

2017

The Development and Validation of the Secondary Trauma in Resident Assistants Scale

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Original Publication Citation

Lynch, R. J. (2017). The development and validation of the secondary trauma in resident assistants scale. *The Journal of College & University Student Housing*, 44(1), 10-29.



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The Development and Validation of the Secondary Trauma in Resident Assistants Scale



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SECONDARY TRAUMATIC STRESS has been described as “the stress resulting from helping or wanting to help a traumatized or suffering person” (Figley, 1999, p. 10). College resident assistants often serve as first-responders to students who have experienced traumatic life events such as severe mental illness, substance abuse, sexual violence, and hate crimes. To date, the literature has not thoroughly addressed the impact of providing this level of support on collegiate resident assistants. This study aimed to explore one possible outcome identified in individuals in other helping professions: secondary traumatic stress. The researcher set out to develop and validate an instrument that may aid in understanding four symptoms associated with secondary trauma within U.S. college resident assistants, as indicated in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V): negative alteration of mood or cognition, arousal and reactivity, avoidance, and intrusive thoughts. Results indicated a four factor model representing internal and external manifestations of negative alteration of mood or cognition, avoidance, and intrusive thoughts. Arousal and reactivity did not emerge as a factor and was therefore excluded. Implications for future research and practical applications are discussed.

Acknowledgements: Thank you to the following individuals for their contribution to the development of this instrument: Chris Glass (Old Dominion), Monica Esqueda (Old Dominion), Dan St. John (Old Dominion), Matt Birnbaum (University of Northern Colorado), Jonathan O'Brien (CSU-Long Beach), Ashley Staples (Ohio State), Marney Randle (UC Berkeley), Bryan Thomas, Jr. (Drake), Kirby Gibson (Syracuse), Andrew Wells (UGA), Jill Zalewski (Duke), Victoria Kaestner (UC Berkeley), Carmen Jovel (UC Berkeley), Blaine Jones (UC Berkeley), Eliza Suppal (UC Berkeley), and Brett Price (UT Knoxville).

Despite more than four decades of studies listing crisis intervention and peer counseling as aspects of the RA portfolio, few studies have explored how such responsibility impacts the mental health of these students, who are often traditional-age undergraduates themselves.

College resident assistants (RAs) working at U.S. colleges and universities have played a vital role in student support, safety, and development for decades (Aamodt, Keller, Crawford, & Kombrough, 1981; Reingle, Thombs, Osborn, Saffian, & Oltersdorf, 2010). The RA position can be very challenging but can also be a rewarding leadership experience on campus (Owens, 2011). Students in this role are frequently charged with a number of administrative responsibilities, the development of their residential communities, and service as crisis first-responders, peer counselors, and disciplinarians. These tasks make the choice to become an RA a serious commitment (Aamodt et al., 1981; Conlogue, 1993; Owens, 2011). Given the scope of RA duties, leaders in residential living have invested considerable resources in maximizing the effectiveness of RA staffs and their impact on residential students (Grosz, 2008; Thombs, Reingle Gonzalez, Osborn, Rossheim, & Suzuki, 2015). Unfortunately, current literature reflects a limited understanding of the impact that the job has on students serving as RAs.

Within the last decade, the number of students who have reported experiencing various psychological traumas has greatly increased (American College Health Association, 2016; Center for Collegiate Mental Health, 2016), which puts additional strain on already under-resourced campus counseling centers. Campus-based traumas vary in nature, but some of the most frequent include loss of loved ones, anxiety, depression, psychosis, and sexual violence (Silverman & Glick, 2010). Suicide remains a leading cause of death on college and university campuses (Suicide Prevention Resource Center, 2014). Although staff

and administrators are ultimately responsible for the protocols meant to support students experiencing trauma, college resident assistants not only bear the burden of being first-responders, but also the responsibility of living in the same building as the trauma victim and others impacted in their residential communities. Current research in other helping professions such as social work, counseling, and K-12 education has indicated that repeated exposure to those experiencing trauma can have deleterious effects on those who provide help and support (Baird & Kracen, 2006; Bride, Robinson, Yegidis, & Figley, 2004; Hydon, 2015). This negative impact on the mental health of caregivers is known as secondary traumatic stress (Figley, 1999). To date, student affairs scholars have yet to extensively study this phenomenon. This study aimed to address the gap in the literature by investigating this phenomenon within college resident assistants through development of the Secondary Trauma in Resident Assistants Scale (STRAS). This scale was intended to explore four symptoms of secondary traumatic stress as identified in the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-V): negative alteration of mood and cognition, arousal and reactivity, avoidance, and intrusive thoughts.

