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WORKING WITH TRAUMATIZED INDIVIDUALS can have potentially negative impacts on professional support personnel, including cognitive decline, increased anxiety, and declines in physical health. Despite the responsibilities of resident assistants as crisis-responders, few studies explore how they are impacted by secondary trauma. This study sought to understand how specific aspects of the RA work environment relate to their self-reported levels of secondary trauma. Using a sample of RAs (*N* = 208), the researcher conducted a quantitative secondary analysis of an existing dataset assessing symptoms of secondary traumatic stress in RAs. Findings indicated relationships between a variety of environmental factors and self-reported symptoms of secondary trauma. Findings also suggested that the type of trauma students experienced impacted RAs' self-report of secondary trauma.

Secondary traumatic stress . . . has been linked to a number of negative occupational outcomes such as anxiety and depression, low self-worth, decreased productivity, and increased physical maladies.

The number of students experiencing one or more traumatic life events during their collegiate career has steadily increased on college and university campuses (Center for Collegiate Mental Health, 2017), and recent research has indicated a marked increase in the rate and magnitude of the traumas experienced by students (Locke & Stauffer, 2015). Nearly half of college counseling centers across the U.S. have indicated an increase in the number of students they serve and in the severity of their conditions (Gallagher, 2014). One study found that 60% of sampled students have been exposed to events that met criteria for trauma under definitions found in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) (Read, Ouimette, White, Colder, & Farrow, 2011). While sexual violence (Gallagher, 2014), discrimination (U.S. Department of Education, 2016), and severe mental health disorders (Center for Collegiate Mental Health, 2017) are common types of student traumas, there are many more. The most frequent crises or traumas that students may face are (a) loss of loved ones, (b) academic crisis, (c) severe economic hardships, (d) suicidal ideation and behavior, (e) anxiety, depression, and psychosis, (f) eating disorders, (g) impulse control, (h) physical or emotional trauma such

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as domestic and sexual violence, (i) natural or man-made disasters, and (j) substance abuse (Lynch, 2017; Silverman & Glick, 2010).

Whether surviving a catastrophic weather event, losing a loved one, or experiencing homelessness, students need the support of higher education helping professionals and paraprofessionals (Dickey, 2016; Fisher, Cullen, & Turner, 2000; Silverman & Glick, 2010). Traditionally, this support would occur within campus counseling centers, yet reports from the Center for Collegiate Mental Health (2017) signify that need is outpacing college counseling centers' ability to serve students. Because of the potential for a long wait in a counseling center and their proximity and established relationships with students, resident assistants (RAs) often find themselves providing first-response support and resources for students experiencing trauma (Canto, Cox, Osborn, Becker, & Hayden, 2017; Reingle, Thombs, Osborn, Saffian, & Oltersdorf, 2010; Thombs, Gonzalez, Osborn, Rossheim, & Suzuki, 2015).

Emerging scholarship has illuminated the potentially negative impacts that trauma support work may have on RAs (Stoner, 2017; Taub, Johnson, & Calhoun, 2016), specifically the potential for developing secondary traumatic stress (Lynch, 2017; Owens, 2011; Sorenson, 2018). Although research in other helping professions has identified a number of work environment factors that may increase the risk of developing secondary trauma (Hensel, Ruiz, Finney, & Dewa, 2015), there is a gap in understanding if these factors hold true for RAs. The present study addresses this gap by investigating the following research questions: How do specific aspects of the RA work envi-

With the rate of students reporting a traumatic experience outpacing institutional capacity for professional counseling, RAs may be called upon to manage the needs of residents experiencing trauma until they receive professional help.

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ronment impact their self-reported symptoms of secondary traumatic stress, and do specific types of trauma differentially impact the self-report of secondary trauma symptoms in RAs? Through understanding the answers to these questions, housing leaders and supervisors may create organizational environments that better support RAs who respond to students experiencing trauma.

