000010381791

Lee, J. J., Gottfried, R., & Bride, B. E. (2018). Exposure to client trauma, secondary traumatic stress, and the health of clinical social workers: A mediation analysis. *Clinical Social Work Journal, 46*(3), 228-235. https://doi.org/10.1007/s10615-017-0638-1

Loo, C. M., Fairbank, J. A., & Chemtob, C. M. (2005). Adverse race-related events as a risk factor for posttraumatic stress disorder in Asian-American Vietnam veterans. *Journal of Nervous and Mental Disease*, *193*(7), 455-463. https://doi.org/10.1097/01.nmd.0000168239.51714.e6

Lynch, R. J. (2017). The development and validation of the secondary trauma in RAs scale. *The Journal of College and University Student Housing*, *44*(1), 10-29. https://tinyurl.com/Lynch2017RA

Lynch, R. J. (2019). Work environment factors impacting the report of secondary trauma in US RAs. *Journal of College & University Student Housing*, 46(1). https://digitalcommons.odu.edu/efl_fac_pubs/59/

MacRitchie, V., & Leibowitz, S. (2010). Secondary traumatic stress, level of exposure, empathy, and social support in trauma workers. *South African Journal of Psychology, 40*(2), 149-158. https://doi.org/10.1177/008124631004000204

Madathil, R., Heck, N. C., & Schuldberg, D. (2014). Burnout in psychiatric nursing: examining the interplay of autonomy, leadership style, and depressive symptoms. *Archives of psychiatric nursing*, *28*(3), 160-166. https://doi.org/10.1016/j.apnu.2014.01.002

Mahoney, M. J., & Lyddon, W. J. (1988). Recent developments in cognitive approaches to counseling and psychotherapy. *The Counseling Psychologist*, *16*(2), 190-234. https://doi.org/10.1177/0011000088162001

Maran, A., Zito, D., & Colombo, L. (2020). Secondary traumatic stress in Italian police officers: the role of job demands and job resources. *Frontiers in Psychology*, *11*, 1435-1447. https://doi.org/10.3389/fpsyg.2020.01435

Mariani, L. (1997). Teacher support and teacher challenge in promoting learner autonomy. *Perspectives: A Journal of TESOL Italy, XXIII*(2). https://tinyurl.com/Mariani1997a

Marshall, C., & Rossman, G. B. (2014). *Designing qualitative research.* Sage.

Maslach, C. (1998). A multidimensional theory of burnout. In C. L. Cooper (Ed.), *Theories of Organizational Stress*, *68-85*. Oxford. https://doi.org/10.1002/(sici)1099-1700(199910)15:4%3C259::aid-smi833%3E3.0.co;2-w

May, C. L., & Wisco, B. E. (2016). Defining trauma: How level of exposure and proximity affect risk for posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy, 8*(2), 233-240. https://dx.doi.org/10.1037/tra0000077

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, *3*(1), 131-149. https://doi.org/10.1002/jts.2490030110

McCann, I. L., & Pearlman, L. A. (1992). Constructivist self-development theory: A theoretical framework for assessing and treating traumatized college students. *Journal of American College Health*, *40*(4), 189-196. https://doi.org/10.1080/07448481.1992.9936281

McNabb, D. E., David, E. (2002). *Research methods in public administration and non-profit management: Quantitative and qualitative approaches*. ME Sharpe.

Menard, S. (1995). *Applied logistic regression analysis*. Sage.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation* (3rd ed.). Jossey-Bass.

Miller, M. K., Flores, D. M., & Pitcher, B. J. (2010). Using constructivist self-development theory to understand judges' reactions to a courthouse shooting: An exploratory study. *Psychiatry, Psychology, and Law*, *17*(1), 121-138. https://doi.org/10.1080/13218710902930309

Miranda, R., Soffer, A., Polanco-Roman, L., Wheeler, A., & Moore, A. (2015). Mental health treatment barriers among racial/ethnic minority versus white young adults six months after intake at a college counseling center. *Journal of American College Health*, *63*(5), 291-298. https://doi.org/10.1080/07448481.2015.1015024

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health Services Research, 39*(5), 341-352. https://doi.org/10.1007/s10488-011-0352-1

Moustakas, C. (1994). *Phenomenological research methods*. Sage. https://doi.org/10.4135/9781412995658

Mulfinger, N., Müller, S., Böge, I., Sakar, V., Corrigan, P.W., Evans-Lacko, S., Nehf, L., Djamali, J., Samarelli, A., Kempter, M., Ruckes, C., Libal, G., Oexle, N., Noterdaeme, M., & Rüsch, N. (2018). Honest, open, proud for adolescents with mental illness: Pilot randomized control trial. *Journal of Child Psychology and Psychiatry*, *59*(6), 684-691. https://doi.org/10.1111/jcpp.12853

Munnangi, S., Dupiton, L., Boutin, A., & Angus, L. D. (2018). Burnout, perceived stress, and job satisfaction among trauma nurses at a level I safety-net trauma center. *Journal of Trauma Nursing*, *25*(1), 4-13. https://doi.org/10.1097/jtn.0000000000000335

Murray, C. (2016). *Protecting victims in research.* Center for Victim Research. https://ncvc.dspacedirect.org/bitstream/handle/20.500.11990/957/CVR%20Quick%20Reference_victim-protections-508-2.pdf?sequence=1&isAllowed=y

Murray, J. L., Snider, B. R., & Midkiff Jr., R. M. (1999). The effects of training on RA job performance. *Journal of College Student Development*, *40*(6), 744-747.

Myers, R. H. (1990). *Classical and modern regression application* (2nd ed.). Duxbury.