Specifically, this study explored the following research questions. To what extent are the instrument and its subscales internally consistent? To what extent do the instrument and its subscales correlate with measures of related and unrelated variables? To what extent do individual items of the instrument represent the factors of intrusive thoughts, avoidance, negative alterations of mood or cognition, and arousal and reactivity?

COLLEGE STUDENT TRAUMA AND THE RESIDENT ASSISTANT

Research investigating psychological trauma is relatively new, yet campus leaders have long grappled with the impact of trauma within college student populations (Farber, 1970; Robertson, 1966; Thwing, 1926). This section serves to situate the reader within an ongoing debate about the boundaries of traumatic events, especially as they relate to the collegiate environment, as well as the implications of trauma support within helping professions, specifically through the perspective of college resident assistants.

Trauma, Secondary Trauma, Burnout, and Compassion Fatigue

Contemporary study of psychological trauma is a relatively new endeavor, beginning in the 1970s, although healthcare providers began recognizing the long-term impacts of trauma as early as the turn of the 20th century (Jones & Wessely, 2006). It was not until 1980 that post-traumatic stress disorder (PTSD) was included in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1980; Weathers & Keane, 2007). Since then, scholars and practitioners have intensely debated factors and contexts that mark the boundaries of trauma as opposed to everyday hardships (Harvey, 1996; May & Wisco, 2016; Weathers & Keane, 2007). Early definitions of trauma were opaque at best, identifying a traumatic event as “a recognizable stressor that would evoke significant symptoms of distress in almost everyone” (Weathers & Keane, 2007, p. 108). Scholars and practitioners also attributed negative trauma reactions to preexisting, or related, mental health disorders (Jones & Wessely, 2006).

In recent years, mental health professionals have pushed for a more nuanced view of how trauma impacts individuals. Harvey (1996) advocated for an ecological perspective, recognizing the nuanced interplay between the event, the environment, and the individual. Other scholars have taken a critical-race approach to understanding trauma (Franklin, Boyd-Franklin, & Kelly, 2006; Sorsoli, 2007). For instance, Franklin et al. (2006) explored the psychological trauma that occurs as a consequence of racism experienced by people of color in the U.S. Given the diversity of traumatic experiences that college students face, this study defines trauma as “the unique individual experience of an event or enduring conditions, in which the individual’s ability to integrate his/her emotional experience is overwhelmed, or the individual experiences (subjectively) a threat to life, bodily integrity, or sanity” (Pearlman & Saakvitne, 1995, p. 60).

More specifically, this study centers on the ripple effect of trauma within one group of caregivers: college resident assistants. McCann & Pearlman (1990) identified this phenomenon as vicarious trauma. Figley (1999) continued this line of inquiry, using the term secondary traumatic stress. According to his research, secondary traumatic stress may be described as “the stress resulting from helping or wanting to help a traumatized or suffering person” (p. 10). Although not mentioned by the same name, secondary traumatic stress is mentioned in the DSM-V under qualifications for PTSD, with an important caveat that symptoms must manifest as a result of an individual’s vocation (American Psychiatric Association, 2013).

Finally, before exploring specific traumas and their impact on caregivers, it should be acknowledged that the terms compassion fatigue, burnout, and secondary traumatic stress are often conflated. While in essence they all describe the impact of an individual's work on their mental health, burnout may be considered a broader description of the impact of job stress, while secondary trauma and compassion fatigue are associated specifically with work with individuals who have experienced trauma (Deville, Wright, & Varker, 2009; Newell & MacNeil, 2010). Perhaps one of the most simplistic distinctions between these phenomena is the association of burnout with the feeling of exhaustion, while compassion fatigue and secondary trauma may be associated with symptoms of PTSD (Deville et al., 2009).

Further distinctions may be drawn between compassion fatigue and secondary traumatic stress, often conflated as the same phenomenon. Contemporary scholars have begun to treat secondary trauma as the distinct impact of working with trauma victims, with compassion fatigue treated as a synonym of burnout and secondary trauma (Cieslak et al., 2014; Stamm, 2010).

Trauma on College and University Campuses

Some of the most recognizable traumas that U.S. collegians experience include severe mental health episodes, sexual assault, or hate-based incidents. This is not surprising given reports suggesting that 1 in 5 women are sexually assaulted while in college, disorders such as schizophrenia and bipolar disorder typically manifesting in college-age individuals, and the expansive literature citing the struggles of students of color (Fisher, Cullen, & Turner,

2000; Joyce, 1984; Pieterse, Carter, Evans, & Walter, 2010). Furthermore, a recent national survey of more than 600 U.S. student affairs professionals identified the five most frequent traumas they support students through as the death of a loved one, sexual violence, suicidal ideation/attempt, severe mental health episodes, and hate crimes/discrimination (Lynch & Glass, 2017). Given the widespread nature of traumatic events in higher education institutions, campus leaders are quickly finding that their institutions lack the professional capacity to meet the needs of these students (Kraft, 2011; Silverman & Glick, 2010). One way they have addressed this issue is relying on peer counseling and increased first-responder training for college RAs. Unfortunately, administrators seem to have given little thought to the fact that RAs are students themselves, and RA peer counseling and first response work has potentially negative psychological impacts on them (Grosz, 2008; Owens, 2011; Reingle et al., 2010; Thombs et al., 2015).