SECONDARY TRAUMA AND THE RESIDENT ASSISTANT

Resident assistants have been identified as paraprofessionals (Koch, 2016; Lynch 2017; Owens 2011) who often come to the role due to their desire to give advice, serve as a student resource, and improve the lives of their peers (Boone, 2018). Burnout has been well documented as a potential hazard of engaging in the work asked of RAs (Hardy & Dodd, 1998; Onofrietti, 2000; Paladino, Murray, Newgent, & Gohn, 2005; Stoner, 2017; Taub et al., 2016). Yet scholars in other helping professions have also identified secondary traumatic stress as an outcome of trauma support work (Crumpei

& Dafinoiu, 2012; Devilly, Wright, & Varker, 2009; Lynch, 2017; Shoji et al., 2015; Sorenson, 2018). Secondary traumatic stress may be defined as "the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley, 1999, p. 10).

Symptoms of Secondary Trauma

Secondary trauma has been linked to a number of negative occupational outcomes such as anxiety and depression, low self-worth, decreased productivity, and increased physical maladies (Figley, 1999; Shoji et al., 2015). Although not mentioned by name, secondary trauma is captured within the DSM-V under criteria for post-traumatic stress disorder or PTSD (American Psychiatric Association, 2013). Using the DSM-V framework, secondary traumatic stress may be identified as the interplay among four specific symptom groups, as well as a number of other factors. These four symptom groups include the following:

- *Intrusion:* The degree to which the trauma victim's experience unintentionally penetrates the caregiver's day-to-day thoughts.

- *Negative alteration to mood and cognition:* The degree to which a caregiver may experience forgetfulness, exaggerated

. . . supporting residents experiencing suicidal ideation was found to have the most significant impact on RA self-reported levels of secondary trauma.

expectations of themselves or others, distancing from others, and persistent negative emotional states.

- *Changes in arousal and reactivity:* The degree to which a caregiver may experience self-destructive behaviors, sleep issues, inability to concentrate, and aggression or irritability.

- *Avoidance:* The degree to which a caregiver avoids thoughts, places, people, or other things that may remind them of their work with trauma victims.

It is important to note that any mental health disorder, including trauma-induced stress disorders, can only be diagnosed by a licensed mental health professional.

Factors Impacting the Development of Secondary Trauma

Scholarship in social work, counseling, nursing, and K-12 education has identified a number of factors that may contribute to the development, or mitigation, of secondary traumatic stress (Baird & Kracen, 2006; Cieslak et al., 2013; Crumpei & Dafinoiu, 2012; Rzeszutek, Partyka, Golab, & Ronald, 2015). These factors may be broadly categorized as personal factors and work environment factors. Personal factors that may increase the likelihood for developing secondary trauma include empathetic dispositions (Crumpei & Dafinoiu, 2012), personal trauma history (Baird & Kracen, 2006), and possession of one or more historically marginalized identities (Connally, 2012; Sorsoli, 2007). Additionally, a caregiver's belief that they are able to support trauma victims and cope with the demands of their work, i.e., self-efficacy, has been linked

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> . . . supporting students witnessing a traumatic event or experiencing severe mental health issues, the death of a loved one, and an eating disorder were also found to impact self-reported secondary trauma.

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to reduced occurrences of secondary trauma (Cieslak et al., 2013; Lynch, 2017).

While personal factors may explain individual characteristics that may predispose caregivers to secondary trauma, a number of work environment factors have been found to impact the development of secondary trauma. For instance, helping professionals who identified strong networks reported lower traumatic stress responses (Rzeszutek et al., 2015). Within this framework, supportive supervisors have also been identified as a crucial mechanism for prevention of secondary trauma (Lynch, 2017; Sorenson, 2018). Finally, specific factors related to trauma support have been found to correlate with self-reported secondary trauma, including cumulative trauma exposure, the average time spent supporting a traumatized individual, and the level of training associated with managing secondary trauma (Hensel et al., 2015; Newell & Nelson-Gardell, 2014).

With the rate of students reporting a traumatic experience outpacing institutional capacity for professional counseling (Association for University and College Counseling Center Directors, 2017), RAs may be called upon to manage the needs of residents expe-

riencing trauma until they receive professional help (American College Health Association [ACHA], 2015). Research in other helping professions has identified secondary trauma as a negative byproduct of trauma support work, but this phenomenon has received little attention within the context of RA work. To date, there is little research within the collegiate housing literature that explores how work environment factors, specifically trauma support responsibilities, may impact the development of secondary trauma in RAs. This study addresses this gap by analyzing the results of a survey that aimed to better understand the nature of secondary trauma within RAs.