Nadal, K. L. (2018). *Microaggressions and traumatic stress: Theory, research, and clinical treatment.* American Psychological Association. https://doi.org/10.1037/0000073-000

Nadal, K. L., Griffin, K. E., Wong, Y., Hamit, S., & Rasmus, M. (2014). The impact of racial microaggressions on mental health: Counseling implications for clients of color. *Journal of Counseling & Development*, *92*(1), 57-66. https://doi.org/10.1002/j.1556-6676.2014.00130.x

Nadal, K. L., King, R., Sissoko, D. G., Floyd, N., & Hines, D. (2021). The legacies of systemic and internalized oppression: Experiences of microaggressions, imposter phenomenon,

and stereotype threat on historically marginalized groups. *New Ideas in Psychology*, *63*, Article e100895. https://doi.org/10.1016/j.newideapsych.2021.100895

Newell, J. M., & MacNeil, G. A. (2010). Professional burnout, vicarious traumatic stress, and compassion fatigue: A review of theoretical terms, risk factors, and preventive methods for clinicians and researchers. *Best Practices in Mental Health: An International Journal, 6*(2), 57-68.

O'Keefe, V. M., Wingate, L. R., Cole, A. B., Hollingsworth, D. W., & Tucker, R. P. (2015). Seemingly harmless racial communications are not so harmless: Racial microaggressions lead to suicidal ideation by way of depression symptoms. *Suicide and Life-Threatening Behavior*, *45*(5), 567-576. https://doi.org/10.1111/sltb.12150

Owens, E. W. (2011). *The RA as paraprofessional counselor and crisis interventionist: A study of lived experience*. Duquesne University.

Padilla-Díaz, M. (2015). Phenomenology in educational qualitative research: Philosophy as science or philosophical science. *International Journal of Educational Excellence*, *1*(2), 101-110. https://doi.org/10.18562/ijee.2015.0009

Paladino, D. A., Murray, T. L., Newgent, R. A., & Gohn, L. A. (2005). RA burnout: Factors impacting depersonalization, emotional exhaustion, and personal accomplishment. *The Journal of College and University Student Housing*, *33*(2), 18-27. http://www.units.miamioh.edu/saf/reslife/reslife/manuals/edl301old/EDL377/Articles/Resident%20Assistant%20Burnout.pdf

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-

analysis. *Plos One*, *10*(9), Article e0138511. https://doi.org/10.1371/journal.pone.0138511

Pascarella, E. T., & Terenzini, P. T. (2005). *How college affects students: A third decade of research.* Jossey-Bass.

Patton, M. (1990). *Qualitative evaluation and research methods* Sage.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, *34*(5), 1189-1208. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1089059/pdf/hsresearch00022-0112.pdf

Pearlman, L. A. (1999). Self-care for trauma therapists: Ameliorating vicarious traumatization. In B. H. Stamm (ed.), *Secondary traumatic stress: Self-care issues for clinicians, researchers, & educators* (2nd ed., pp. 51-64). Sidran.

Pearlman, L. A. (2013). Restoring self in community: Collective approaches to psychological trauma after genocide. *Journal of Social Issues*, *69*(1), 111-124. https://doi.org/10.1111/josi.12006

Pearlman, L. A., & Mac Ian, P. S. (1995). Vicarious traumatization: An empirical study of the effects of trauma work on trauma therapists. *Professional Psychology: Research and practice*, *26*(6), 558-565. https://doi.org/10.1037/0735-7028.26.6.558

Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy and incest survivors.* W.W. Norton & Company.

Pejtersen, J. H., Kristensen, T. S., Borg, V., & Bjorner, J. B. (2010). The second version of the Copenhagen Psychosocial Questionnaire. *Scandinavian Journal of Public Health*, *38*, 8-24. https://doi.org/10.1177/1403494809349858

Perron, B. E., & Hiltz, B. S. (2006). Burnout and secondary trauma among forensic interviewers of abused children. *Child and Adolescent Social Work Journal*, *23*(2), 216-234. https://doi.org/10.1007/s10560-005-0044-3

Piaget, J. (1977). *The development of thought: Equilibration of cognitive structures.* (Trans. A. Rosin). Viking. https://doi.org/10.2307/1175382

Pierce, C. M. (1978). *Television and education.* Sage.

Pieterse, A. L., Carter, R. T., Evans, S. A., & Walter, R. (2010). An exploratory examination of the associations among racial and ethnic discrimination, racial climate, and trauma-related symptoms in a college student population. *Journal of Counseling Psychology*, *57*, 255-263. https://doi.org/10.1037/a0020040

Pieterse, A. L., Todd, N. R., Neville, H. A., & Carter, R. T. (2012). Perceived racism and mental health among Black American adults: A meta-analytic review. *Journal of Counseling Psychology*, *59*(1), 1-9. https://doi.org/10.1037/a0026208

Reingle, J., Thombs, D., Osborn, C., Saffian, S., & Oltersdorf, D. (2010). Mental health and substance use: A qualitative study of resident assistants' attitudes and referral practices. *Journal of Student Affairs Research and Practice*, *47*(3), 325-342. https://doi.org/10.2202/1949-6605.6016

Reynolds, A. L. (2009). *Helping college students*. Jossey-Bass.

Rinto, E., Watts, J., & Mitola, R. (Eds.). (2017). *Peer-assisted learning in academic libraries*. Libraries Unlimited.

Roberts, A. L., Gilman, S. E., Breslau, J., Breslau, N., & Koenen, K. C. (2011). Race/ethnic differences in exposure to traumatic events, development of posttraumatic stress disorder,

and treatment-seeking for posttraumatic stress disorder in the United States. *Psychological Medicine*, *41*, 71-83. https://doi.org/10.1017/S0033291710000401

Romans, S. E., Martin, J. L., Morris, B. A., & Herbison, G. P. (1999). Psychological defense styles in women who report childhood sexual abuse: A controlled community study. *American Journal of Psychiatry, 156*, 1080-1085.