RAs as Peer Counselors and Crisis Interventionists

As the frequency and complexity of college student trauma increases, university leaders have been forced to be creative in their response to this phenomenon while also facing national budget crises in higher education. Since early iterations of the RA position emerged on U.S. campuses in the early 20th century, these students have acted in the role of peer counselor and crisis interventionist (Upcraft & Pilato, 1982). Job preparation in this area has mirrored changes in the counseling needs of students, as trainings have become more focused on issues such as suicide intervention, prevention of drug and alcohol abuse,

and protocols for responding to sexual assault (Grosz, 2008; Reingle et al., 2010; Thombs et al., 2015). Even before the advent of today's collegiate trauma epidemics, Conlogue (1993) reported that RAs perceived crisis management and campus resource referrals as the two most important aspects of their positions. Interestingly, the same study found that RAs gained the most personal satisfaction from their role as peer counselor and crisis interventionist. Despite more than four decades of studies listing crisis intervention and peer counseling as aspects of the RA portfolio, few studies have explored how such responsibility impacts the mental health of these students, who are often traditional-age undergraduates themselves.

Past decades of research have explored the impact of job responsibilities on RAs but have centered mainly on factors attributed to burnout or job attrition (Deluga & Winters, 1990; Gardner, 1987; Paladino, Murray, Newgent, & Gohn, 2005). Three consistent factors in these studies included workload, gender, and inadequate training. Recently, Owens (2011) extended this area of investigation by exploring the psychological impact of crisis management on undergraduate RAs through an in-depth phenomenological study illustrating the lived experiences of these student leaders. His study uncovered themes related to the impact of training programs, the role of the Internet in contemporary peer counseling, protective factors, and the experience of emotion. Although this study provided an excellent introduction to the lived experiences of RAs through their role as crisis interventionists and peer counselors, the sample size and methodology did not lend to information that may be generalizable to the larger population

of resident assistants.

The present study builds on the work of Owens (2011), as well as that of Bride et al. (2004), by quantitatively exploring the concept of secondary traumatic stress in U.S. college resident assistants. In the sections that follow, I have described the process of developing the instrument, results related to the validity and reliability of the instrument, and its potential use for scholars and practitioners.

INSTRUMENT DEVELOPMENT

The instrument was inspired by the Secondary Traumatic Stress Scale developed by Bride et al. (2004). Their scale primarily focused on professionals within the field of social work and was theoretically based on information from the DSM-IV; therefore, it was prudent to adapt the scale to fit an undergraduate population of U.S. resident assistants using criteria from the updated DSM-V. This scale was also developed as a parallel study seeking to develop a scale to measure secondary traumatic stress in U.S. college student affairs professionals (Lynch & Glass, 2017).

Development of the instrument began with personal narratives gathered from former RAs who have supported residents through a variety of traumas. Behaviors and dispositions were extrapolated from the narratives that were consistent with secondary traumatic stress symptomologies identified within the DSM-V and developed as items for the initial instrument. These items were then reviewed for content validity by a panel of 15 individuals representing higher education scholars, resident directors, former RAs, and other leaders within college housing and residence life.

Upon completion of the panel review, two items related to social media use were added and four items were removed from the survey, leaving an instrument composed of 33 content items plus a number of demographic items. The survey instrument was then distributed to a pilot sample of RAs across the U.S. Pilot distribution procedures and results are described in the following sections.

PARTICIPANT RECRUITMENT AND SELECTION

During the summer of 2016, participants were recruited by sending an email to directors, associate directors, and resident directors of housing and residence life programs from 437 colleges and universities across the U.S., asking them to forward the email to student staff who served as resident assistants or in similar positions. In total more than 500 individuals were contacted to distribute the survey instrument. Participants were required to be student employees serving in the capacity of resident assistant or in a similar position and having more than one full semester of experience. A resident assistant was defined as a student employed by the college or university to live in a residence hall in order to provide peer guidance, community development, emergency response, and administrative support.

PILOT DISTRIBUTION

Using Qualtrics Survey Software, a link was embedded in recruitment emails leading to an electronic form containing the instrument. Participants electronically acknowledged their informed consent by reading and selecting their decision to agree on the first page of the electronic form. Participants were also asked

to acknowledge that they understood that the nature of the survey might cause some psychological discomfort and that they were aware of a list of psychological resources that was provided for them in the electronic form.