THE SECONDARY TRAUMA IN RESIDENT ASSISTANTS SCALE

This study was a secondary analysis of a 2016 study that sought to develop and validate the *Secondary Trauma in Resident Assistants Scale* (STRAS) (Lynch, 2017). This scale is meant to measure symptoms of secondary traumatic stress in college resident assistants. The original survey was administered electronically using Qualtrics software during the summer of 2016 to a purposeful sample of resident assistants from across the country ($N = 208$). Participants were required to be an undergraduate student and a current resident assistant slated for employment during the fall 2016 semester. They were also required to have had at least one full semester of RA experience.

A total of 33 items were included in the original administration of the survey, each mapping to one of four symptoms associated with traumatic stress disorders defined within the 5th edition of the *Diagnostic and Statistical Manual for Mental Disorders* (DSM-V). These

symptoms included the following: arousal and reactivity, intrusion, avoidance, and negative alteration to mood or cognition (American Psychiatric Association, 2013). Participants rated items using a 6-point Likert scale: 1 = completely untrue, 6 = completely true.

METHODS

Dependent Variables

The five scales of the STRAS instrument were used as the dependent variables for this study and included intrusion ($\propto$ = .89), avoidance ($\propto$ = .89), negative alteration to mood and cognition-internal ($\propto$ = .88), negative alteration to mood and cognition-external ($\propto$ = .88), and secondary traumatic stress ($\propto$ = .94). Lynch (2017) contains a complete list of items associated with the STRAS instrument.

Intrusion (INT). This scale measured the extent to which a particular trauma incident unintentionally remains in an RA's day-to-day consciousness. Participants rated items such as "Supporting students who have experienced various traumas has left me feeling as if I was reliving the trauma experienced by residents."

Avoidance (AVD). This scale measured the extent to which an RA avoids people, places, and thoughts related to their support of residents experiencing trauma. Participants rated items such as "Supporting students who have experienced various traumas has left me avoiding working with some residents, if possible."

Negative alteration to mood or cognition-external (NAMEX). This scale measured the extent to which an RA's work has negatively impacted their relationships with others and their interactions with the external world. Participants rated items such as "Supporting stu-

dents who have experienced various traumas has left me less physically active than usual."

Negative alteration to mood or cognition-internal (NAMIN). This scale measured the extent to which an RA's work has negatively impacted their thought processes and emotions. Participants rated items such as "Supporting students who have experienced various traumas has left me feeling empty."

Secondary traumatic stress (STRAS). This scale uses an average of all items from the subscales INT, AVD, NAMEX, and NAMIN to create a composite secondary traumatic stress score between 1 and 6, with 1 indicating lesser magnitudes of self-reported symptoms of secondary trauma and 6 indicating higher magnitudes of self-reported symptoms.

Independent Variables

Several independent variables related to the RA work environment were used to assess the impact of trauma support work on resident assistants. These included RA caseload, experience, training, trauma type, and volume of trauma support.

RA caseload. Other helping professions have reported caseload as a potential catalyst for secondary traumatic stress (Hensel et al., 2015). RA caseload was measured by asking participants to select the number of residents they directly serve in their floor community. They selected from a 6-point Likert scale ranging from 1 = less than 20, 2 = 20–40, 3 = 41–60, 4 = 61–80, 5 = 81–100, and 6 = more than 100.

RA experience. Other helping professions have reported length of service as a potential catalyst for secondary traumatic stress (Siegfried, 2008). RA experience was measured by asking participants to select the number of

semesters they have served as a resident assistant. They selected from a 5-point Likert scale ranging from 1 = 1-2 semesters, 2 = 3–4 semesters, 3 = 5–6 semesters, 4 = 7–8 semesters, and 5 = more than 8 semesters. Summer sessions were counted as one semester.