Rotter, J. B. (1954). *Social learning and clinical psychology*. Prentice-Hall. https://doi.org/10.1037/10788-000

Rotter, J. B. (1966). Generalized expectations for internal versus external control of reinforcement. *Psychological Monograph*, *80*, 1-28. https://doi.org/10.1037/h0092976.

Roulston, K. (2010). *Reflective interviewing: A guide to theory and practice*. Sage. https://doi.org/10.4135/9781446288009

Rutter, M. (1993). Resilience: some conceptual considerations. *Journal of Adolescent Health, 14*(8), 626-631. https://doi.org/10.1016/1054-139x(93)90196-v

Saakvitne, K. W., & Pearlman, L. A. (1996). *Transforming the pain: A workbook on vicarious traumatization*. W.W. Norton & Co.

Saakvitne, K. W., Tennen, H., & Affleck, G. (1998). Exploring thriving in the context of clinical trauma theory: Constructivist self-development theory. *Journal of Social Issues*, *54*(2), 279-299. https://doi.org/10.1111/j.1540-4560.1998.tb01219.x

Salloum, A., Kondrat, D. C., Johnco, C., & Olson, K. R. (2015). The role of self-care on compassion satisfaction, burnout, and secondary trauma among child welfare workers. *Children and Youth Services Review, 49*, 54-61. https://doi.org/10.1016/j.childyouth.2014.12.023

Samuelson, K. W. (2011). Post-traumatic stress disorder and declarative memory functioning: A review. *Dialogues in Clinical Neuroscience*, *13*(3), 346-351. https://doi.org/10.31887/dcns.2011.13.2/ksamuelson

Saunders, B., Sim, J., Kingstone, T., Baker, S., Waterfield, J., Bartlam, B., Burroughs, H., & Jinks, C. (2018). Saturation in qualitative research: exploring its conceptualization and operation. *Quality and Quantity*, *52*(4), 1893-1907. https://doi.org/10.1007/s11135-017-0574-8

Schnurr, P. P., Vieillhauer, M. J., Weather, F., & Findler, M. (1999). *The brief trauma questionnaire*. National Center for Post-Traumatic Stress. https://doi.org/10.1037/t07488-000

Schreiner, L. A., Noel, P., & Cantwell, L. (2011). The impact of faculty and staff on high-risk college student persistence. *Journal of College Student Development*, *52*(3), 321-338. https://doi.org/10.1353/csd.2011.0044

Servicemen's Readjustment Act of 1944, 38 U.S.C. § 4101 *et seq.* (1944). https://www.ourdocuments.gov/doc.php?flash=false&doc=76#

Shalev, A. Y. (2002). Acute stress reactions in adults. *Biological Psychiatry*, *51*(7), 532-543. https://doi.org/10.1016/S0006-3223(02)01335-5

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63-75. https://doi.org/10.3233/efi-2004-22201

Silverman, M., & Glick, R. (2010). Crisis and crisis intervention on college campuses. In J. S. Kay & V. Schwartz (Eds.). *Mental Health Care in the College Community* (pp. 147-178). Wiley & Sons, Ltd. https://doi.org/10.1002/9780470686836.ch9

Silverstein, R. (1996). Combat-related trauma as measured by ego development indices of defenses and identity achievement. *Journal of Genetic Psychology*, *157*, 169-179. https://doi.org/10.1080/00221325.1996.9914855

Sinozich, S., & Langton, L. (2014). *Rape and sexual assault victimization among college-age females, 1995-2013.* U.S. Department of Justice. https://downloads.regulations.gov/ED-2019-OPE-0080-16937/attachment_9.pdf

Sontag-Padilla, L., Woodbridge, M. W., Mendelsohn., J., D'Amico, E. J., Osilla, K. C., Jaycox, L. H., Eberhart, N. K., Burnam, A. M., & Stein, B. D. (2016). Factors affecting mental health service utilization among California public college and university students. *Psychiatric Services*, *67*(8), 890-897. https://doi.org/10.1176/appi.ps.201500307

Sorsoli, L. (2007). Where the whole thing fell apart: Race, resilience, and the complexity of trauma. *Journal of Aggression, Maltreatment, & Trauma*, *14(*1-2), 99-121. https://doi.org/10.1300/j146v14n01_06

Sotero, M. (2006). A conceptual model of historical trauma: Implications for public health practice and research. *Journal of Health Disparities Research and Practice*, *1*(1), 93-108.

Stolzenberg, E. B., Aragon, M. C., Romo, E., Couch, V., McLenna, D., Eagan, M. K., & Kang, N. (2020). The American freshman: National norms fall 2019. *Higher Education Research Institute and Cooperative Institutional Research Program.* https://www.heri.ucla.edu/monographs/TheAmericanFreshman2019.pdf

Stoner, J. C. (2017). Revisiting RA burnout: Functions of gender, community composition, choice to continue employment, and job satisfaction. *The Journal of College and University Student Housing*, *44*(1), 30-47. https://eric.ed.gov/?id=EJ1177336

Stout, J. G., Dasgupta, N., Hunsinger, M., & McManus, M. A. (2011). STEMing the tide: Using ingroup experts to inoculate women's self-concept in science, technology, engineering, and mathematics (STEM). *Journal of Personality and Social Psychology*, *100*(2), 255-270. https://doi.org/10.1037/a0021385

Tarcan, G. Y., Tarcan, M., & Top, M. (2017). An analysis of relationship between burnout and job satisfaction among emergency health professionals. *Total Quality Management and Business Excellence*, *28*(11), 1339-1356. https://doi.org/10.1080/14783363.2016.1141659

Theofanidis, D., & Fountouki, A. (2018). Limitations and delimitations in the research process. *Perioperative Nursing*, *7*(3), 155-163. https://doi.org/10.5281/zenodo.2552022