PARTICIPANT DESCRIPTION

In total 208 individuals participated in the pilot distribution of the instrument. This sample size fits standards used for factor analysis using a subject-to-item ratio of 5:1 (Costello & Osborne, 2005; DeVellis, 2011). All participants were full-time undergraduate students serving as a resident assistant or in a comparable position at a four-year accredited college or university and having at least one complete semester of RA experience. Participants represented a range of backgrounds, but the majority of students in the sample identified as White (70.7%), Straight (76.4%), Female (56.3%), or Third-Year Student (47.6%). Additionally, most students were attending public universities (73.6%), were within their first year as an RA (47.1%), and were responsible for communities ranging from 20 to 40 undergraduate residents (63.5%). Table 1 summarizes participant demographic information.

MEASURES

Independent Variables

Types of trauma(s) supported. Participants reported the types of traumas that they have helped their residents through via a predetermined list of the most frequent crises experienced by college students (Silverman & Glick, 2010). Response options included hate crimes and discrimination; domestic violence; sexual violence; physical assault; robbery; life-threatening illness or injury; witness to

Table 1

Participant Demographic Information (N = 208)

	<i>n</i>	<i>%</i>		<i>n</i>	<i>%</i>
Gender identity			Primary major		
Man or male or masculine	73	35.1	Arts & Humanities	15	7.2
Woman or female or feminine	117	56.3	Biological Sciences	36	17.3
Non-binary*	2	1.0	Business	24	11.5
Prefer not to answer	16	7.7	Education	23	11.1
Race			Engineering	14	6.7
African American or Black	13	6.3	Physical Science	10	4.8
Asian	3	1.4	Professional Studies	9	4.3
Latinx or Hispanic or Chicax	10	4.8	Social Sciences	27	13.0
American Indian or Alaska Native or Indigenous or First Nations	2	1.0	Other	38	18.3
Pacific Island Native	2	1.0	Prefer not to answer	12	5.8
South Asian	2	1.0	Institution type		
Multiracial or Biracial	4	1.9	Public	153	73.6
White or Caucasian or European American	147	70.7	Private	37	17.8
Prefer not to answer	25	12.0	Prefer not to answer	18	8.7
Sexual orientation			Length of RA service		
Straight	159	76.4	1-2 semesters	98	47.1
Gay or lesbian	9	4.3	3-4 semesters	71	34.1
Bisexual	5	2.4	5-6 semesters	22	10.6
Other**	8	3.8	7-8 semesters	10	4.8
Prefer not to answer	27	13.0	More than 8 semesters	2	1.0
U.S. region			Prefer not to answer	5	2.4
Northeast	19	9.1	Number of residents		
South	58	27.9	Less than 20	7	3.4
Midwest	76	36.5	20-40	132	63.5
West	49	23.6	41-60	49	23.6
No response	6	2.9	61-80	13	6.3
Academic standing			81-100	3	1.4
First year	1	0.5	More than 100	3	1.4
Second year	25	12.0	Prefer not to answer	1	0.5
Third year	99	47.6	* Non-binary includes transgender, gender non-conforming, gender queer, intersex, fluid, agender, and other related terms. ** "Other" encompasses fluid, asexual, pansexual, queer, and questioning. Although these categories represented varied experiences, they were condensed for analytical purposes.		
Fourth year	64	30.8			
Fifth (or more) year	9	4.3			
Graduate student	5	2.4			
Prefer not to answer	5	2.4			



Some of the most recognizable traumas that U.S. collegians experience include severe mental health episodes, sexual assault, or hate-based incidents.



traumatic event; suicidal ideation, attempt, or completion; severe mental health episode such as schizophrenic episodes and anxiety/panic attacks; death of a loved one; natural or man-made disasters such as tornados and fires; mental or physical injury from military combat; eating disorder; economic hardship such as homelessness and hunger; substance abuse; and family issues such as abuse and divorce (Silverman & Glick, 2010).

Frequency of support. Participants reported the frequency of their support of students who have experienced traumas by responding to the question, “On average, how often do you support students who have experienced trauma?” Participants selected *never, about once a year, a few times a year, about once a month, a few days a month, a few days a week, or about every day*.

Secondary trauma self-efficacy (STSE). The 7-item STSE scale used a Likert-type 6-point scale (1 = *untrue*; 2 = *somewhat untrue*; 3 = *slightly untrue*; 4 = *slightly true*; 5 = *somewhat true*; and 6 = *true*) to measure the extent to which the respondent felt capable of managing various emotions while working with traumatized

students: feeling anger, sadness, and anxiety; handling distressing thoughts about traumatized students; finding some meaning in what happened to traumatized students; and coping with thoughts of not being able to support students who experienced trauma anymore. This scale was modified for a residential student staff context from the scale measuring self-efficacy in social workers used by Cieslak, Luszczyńska, Taylor, Rogala, and Benight (2013).