RA training type. Self-efficacy has been identified as a buffer for professional helpers against secondary traumatic stress (Cieslak et al., 2013; Lynch, 2017). Training may aid in developing RAs' ability to build confidence in their ability to support others through trauma. Participants were asked to select any of the following trainings in which they participated: summer RA training, staff meetings, spring RA training, in-service training, online training, and no formal training.

RA trauma type. Severity of trauma has been identified as a potential factor for developing trauma-related mental illness (May & Wisco, 2016). Participants were asked to indicate all trauma types for which they have supported a resident. Options included death of a loved one; family issues (divorce, child abuse, etc.); suicidal ideation, attempt, or completion; severe mental health episode (anxiety attack, schizophrenia, severe depression, etc.); hate crimes and discrimination; sexual violence; witness to traumatic event; substance abuse; life-threatening illness or injury; eating disorders; domestic violence; economic hardship; robbery; physical assault; military combat mental or physical injury; natural or man-made disasters; or other.

Sum of trauma types. As previously mentioned, RAs are often asked to provide the first response to a diverse array of traumas. Cumulative exposure to trauma has been found

to be related to the development of secondary traumatic stress (Baird & Kracen, 2006). To assess this, an additional variable, sum of trauma types, was created by adding together the number of individual trauma types indicated by the RA trauma type variable.

Average amount of trauma support. The amount of time a professional helper spends supporting trauma victims has been found to impact levels of secondary trauma (Hensel et al., 2015). Participants were asked to select the average amount of time in which they engaged in trauma support work per year. Options included never, once a year, a few times a year, once a month, a few days a month, a few days a week, every day, and prefer not to answer.

Data Analysis

IBM SPSS Version 23 was used to analyze the dataset. Independent samples t-tests were used to investigate differences in the means of categorical variables on the STRAS and its subscales. Eta squared values were calculated to measure the effect size of any differences. A Bonferroni adjustment ($p < .003$) was applied to account for Type 1 error. Additionally, bivariate correlations were used to investigate the relationship between continuous variables dealing with work environment factors.

RESULTS

Table 1 summarizes the demographic characteristics of the participants.

Results of Bivariate Correlations for Work Environment and STRAS Scale and Subscales

Table 2 summarizes the results of the bivariate correlations between selected work factors, the STRAS, and its subscales. Results indicated that

as the types of trauma support in which an RA engaged increased, the higher were their self-reported rates of secondary trauma. Additionally, the more time an RA dedicated to supporting residents through trauma, the more their self-reported rates of secondary trauma increased.

Results also demonstrated a positive relationship between the number of semesters RAs serve in their role and the sum of trauma types for which they have supported residents. This indicated that, over time, RAs may be more likely to encounter a variety of trauma types.

Table 1

Participant Demographic Data

	n	%		n	%
Gender identity			**Institution type**		
Man or male or masculine	73	35.1	Public	153	73.6
Woman or female or feminine	117	56.3	Private	37	17.8
Non-binary*	2	1.0	Prefer not to answer	18	8.7
Prefer not to answer	16	7.7	**Length of RA service**		
Race			1-2 semesters	98	47.1
African American or Black	13	6.3	3-4 semesters	71	34.1
Asian	3	1.4	5-6 semesters	22	10.6
Latinx or Hispanic or Chicanx	10	4.8	7-8 semesters	10	4.8
American Indian or Alaska Native or Indigenous or First Nations	2	1.0	More than 8 semesters	2	1.0
Pacific Island Native	2	1.0	Prefer not to answer	5	2.4
South Asian	2	1.0	**Number of residents**		
Multiracial or biracial	4	1.9	Less than 20	7	3.4
White or Caucasian or European American	147	70.7	20-40	132	63.5
Prefer not to answer	25	12.0	41-60	49	23.6
Sexual orientation			61-80	13	6.3
Straight	159	76.4	81-100	3	1.4
Gay or lesbian	9	4.3	More than 100	3	1.4
Bisexual	5	2.4	Prefer not to answer	1	0.5
Other**	8	3.8	**U.S. region**		
Prefer not to answer	27	13.0	Northeast	19	9.1
Academic standing			South	58	27.9
First year	1	0.5	Midwest	76	36.5
Second year	25	12.0	West	49	23.6
Third year	99	47.6	No response	6	2.9
Fourth year	64	30.8			
Fifth (or more) year	9	4.3			
Graduate student	5	2.4			
Prefer not to answer	5	2.4			

*Non-binary includes transgender, gender non-conforming, gender queer, intersex, fluid, agender, and other related terms.
** "Other" category encompasses fluid, asexual, pansexual, queer, and questioning. Although these categories represented varied experiences, they were condensed for analytical purposes.