Thompson, I., Amatea, E., & Thompson, E. (2014). Personal and contextual predictors of mental health counselors' compassion fatigue and burnout. *Journal of Mental Health Counseling*, *36*(1), 58-77. https://doi.org/10.17744/mehc.36.1.p61m73373m4617r3

Tjaden, P. G., & Thoennes, N. (1998). *Stalking in America: Findings from the National Violence Against Women Survey*. National Institute of Justice. https://doi.org/10.1037/e521072006-001

Ullman, S. E., Relyea, M., Peter-Hagene, L., & Vasquez, A. L. (2013). Trauma histories, substance use coping, PTSD, and problem substance use among sexual assault victims. *Addictive Behaviors, 38*(6). 2219-2223. https://doi.org/10.1016/j.addbeh.2013.01.027

Ungar, M. (2008). Resilience across cultures. *The British Journal of Social Work*, *38*(2), 218-235. https://doi.org/10.1093/bjsw/bcl343

Van Teijlingen, E., & Hundley, V. (2002). The importance of pilot studies. *Nursing Standards*, *16*(40), 33-36. https://doi.org/10.7748/ns2002.06.16.40.33.c3214

Vygotsky, L. S. (1978). *Mind in society: The development of higher psychological processes* (M. Cole, V. John-Steiner, S. Scribner, & E. Souberman. [Eds.]; A. R. Luria, M. Lopez-Morillas, & M. Cole [with J. V. Wertsch], Trans.).

Wall, M., & Wheeler, S. (1996). Benefits of the placebo effect in the therapeutic relationship. *Complementary Therapies in Nursing and Midwifery*, *2*(6), 160-163. https://doi.org/10.1016/s1353-6117(96)80050-3

Weathers, F. W., & Keane, T. M. (2007). The Criterion A problem revisited: Controversies and challenges in defining and measuring psychological trauma. *Journal of Traumatic Stress*, *20*(2), 107-121. https://doi.org/10.1002/jts.20210

Whiteman, S. D., Barry, A. E., Mroczek, D. K., & MacDermid Wadsworth, S. (2013). The development and implications of peer emotional support for student service members/veterans and civilian college students. *Journal of Counseling Psychology*, *60*(2), 265-278. https://doi.org/10.1037/a0031650

Widom, C. S., & Czaja, S. J. (2006). Reactions to research participation in vulnerable subgroups. *Accountability in Research*, *12*(2), 115-138. https://doi.org/10.1080/0899620590957193

Winston, R. B., & Buckner, J. D. (1984). The effects of peer helper training and timing on reported stress of RAs. *Journal of College Student Personnel, 25*, 430-436. https://psycnet.apa.org/record/1985-29164-001

Yigit, I. H., & Tatch, A. (2017). Syrian refugees and Americans: Perceptions, attitudes, and insights. *American Journal of Qualitative Research, 1*(1), 13-31. https://doi.org/10.29333/ajqr/5789

Appendix A

Research Summary Matrix

Research Questions	Constructs or Variables	Instruments	Data Collection	Data Analysis Method
RQ1: To what degree are RAs experiencing job-related secondary traumatic stress?	IV(1): Years of RA Experience IV(2): # of RA Trainings IV(3): Incidences of Trauma DV: Secondary Traumatic Stress (STS) Experience with Secondary Trauma	Survey based on Bride (2009) Individual Phenomenological Interviews (Roulston, 2010)	Qualtrics *(Once in early Fall)* Zoom *(Once following quant analysis, follow-up as needed)*	Descriptive statistics, Hierarchical Multiple regression Theoretical Thematic Analysis (Braun & Clarke, 2006)
RQ 2: What supports and barriers influence how RAs respond to secondary trauma stress?	IV(1): Personal supports and barriers (e.g., understanding of the role, job confidence, coping mechanisms, supportive work environment, job satisfaction) IV(2): Institutional supports and barriers (e.g., job autonomy, supportive supervision, faculty interactions, programs, and services) DV: Secondary Traumatic Stress (STS)	Survey based on Pejtersen et al. (2010) Individual Phenomenological interviews (Roulston, 2010)	Qualtrics Survey *(Once in early Fall)* Zoom *(once following quant analysis, follow-up as needed)*	Descriptive Statistics Hierarchical Multiple Regression Theoretical Thematic Analysis (Braun & Clarke, 2006)
RQ3: To what degree are STS and job satisfaction predictors of risk of attrition in resident assistants?	IV(1): STS IV(2): Job Satisfaction DV: Risk of Attrition	Survey based on Bride (2009) Individual phenomenological interviews (Roulston, 2010)	Qualtrics Survey *(Once in early Fall)* Zoom *(once following quant analysis, follow-up as needed)*	Descriptive Statistics Logistic Regression Theoretical thematic analysis (Braun & Clarke, 2006)

Appendix B

Secondary Trauma in RAs Survey Instrument

This survey was developed from the Secondary Traumatic Scale developed by Bride et al. (2009) and the Copenhagen Psychosocial Questionnaire developed by Pejtersen et al. (2010). For the purposes of this study, the term "employee" was changed to "RA."