Dependent Variables

Participants made their selections based on a 6-point Likert scale (1 = *untrue*; 2 = *somewhat untrue*; 3 = *slightly untrue*; 4 = *slightly true*; 5 = *somewhat true*; and 6 = *true*) for each of the four dimensions of secondary traumatic stress with items adapted from existing measures of symptoms of secondary trauma (American Psychiatric Association, 2013; Bride et al., 2004).

Changes in arousal and reactivity (AR).

The AR items measured the extent to which supporting students experiencing trauma had left resident assistants with feelings of hypervigilance, jumpiness, or irritability.

Negative alteration of mood or cognition (NAM).

The NAM items measured the extent to which supporting students experiencing various traumas had left RAs feeling drained, discouraged about the future, emotionally numb, or less interested in being around other people.

Avoidance (AVD).

The AVD items measured the extent to which supporting students experiencing various traumas had left RAs avoiding people, places, or things that reminded them of their work with students; avoiding working with some students, if pos-

sible; or avoiding aspects of their job that reminded them of interactions with students.

Intrusive thoughts (INT). The INT items measured the extent to which supporting students experiencing various traumas had left RAs unintentionally thinking about their support of students who experienced trauma, feeling tense when thinking about supporting students who experienced trauma, or unable to stop thinking about the details of the trauma the student shared.

DATA ANALYSIS

For the initial validation of the instrument, exploratory factor analysis (EFA) was used. This technique explores relationships between variables but does not assume a predetermined number of factors. The sample for EFA comprised 208 individuals ($N = 208$). Researchers applied an oblique rotation, more specifically a Direct Oblimin rotation, due to anticipated factors stemming from established frameworks regarding secondary traumatic stress (Costello & Osborne, 2005; DeVellis, 2011; MacCullum, Widaman, Zhang, & Hong, 1999). The researcher then used a Maximum Likelihood Analysis to condense the original 33-item instrument into a series of linear uncorrelated components (Costello & Osborne, 2005). In order to determine reliability of the instrument, and its subscales, Cronbach alphas were calculated.

Whereas EFA attempts to reveal a set of latent factors from a set of variables, confirmatory factor analysis (CFA) begins with the assumption of a fixed number of latent factors. In this study, CFA was used to investigate a first order set of latent variables using results of the EFA: NAMEX, NAMIN, AVD, and INT. After

performing the CFA, the four latent factors were then used for a second CFA, assuming that the four latent factors would reveal an additional second order latent factor: Secondary Traumatic Stress (STS). The CFA sample was composed of the same sample used for exploratory factor analysis ($N = 208$). The literature reflects a debate regarding the appropriateness of using the same participant sample for CFA and EFA, but for the purposes of this study, the sample was not split as the participant-to-item ratio would have been greatly diminished (Costello & Osborne, 2005; Van Prooijen & Van Der Kloot, 2001).

Finally, to illustrate discriminant and convergent validity, the researcher used bivariate correlations to investigate the relationship between the results of the instrument pilot and the results of the adapted Secondary Trauma Self-Efficacy scale (STSE), as well as the average amount of time each participant reported supporting students in crisis. Findings from these analyses are presented below.

RESULTS

Table 2 summarizes the frequency with which sampled resident assistants supported students through a traumatic event, as well as the frequency of particular types of traumatic events. Of the types of student traumas listed, sampled resident assistants responded that the most frequently reported types of trauma were death of a loved one (56.7%); family issues (46.2%); suicidal ideations, attempts, or completions (43.3%); and severe mental health episodes (36.1%). Additionally, nearly a third of respondents reported responding to student crises as frequently as once a month to every day.

Table 2

RA Experiences with Trauma Support (N = 208)

	<i>n</i>	<i>%</i>
Most frequent types of trauma		
Death of a loved one	118	56.7
Family issue	96	46.2
Suicidal ideation, attempt, or completion	90	43.3
Severe mental health episode	75	36.1
Hate crimes & discrimination	73	35.1
Sexual violence	62	29.8
Witness to traumatic event	47	22.6
Life-threatening illness or injury	41	19.7
Substance abuse	40	19.2
Eating disorder	37	17.8
Domestic violence	33	15.9
Economic hardship	33	15.9
Robbery	25	12.0
Physical assault	23	11.1
Military combat mental or physical injury	8	3.8
Natural or man-made disaster	5	2.4
Most frequent types of training addressing trauma support		
Summer RA training	159	76.4
Staff meetings	141	67.8
Spring RA training	134	64.4
In-service training	129	62.0
Online training	63	30.3
No formal training	0	0.0
Average time supporting students experiencing trauma		
Never	20	9.6
Once a year	40	19.2
Few times a year	87	41.8
Once a month	32	15.4
Few days a month	19	9.1
Few days a week	9	4.3
Every day	1	0.5
Prefer not to answer	1	0.5

Table 3 displays the results of the exploratory factor analysis (EFA). Researchers used multiple criteria when determining the number of factors to retain. Factor retention was determined using the criterion of eigenvalue greater than 1.00. Item retention was determined using items that produced factor weights above .30 and factors that had a minimum of three items (DeVellis, 2011; Henson & Roberts, 2006). Results indicated a four factor model consistent with the DSM-V post-traumatic stress disorder symptoms of intrusive thoughts and avoidance. The symptom of arousal and reactivity was excluded, while dividing the symptom of negative alteration in mood and cognition into two factors. These two factors were described as external (NAMEX) and internal (NAMIN), with items clustered in relation to their orientation to the external self and the inner self. Communalities ranged from .41 to .97. Additionally, all subscales resulted in satisfactory alpha levels, between .88 and .89, with the overall instrument reflecting an alpha of .94.

Table 4 illustrates results of the confirmatory factor analysis. Results demonstrated a model of reasonable fit using root mean square of error approximations (RMSEA), comparative fit indices (CFI), and chi-square values (Hooper, Coughlan, & Mullen, 2008). Analyses indicated that the data adequately fit within the first order model, $X^2(246) = 453.88$, $p < .01$, CFI = .92, RMSEA = .07. Analyses also indicated that the data adequately fit the second order model, $X^2(248) = 457.08$, $p < .01$, CFI = .92, RMSEA = .07.

Table 3

STRAS Exploratory Factor Analysis Results

Item	INT	NAMEX	AVD	NAMIN	STRAS	Communalities
1 ...feeling as if I was reliving the trauma experienced by residents	0.55					0.41
2 ...feeling tense when I thought about work with traumatized residents	0.47					0.53
3 ...feeling my heart pound when I thought about residents who experienced trauma	0.80					0.69
4 ...having trouble completing class assignments because I kept thinking about the residents' trauma	0.49					0.61
5 ...having distressing flashbacks of working with residents experiencing trauma	0.66					0.62
6 ...having disturbing dreams about my work with traumatized residents	0.57					0.56
7 ...unintentionally thinking about my support of residents who experienced trauma	0.52					0.49
8 ...less physically active than usual		-0.41				0.57
9 ...less interested in being around other people		-0.38				0.63
10 ...interacting less with residents		-0.72				0.67
11 ...interacting less with friends		-0.93				0.97
12 ...avoiding working with some residents, if possible			-0.82			0.69
13 ...avoiding people, places, or things that remind me of my support of residents			-0.74			0.69
14 ...avoiding aspects of my job that remind me of interactions with residents			-0.79			0.68
15 ...avoiding thinking about details of residents' traumatic experiences			-0.63			0.51
16 ...avoiding interacting with residents in general			-0.77			0.63
17 ...feeling empty				0.74		0.64
18 ...feeling emotionally numb				0.71		0.63
19 ...feeling drained				0.42		0.42
20...feeling generally discouraged about the future				0.50		0.62
21 ...feeling guilt related to the event the traumatized resident experienced				0.45		0.48
22...feeling hopeless				0.75		0.69
Eigenvalue	11.86	2.60	1.62	2.57		
% variance explained	35.94	7.89	4.90	2.57	51.3	
Cronbach's ∞	0.89	0.88	0.89	0.88		0.94

Table 4

STRAS Confirmatory Factor Analysis Results

	RMSEA	CFI	df	χ²	df/χ²
First order latent variable analysis	0.07	0.92	246	453.88	1.85
Second order latent variable analysis	0.07	0.92	248	457.08	1.84

**p* < .001

Table 5

Scale and Subscale Bivariate Correlation Matrix

Item	Mean	Max	SD	1	2	3	4	5	6
1 NAMEX scale	2.90	6.00	1.30	-					
2 AVD scale	2.00	5.83	1.20	0.48	-				
3 NAMIN scale	2.21	6.00	1.32	0.67	0.53	-			
4 STSE scale	5.11	6.00	0.82	-0.34	-0.39	-0.37	-		
5 INT scale	2.53	6.00	1.24	0.62	0.58	0.70	-0.32	-	
6 STRAS	2.40	5.52	1.05	0.79	0.78	0.86	-0.42	0.90	-
7 Average time spent supporting students	3.10	7.00	1.25	0.23	0.24	0.28	-	0.27	0.31

**p* < .001

Finally, Table 5 provides a summary of bivariate correlations between the instrument, its subscales, the Secondary Trauma Self-Efficacy scale, and frequency of RA support of residents. Results indicated a moderate significant negative correlation between the instrument ($\alpha = 0.94$) and the STSE scale ($\alpha = 0.83$) scores, $r(206) = -.42, p < .01$. Results also indicated a moderate significant positive correlation between the instrument ($\alpha = 0.94$) and the amount of time RAs reported supporting residents, $r(206) = .31, p < .01$.