Demographics Questions Part I

1. How would you classify your current academic major?
    a. Helping profession (e.g., education, psychology, nursing, or social work)
    b. Non-helping profession (e.g., mathematics, business)
2. How many semesters of experience do you have as an RA?
3. How many students live in your designated community? *Only include students living on your floor or individual building (i.e., Hand Village, Meacham Apartments, or Emerald Hill/Two Rivers).*
4. To what degree do you find your role as an RA rewarding?
    a. Very rewarding
    b. Somewhat rewarding
    c. Not rewarding nor unrewarding
    d. Somewhat Unrewarding
    e. Very unrewarding
5. How likely are you to return as an RA for the 2022-2023 academic year?
    a. Very Likely
    b. Likely
    c. Unsure
    d. Unlikely
    e. Very Unlikely
6. What factors are impacting your decision to return as an RA for the upcoming semester? (Choose all that apply)
    a. Graduation/Transferring/Withdrawing from [university name]
    b. Burnout
    c. The position is not a good fit for me/not what I expected
    d. Lack of support from friends and family
    e. Lack of support from fellow RAs/work colleagues
    f. Lack of support from supervisors
    g. Other: _____
7. To what degree has secondary traumatic stress impacted your decision?
    a. A great deal
    b. A lot
    c. A moderate amount
    d. A little
    e. None at all

Secondary Traumatic Stress Scale (Bride, 2009)

The following is a list of statements made by persons who have been impacted by their work with traumatized students. Read each statement then indicate how frequently the statement was true for you in the past **seven (7) days** by selecting the corresponding answer.

All responses use a five-point Likert-type scale (Never, Rarely, Occasionally, Often, Very Often).

1. I felt emotionally numb.
2. My heart started pounding when I thought about my work with my residents.
3. It seemed as if I was reliving the trauma(s) experienced by my residents.
4. I had trouble sleeping.
5. I felt discouraged about the future.
6. Reminders of my work with residents upsets me.
7. I had little interest in being around others.
8. I felt jumpy.
9. I was less active than usual.
10. I thought about my work with residents when I do not intend to.
11. I had trouble concentrating.
12. I avoided people, places, or things that reminded me of my work with residents.
13. I had disturbing dreams about my work with residents.
14. I wanted to avoid working with some residents.
15. I was easily annoyed.
16. I expected something bad to happen.
17. I noticed gaps in my memory about interactions with residents.
18. I experienced negative emotions.
19. I engaged in reckless or self-destructive behavior.
20. I unrealistically blamed others for the cause or consequences of trauma(s) experienced by my resident(s).
21. I had negative expectations about myself, others, or the world.

Copenhagen Psychosocial Questionnaire (Pejtersen et al., 2010)

The following questions are about your psychosocial work environment. Please choose the answer that fits best to each of the questions.

All responses use a five-point Likert-type scale (Always, Often, Sometimes, Seldom, Never).

1. How often do you get behind with your RA work?
2. How often do you not have time to complete all your RA-related tasks?
3. How often is your workload unevenly distributed so it piles up?
4. How often do you have to work very fast?
5. How often does your work put you in emotionally disturbing situations?
6. How often do you have to deal with other people's personal problems as part of your work?
7. How often does your work require that you do not state your opinion?

8. How often do you have a large degree of influence on the decisions concerning your work?
9. How often can you influence the amount of work assigned to you?
10. How often do you have any influence on what you do at work?
11. How often do you have any influence on how you do your work?
12. Can you decide when to take a break?
13. Can you take vacation, or time away, more less when you wish?
14. Can you leave your work to have a chat with a colleague?
15. If you have some private business, is it possible for you to leave your place of work for half an hour without special permission?
16. How often is your immediate supervisor willing to listen to your problems at work, if needed?
17. How often do you get help and support from your immediate supervisor, if needed?
18. How often do you get help and support from colleagues, if needed?
19. How often are your colleagues willing to listen to your problems at work, if needed?
20. Is there a good atmosphere between you and your colleagues?
21. Do you feel part of a community at your place of work?

All responses use a five-point Likert-type school (To a Very Large Extent, To a Large Extent, Somewhat, To a Small Extent, and To a Very Small Extent).

1. Do you work at ahigh pace throughout the day?
2. Is your work emotionally demanding?
3. Does your work require that you hide your feelings?
4. Are you required to be kind and open towards everyone-regardless of how they behave towards you?
5. Do you have the possibility of learning new things through your work?
6. Can you use your skills and expertise in your work?
7. Does your work give you the opportunity to develop your skills?
8. Is your work meaningful?
9. Do you feel that the work you do is important?
10. At your place of work are you informed well in advance concerning for example important decisions, changes, or plans for the future?
11. Do you receive information you need in order to do your work well?
12. Does your work have clear objectives?
13. Do you know exactly which areas are your responsibility?
14. Do you know exactly what is expected of you at work?
15. Are contradictory demands placed on you at work?
16. Do you sometimes have to do things which ought to have been done a different way?
17. Do you sometimes have to do things which seem to be unnecessary?
18. To what extent does your immediate supervisor…
    a. make sure that the members of the staff have good development opportunities?
    b. give high priority to job satisfaction?
    c. is good at work planning?
    d. is good at solving conflicts?

19. Are you worried about the schedule being changed (e.g., shifts, duty nights) against your will?
20. Are you worried about a decrease in salary?
21. Are you satisfied with the quality of work performed at your workplace?

All responses use a four-point Likert-type scale (Very Satisfied, Satisfied, Neither Satisfied nor Unsatisfied, Unsatisfied, Very Unsatisfied).

1. How pleased are you with your work prospects?
2. How pleased are you with your job as a whole, everything taken into consideration?
3. How pleased are you with your salary?

The next two questions are about the way your work affects your private life and family life.

All responses use a five-point Likert-type school (To a Very Large Extent, To a Large Extent, Somewhat, To a Small Extent, and To a Very Small Extent).

1. Do you feel that your work drains so much of your energy that it has a negative effect on your private life?
2. Do you feel that your work takes so much of your time that it has a negative impact on your private life?

The next four questions are not about your job but about the Department of Housing/Residence Life and Dining Services as a whole.

All responses use a five-point Likert-type school (To a Very Large Extent, To a Large Extent, Somewhat, To a Small Extent, and To a Very Small Extent).

1. Do employees in general trust each other?
2. Does the management trust the employees to do their work well?
3. Can the employees trust the information that comes from the management?
4. Does the management withhold important information from the employees?
5. Are the employees able to express their views and feelings?
6. Are conflicts resolved in a fair way?
7. Is work distributed fairly?

These questions are about your health and well-being during the **last four (4) weeks**.

All questions use a five-point, Likert-type scale (Excellent, Very Good, Good, Fair, Poor).

1. In general, would you say your physical health is:
2. In general, would you say your mental health is:

Demographics Questions Part II

1. Has a resident ever shared their experiences of serving in a war zone, or in a noncombat job that exposed them to war-related casualties?
    a. Yes
    b. No
2. Has a resident ever shared their experiences of having been in a serious car accident, or a serious accident at work or somewhere else?
    a. Yes
    b. No
3. Has a resident ever shared their experiences of having been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, illness-based pandemic, or chemical spill?
    a. Yes
    b. No
4. Has a resident ever shared their experiences of having a life-threatening illness such as cancer, a heart attack, leukemia, AIDs, multiple sclerosis, etc.?
    a. Yes
    b. No
5. Has a resident ever shared their experiences of being physical punished or beaten by a parent, caretaker, or teacher so that: they were frightened; or they thought they would be injured; or they received bruises, cuts, welts, lumps, or other injuries?
    a. Yes
    b. No
6. Not including those already reported in Question 5, has a resident ever shared their experiences of being attacked, beaten, or mugged by anyone including friends, family members or strangers?
    a. Yes
    b. No
7. Has a resident ever shared their experiences of someone forcing them or pressuring them into having some type of sexual contact?
    a. Yes
    b. No
8. Has a resident ever shared their experiences of being in any other situation in which they were seriously injured or feared they might be seriously injured or killed?
    a. Yes
    b. No
9. Has a resident ever shared their experiences of a close family member or friend dying violently, for example, in a serious car crash, mugging, or attack?
    a. Yes
    b. No
10. How many of each of the following types of trainings have you attended as an RA?
    a. On-Site Training
    b. Online Training
    c. RA Class during the RA hiring process
    d. In-Service Training

e. Staff Development Exercises (e.g., training activities during staff meetings)

Interview Recruitment

1. Would you be willing to participate in a 45- to 60-minute interview related to your experiences with secondary traumatic stress?
    a. Yes
    b. Maybe, but I would like more information
    c. No
2. *(Displayed if participant answers "Yes" or "Maybe, but I would like more information" to question above)* Please provide your email address for follow-up communication: ____

Appendix C

Semistructured Interview Protocol

Interview questions were developed based on the Copenhagen Psychosocial Questionnaire developed by Pejtersen et al. (2010). Note: The following questions are examples of the content that were discussed in the interviews. In the interest of creating conversational space, questions evolved during interviews.

Thank you for agreeing to be interviewed as part of this study. The purpose of this interview will be to explore phenomenon of secondary traumatic stress in RAs as well as identify possible barriers and supports to the effectively navigating secondary traumatic stress. These findings could be used to guide future training initiatives for RAs.

I want to ensure that I capture what you say accurately so I would like to record our interview with your permission. Do I have your permission to record this interview session?

General Understanding of Trauma and STS

Before we begin exploring your experiences with trauma and secondary traumatic stress, I would like to first understand your views on trauma and STS.

1. Trauma, according to some researchers, is defined as the effects of a trauma event either through direct exposure or the experiences of close friends or family members. What is your understanding of trauma?
2. Similarly, secondary traumatic stress is defined as the stress we take on when helping someone else through a traumatic event. What is your understanding of STS?

Research Question 1

Let's begin by understanding the degree to which you have experienced secondary traumatic stress as an RA. As a reminder in this study, we are defining "trauma" as the effects of one or more of the following scenarios: direct experiences with a traumatic event, witnessing a traumatic event, learning of a traumatic event experience by a close friend or family member, or experiencing first-hand repeated or extreme exposure to the details of a traumatic event, and we are defining "secondary traumatic stress" as the stress we take on when helping someone else through a traumatic event.

1. How frequently are you helping residents through traumatic situations (e.g., daily, twice a week, at least weekly)?
    a. Which types of traumatic situations do you consider to be "severe" versus "moderately severe"?
2. What STS symptoms did you experience related to helping a resident through a traumatic event?

a. *Prompt: Have you noticed any changes in your demeanor/outlook on life, daily habits (e.g., sleeping, eating), or interactions with others?*
    i. How has STS affected your mental health?
    ii. How has STS affected your physical health?
        1. *Prompt: Do you find yourself engaging in healthy/unhealthy behaviors?*

Research Question 2_A:

Next, I would like to explore any personal supports/resiliency factors that may have helped or hindered you in dealing with STS in your life. Note: During this section, the researcher will keep a list of resiliency factors discussed. This list will be used in the interview later.

1. What personal supports/resiliency factors are important in dealing with residents experiencing trauma and the aftermath in life, such as STS? *Prompt*: *coping mechanisms*
2. What personal barriers are important in dealing with residents experiencing trauma and the aftermath in life, such as STS? *Prompt: self-blame*

I would like to dive deeper into your responses on the survey. Based on your responses, it is evident that X *and* Y *factors impacting your well-being at work and STS. I would like to ask you a few questions about* X *and* Y.
Example Questions:

3. **Understanding of Role:** How would you describe your role as an RA? How does your understanding of your role as an RA relate to how you deal with STS in your life, if at all?
4. **Job Confidence:** How confident do you feel in your abilities as an RA, if at all? How does your confidence in your abilities as an RA relate to how you deal with STS in your life, if at all?
5. As we wrap up personal resiliency factors, are there other relevant personal supports or resiliency factors that we have not discussed?
    a. Do you feel as though these are less important, equally important, or more important than the other factors we have already discussed?
6. Are there other relevant personal barriers that we have not discussed?
    a. Do you feel as though these are less important, equally important, or more important than the other factors we have already discussed?