DISCUSSION

Through this study, the researcher aimed to create and assess the validity and reliability of an instrument meant to measure symptoms associated with secondary traumatic stress within a population of U.S. college resident assistants. After the pilot of the initial 33-item instrument, 11 items were removed from the scale due to low factor loadings or low communalities. EFA also indicated a four factor structure with strong internal validity measur-

ing intrusive thoughts (INT), avoidance (AVD), and internal and external indicators of negative alteration of mood and cognition (NAMIN and NAMEX). This model differs from the four symptoms described within the DSM-V, indicating that items meant to measure the fourth symptom, arousal and reactivity, may need revision or that the resident assistants in this study may not express criteria associated with this symptom. Confirmatory factor analysis supported the model derived from EFA, indicating four latent variables: AVD, INT, NAMEX, and NAMIN. Secondary analysis of the first order latent variables indicated an additional second order latent variable: secondary trauma.

Furthermore, current scholarship regarding secondary traumatic stress suggests a negative relationship between a professional helper's self-efficacy and their self-reported levels of secondary trauma, as well as a positive correlation between the helper's caseload and self-reported levels of secondary trauma (Cieslak et al., 2013; Newell & MacNeil, 2010). Given this, the researcher sought to illustrate discriminant validity by testing the relationship between the instrument and the STSE scale and convergent validity between the instrument and the amount of time RAs reported supporting students (Cieslak et al., 2013). As anticipated, results mirrored those of the existing literature. This may suggest the development of self-efficacy as a buffer to secondary trauma, and RAs spending more time supporting students in crisis may increase their risk of secondary traumatic stress.

Using DeVellis (2011) as a guide for scale development, this instrument was created through a systematic process resulting in a robust tool that measures indicators of second-

ary traumatic stress in U.S. college resident assistants. The next sections describe limitations of this instrument and offer suggestions for how the instrument may be used in future scholarship and practice.

LIMITATIONS

Before discussing the theoretical and practical applications of this study, it is important to consider the scope and limitations associated with the data. Primarily, scholars and practitioners should understand that this instrument was not intended to be used as a diagnostic tool. Only a formally trained mental health provider can diagnose mental health disorders. Given that traumatic stress symptomatology can exist alongside other mental health disorders, it is also possible that this instrument may be measuring symptoms of other underlying psychological ailments. Instead, this instrument should be used as a tool to better understand individual, or organizational, dispositions framed within the context of symptoms associated with secondary traumatic stress.

Costello and Osborne (2005) offer a number of criteria recommended for sample sizes in exploratory factor analysis, which this sample met. It should be acknowledged that no national datasets exist to compare this population to the entire resident assistant population in the U.S.; therefore, generalizing the results of this study should be done with caution. It should also be noted that most participants identified as heterosexual (76.4%), White (70.7%), and woman/female/feminine (56.3%) and were from public universities (73.6%), had one year of experience (47.1%), and were in the third year (47.6%) of their undergraduate education.

Additionally, while the sample population size fits the criteria for factor analysis and care was taken to recruit a diverse range of RAs, results should be interpreted tentatively as it is possible that self-selection bias impacted the sample. For instance, RAs who have had more experience supporting students through trauma may have decided to participate, or RAs with more experience supporting residents may have avoided participation due to the risk of psychological distress resulting from recalling their experiences.

Finally, Worthington and Whittaker (2006) suggest completing confirmatory and exploratory factor analysis with independent samples as best practice for scale development. Given the size of the sample in this study, the researcher chose to complete the confirmatory and exploratory factor analysis using the same sample of RAs (Van Prooijen & Van Der Kloot, 2001).

IMPLICATIONS

The results of this study have the potential for having long-term and wide-ranging impacts on the understanding of secondary traumatic stress within college resident assistants and U.S. higher education. The findings of this study also support current literature regarding secondary traumatic stress in helping professions, while also expanding our understanding of this phenomenon in part-time positions within a sample of undergraduate college students.

USES OF THE INSTRUMENT

Resident Assistants

College students balance multiple responsibilities and roles both on and off campus.

Resident assistants are no different and are frequently asked to balance these responsibilities with a myriad of additional tasks, leaving little time to pause to reflect on their own health and wellness. The instrument may be used as a means to allow RAs to intentionally reflect on their own mental health, as well as a way to put words to thoughts and feelings they may experience after supporting residents through crisis events. As RAs reflect, they may be able to use a common language to provide peer support or to address concerns with supervisors during one-on-one meetings.