Research Question 2_B:

RAs do not operate in a bubble. There are external factors that impact your ability to do your job. I would like to transition to exploring support mechanisms/resiliency factors and barriers related to [university name] that may have played in your experiences with secondary trauma. Note: During this section, the researcher will keep a list of resiliency factors/barriers discussed. This list will be used in the interview later.

1. What institutional supports/resiliency factors are important in dealing with residents experiencing trauma and the aftermath in life, such as STS? *Prompt: faculty member, offices, or services*

2. What institutional barriers are important in dealing with residents experiencing trauma and the aftermath in life, such as STS? *Prompt: your relationship or lack thereof with faculty or services that you think are needed*

I would like to dive deeper into your responses on the survey. Based on your responses, it is evident that X and Y institutional factors impacting your well-being at work and STS. I would like to ask you a few questions about X and Y.
Example Questions:

3. **Autonomy:** Do you feel as though your job provides a lot of freedom? *Prompts*: *Are you able to choose when and how you interact with your residents? When you find you need to take time away, are you able to take time with little to no resistance?* How does your sense of freedom play a role in the manifestation of STS in your life?
4. **Supportive Supervision:** Do you feel as though you receive support from your supervisor, specifically in dealing with STS? *Prompts*: *Do they provide an opportunity for you to voice your concerns? Do you feel as though they validate your experiences with STS?* How does the quality of your supervisor play a role in the manifestation of STS in your life?
5. As we wrap up institutional supports/barriers, are there other relevant institutional supports or resiliency factors that we have not discussed? *Prompt: Do you feel as though these*
    a. Do you feel as though these are less important, equally important, or more important to what we have already discussed?
6. Are there other relevant institutional barriers that we have not discussed?
    b. Do you feel as though these are less important, equally important, or more important to the other factors we have already discussed?

Research Question 2C:

Now that we have discussed both resiliency factors and barriers individually, I would like to discuss these items as a whole. I have been compiling a list of the topics we have discussed, and I would like for us to explore them a bit further. You mentioned the following supports/resiliency factors and barriers. Note: The list from sections 2A and 2B will be provided to the participant as a reminder of the topics discussed.

1. Which are the most important in helping you deal with STS? *What helped you the most?*
2. What are the most detrimental barriers that impeded your ability to navigate STS effectively? *Thinking back on those experiences, were there ever times where you said, "I wish I had known this or had this person/resource?"*

Research Question 3:

Being an RA is a difficult job, and often people choose to the leave the position for reasons other than graduation or withdrawal from [university name]. When asked how confident you were in planning to return as an RA, you chose ___. You mentioned that X, Y*, and* Z *were reasons for your decision. I would like to explore the role STS played in your plans of returning as an RA.*

1. How did STS play a role in your decision to return or not return as an RA, if at all?
2. How satisfied are you in your roles as an RA, if at all? *Do you feel fulfilled when helping others?* Did STS play a role in your level of satisfaction?

We have discussed a lot today, and I thank you for your vulnerability and willingness to participate in this interview. You have provided great information that can be used to help future RAs. As we are wrapping up, are there other topics related to your experiences with STS that we have not discussed?

Once again, thank you for your time. I understand that you have shared experiences that may cause distressing emotions, so I have provided a list of local, regional, and national resources that may be of benefit. If you find yourself experiencing distressing emotions, I encourage you to consider contacting one of these resources. If you have any questions regarding this study, I encourage you to contact me via email at inmanz@apsu.edu or via phone at 931-221-6725.

Appendix D

Informed Consent

INFORMED CONSENT STATEMENT

Risk or Reward: The Exploration of Secondary Traumatic Stress in Resident Assistants

INTRODUCTION
The Department of Education Specialties at Austin Peay State University supports the practice of protection for human subjects participating in research. The following information is provided to help you decide whether you wish to participate in the present study. You retain the right to refuse to sign this form and not participate in this study. You should be aware that even if you consent to participate in this study, you may withdraw from this study at any time without consequence. If you choose to withdraw from this study, it will not affect your relationship with this department, the services it may provide to you, or [university name].

PURPOSE
The purposes of this study are to explore (a) the prevalence of secondary traumatic stress in RAs at a 4-year public university in the southeastern United States, (b) the personal and institutional supports and barriers that impact RAs' responses to this secondary traumatic stress, and (c) the roles secondary traumatic stress plays in RA job satisfaction.

PROCEDURES
You are being asked to participate in a survey and, potentially a follow-up interview related to your experience with the secondary traumatic stress as a resident assistant. After providing your digital signature, you will be taken to the survey. At the end of the survey, you will be asked to indicate, by providing your contact information, if you would be willing to participate in a follow-up interview. The link will be open for two weeks. A reminder email will be sent after 5 and 10 days. The survey is expected to take approximately 15-20 minutes to complete. The follow-up interview will last approximately 45 minutes.

RISKS
The risks associated with participation in this study are no greater than those encountered in daily life.

BENEFITS
Gaining an understanding of secondary traumatic stress may guide the incorporation of trauma-informed practices in RA training and supervision of RAs within the context of the study. The incorporation of trauma-informed practices could result in noteworthy gains in knowledge and understanding of trauma and improved assistance for college students who have experienced trauma. Finally, as college administrators understand the implications of trauma and implement trauma-informed principles within RA training, staff turnover due to secondary traumatic stress and burnout may decrease; thus, residential students will benefit from staff adequately trained in responding to crises.

COMPENSATION
Participants will not receive compensation.