RA Supervisors

From a constructivist developmental lens, supervisors of resident assistants may consider using this tool to create a common language to understand RA experiences of secondary traumatic stress. Using the subscales, and the instrument as a whole, supervisors may be able to proactively address and process issues with RAs throughout the academic year or as a means of group processing during staff meetings or one-on-one meetings. Using the instrument with a collective staff may also help supervisors know when to increase levels of support for staff throughout the year if they are indicating high levels of secondary trauma. RAs should be surveyed at either regular intervals or at least approximately one month after their support of a student in crisis, in order to monitor any potential long-term psychological impacts.

Departmental Leaders

Results of this study may also be of use for departmental leaders in university housing functional areas. In particular, department leaders and policy makers may use the tool to take an

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Given the widespread nature of traumatic events in higher education institutions, campus leaders are quickly finding that their institutions lack the professional capacity to meet the needs of these students.

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in-depth look at how the RA role is impacting their student staff. Resulting information may help leaders redefine the role of the RA on college and university campuses or inform hiring practices for live-in student staff. For instance, job descriptions may include a statement regarding required counselor evaluation on a periodic basis or at least immediately following support of a major trauma within an RA's community.

Future Scholarship

Although the results of this study take a step in illustrating the experience of secondary traumatic stress in U.S. college resident assistants, there is still much left to understand about this phenomenon. The instrument provides a tool to extend future scholarship in regard to the intersection of student trauma and peer support. Examples may include repeated measures studies identifying the impact of various training interventions on instrument results or longitudinal studies to better understand patterns of secondary traumatic stress. The instrument may also be used as a template for the creation of related instruments to investigate secondary trauma in undergraduate or graduate

peer-support roles such as orientation leaders, TRiO mentor programs, or First-Year Experience mentor programs. This instrument may also be useful in comparative studies using quality of life measures such as the ProQOL (Stamm, 2010). Finally, given the homogeneity of this study's sample, future studies should be conducted to investigate secondary trauma as it applies to diverse demographics.

CONCLUSION

College resident assistants in the United States are often called upon as first-responders to crises that many professionals themselves would consider challenging, at best. For decades, scholars and practitioners in higher education have invested a great deal of time and resources in understanding how to develop the full capacity of resident assistants in order to most effectively meet the needs of an ever evolving student body. Yet few scholars and practitioners have called attention to the potential impact of the resident assistant's work on the individual student. Those that do often frame their discussion around the concept of burnout or job attrition. One overarching goal of this study was to call attention to a potentially detrimental impact identified in many helping professions that has yet to be explored within the resident assistant role: secondary traumatic stress. The researcher's primary goal was to develop an instrument that allows scholars and practitioners to identify key symptoms related to secondary trauma.

The results of this study yielded a tool that indicates standard criteria associated with the validity and reliability of a survey instrument. Additionally, the results of the pilot survey also painted a poignant, yet informative, portrait

of the phenomenon of secondary traumatic stress in U.S. college resident assistants. Policy makers and leaders affiliated with collegiate residential living programs are encouraged to use this study to begin conversations regarding the well-being of their student staff, as well as about how to mitigate unintended, but potentially hazardous, outcomes associated with the important work of resident assistants across the United States.

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Discussion Questions

1. The Development and Validation of the Secondary Trauma in Resident Assistants Scale
2. The author states that “unfortunately, administrators seem to have given little thought to the fact that RAs are students themselves, and RA peer counseling and first response work has potentially negative psychological impacts on them.” Do you agree with this statement? Why/why not?
3. Do you think the findings would be any different if the sample were predominately or exclusively male students? Students of color? RAs with more than one year of experience?
4. What other student roles/positions on a typical campus might be affected by secondary trauma resulting from working with others?
5. As noted by the author, RAs as frontline responders have been greatly impacted by the increase in serious psychological challenges associated with the college population they serve. Discuss contemporary training ideas that you have utilized to prepare RAs for the crisis management aspect of their work.
6. The author identifies RAs as crisis “first-responders.” Do you agree with this terminology, and how might use of this comparison influence perceptions of RAs’ feelings towards the degree of responsibility associated with this task?
7. The author notes that the RA role has become more stressful as mental health issues have become more pronounced in the college setting. Through a student development lens, discuss your thoughts on RAs’ capacity to effectively respond to psychological trauma. And associated with this, in your opinion, should RAs be tasked with responding to incidents involving psychological trauma, or should such response be delegated to professional housing/residence life staff?
8. This article describes the validation of an instrument that can measure symptoms associated with secondary traumatic stress in RAs. Given the discussion of its limitations, would you make the decision to use this tool with student staff? Why/why not?

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