PARTICIPANT CONFIDENTIALITY
Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Austin Peay State University Institutional Review Board. Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

REFUSAL TO SIGN CONSENT
You are not required to sign this Consent and you may refuse to do so without affecting your right to participate in any programs or events of [university name] or any services you are receiving or may receive from [university name]. However, if you refuse to sign, you cannot participate in this study.

CANCELLING THIS CONSENT
You may withdraw your consent to participate in this study at any time. If you choose to withdraw from the study before data collection is completed, any collected data will be destroyed and not used.

QUESTIONS ABOUT PARTICIPATION
If you have any questions about the procedures, you may direct them to the principal investigator, Zachary W. Inman.

CONSENT
I have read the above information and received a copy of this form. I have had the opportunity to ask questions regarding my participation in this study. I agree to take part in this study as a research participant.

By my digital signature I affirm that I am at least 18 years old.

_____
Print Participant's Name Date

_____
Participant's Signature Date

RESEARCHER CONTACT INFORMATION

Primary Investigator: Zachary W. Inman
Email: inmanz@apsu.edu
Phone: 270-303-5551

Faculty Advisor: Dr. Sherri Prosser
Email: prossers@apsu.edu
Phone: 270-303-5551

IRB Contact Information
Dr. Harold Young, Chair
Beth Hoilman, IRB Assistant
irb@apsu.edu | (931) 221-7881

Appendix E

Austin Peay State University Institutional Review Board Approval

AUSTIN PEAY STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD

Date: 1 0 /03/2021

IRB 21-040: Risk or Reward: The Exploration of Secondary Traumatic Stress in Resident Assistants

Dear Dr. Prosser and Mr. Inman,

We appreciate your cooperation with the human research review process. This letter is to inform you that the study **21-040** was reviewed on an expedited level. It is my pleasure to inform you that your application to amend has been approved.

This approval is subject to APSU Policies and Procedures governing human subject research. The IRB reserves the right to withdraw approval if unresolved issues are raised during the review period. Any changes or deviations from the approved protocol must be submitted in writing to the IRB for further review and approval before continuing.

The approval remains for one calendar year and a closed study report or request for continuing review is required on or before the original expiration date of 9/30/2022. If you have any questions or require further information, you can contact me by phone (931-221-7059) or email (youngh@apsu.edu).

Sincerely,

H.A. Young
Harold 'Harry' Young

Chair, APIRB

Appendix F

Participant Recruitment Email

Dear prospective study participant,

My name is Zach Inman, and I am a doctoral candidate at Austin Peay State University.
I am writing this email to invite you to participate in a research study regarding your experiences with secondary traumatic stress as an RA. As RAs, you are often tasked with supporting students through various life experiences, including trauma. However, we may rarely stop to understand the effects of trauma on ourselves. The purpose of this study is to examine the role secondary traumatic stress has played in your views of being an RA.

The study has been reviewed and received ethics clearance through Austin Peay State University Institutional Review Board.

This study will be conducted during fall of 2021. During that time, I will collect and analyze data related to your exposure to secondary traumatic stress. If you agree to participate, you will be asked to complete a survey using Qualtrics, which is expected to take 10-15 minutes. Your survey responses will be anonymous unless you indicate you would be willing to participate in a follow-up interview, in which case you would be asked to provide a contact email address.

Your participation in this study is entirely voluntary. If you choose to participate in the study, you can stop your participation at any time. Participation or non-participation will have no bearing on your evaluations as an RA or future employment. Furthermore, any information you provide during the study will not be shared with your supervisors.

By participating in this study, you will provide insights into the phenomenon of secondary traumatic stress in RAs as well as identify possible barriers and supports to the effectively navigating secondary traumatic stress. Furthermore, this study explores the role of secondary traumatic stress and job satisfaction in risk of attrition. These findings could be used to guide future training initiatives for RAs.

If you are interested in participating, please complete the survey linked below. This survey includes an informed consent document for your review. As previously mentioned, if you are interested in participating in a follow up interview, you may indicate your interest at the end of the survey.

Thank you very much for your consideration. If you have any questions regarding this study or the consent document, please contact me via email at inmanz@apsu.edu.

Sincerely,
Zachary W. Inman
Functional Support Specialist
Department of Housing/Residence Life and Dining Services – Miller 121
Austin Peay State University

Name and address of the faculty advisor:
Dr. Sherri Prosser
Assistant Professor, Doctor of Education Program
Austin Peay State University, Eriksson College of Education
601 College Street, Clarksville, TN 37044

Appendix G

Mental Health Resources Handout

Mental Health Resources

Thank you for your participation in this study. Talking about your experiences may have been difficult or they may lead you to experience feelings that can be distressing. If this happens, we encourage you to speak to someone, such as your current therapist or mental health care provider.

You may also contact one of these resources:

APSU Student Counseling Services - This office provides direct care services to APSU students including individual counseling, drop-in counseling, and group support. This service is available M-F 8 a.m. – 4:30 p.m. CST.
P: 931-221-6162 E: counselingservices@apsu.edu

Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Referral Helpline – This service provides free information for individuals facing mental or substance use disorders. The SAMHSA Treatment Referral Helpline provides referrals to local treatment facilities, support groups, and community-based organizations. This service is available 24 hours per day, 365 days per year.
P: 1-800-662-HELP (4357)

National Alliance on Mental Illness (NAMI) Helpline – The NAMI helpline provides support and resources for individuals experiencing mental health concerns. This service is available M-F 9 a.m. – 7 p.m. CST.
P: 1-800-950-NAMI (6264) E: info@nami.org

Crisis Text Line – The Crisis Text Line provides support through a variety of crises including anxiety, depression, eating disorders, suicidal ideation, and self-harm. This service is available 24 hours per day, 365 days per year. To utilize this service, text HOME to 74171.

Once again, thank you for your involvement in this study. The information you provided will help to improve the experiences of other resident assistants and the resident assistant program.