Table 2

Results of Bivariate Correlations for Work Environment Factors, STRAS Scale, and Subscales

	M	SD	INT	NA MEX	NA MIN	AVD	STRAS	Sum of trauma types
Sum of trauma types	3.88	2.83	.41	.35	.38	.38	.46	-
Average amount of trauma support work per year	3.10	1.25	.27	.23	.28	.24	.31	-
Number of semesters of RA service	1.75	.91	-	-	-	-	-	.30

Note. p < .001

. . . helping professionals who identified strong networks reported lower traumatic stress responses. Within this framework, supportive supervisors have also been identified as a crucial mechanism for prevention of secondary trauma.

No significant relationship existed between the STRAS, or its subscales, and the number of semesters of RA service, diversity of training types, number of residents in the RA's community, or the average amount of time RAs serve on-call per year.

Results of Independent Samples *t*-Test for Trauma Types

Results indicated a number of statistically significant differences between RAs who supported students through specific types of traumas versus those who did not. Table 3 summarizes the results of the independent samples *t*-tests for specific trauma types that reached statistical significance. In sum, RAs who supported residents who had witnessed a traumatic event or who had experienced suicidal ideation, a severe mental illness, the death of a loved one, or an eating disorder reported higher average scores across the STRAS and its subscales. RAs supporting residents who had experienced suicidal ideation resulted in the largest difference in STRAS average scores compared to RAs who had not engaged in this type of support.

Scholarship in other helping professions has demonstrated that training focused on building awareness of secondary traumatic stress can help to mitigate the development of this phenomenon.

Table 3

Results of *t*-Test Comparing RA Support of Specific Student Trauma with STRAS Scale and Subscales

	Yes			No					
	M	*SD*	*n*	*M*	*SD*	*n*	*t*	*df*	Eta²
Trauma type									
INT scale									
Witness to traumatic event	3.10	1.47	47	2.33	1.09	140	-3.29	63.9	.06
Suicidal ideation, attempt, or completion	2.92	1.32	90	2.16	1.03	97	-4.36	168.2	.09
Severe mental health episode	2.92	1.33	75	2.26	1.10	112	-3.54	137.6	.06
Death of a loved one	2.78	1.30	117	2.11	1.00	70	-3.98	174.1	.08
Eating disorder	3.15	1.38	37	2.38	1.16	150	-3.49	185.0	.06
NAMEX scale									
Witness to traumatic event	2.82	1.46	47	2.01	1.22	140	-3.39	68.6	.06
Eating disorder	2.79	1.52	37	2.08	1.24	150	-3.00	185.0	.05
NAMIN scale									
Suicidal ideation, attempt, or completion	3.25	1.35	90	2.50	1.11	97	-4.13	173.1	.08
Severe mental health episode	3.21	1.34	75	2.62	1.19	112	-3.14	185.0	.05
AVD scale									
Suicidal ideation, attempt, or completion	2.32	1.37	90	1.65	0.83	97	-4.09	144.6	.08
STRAS scale									
Witness to traumatic event	2.91	1.24	47	2.23	0.92	140	-3.45	63.9	.06
Suicidal ideation, attempt, or completion	2.75	1.13	90	2.08	0.85	97	-4.57	165.5	.10
Severe mental health episode	2.73	1.12	75	2.18	0.94	112	-3.58	185.0	.06
Death of a loved one	2.60	1.10	117	2.06	0.87	70	-3.50	185.0	.06
Eating disorder	2.97	1.24	37	2.26	0.95	150	-3.25	46.9	.05

Note. p < .003 (Bonferroni adjustment)

DISCUSSION

Despite warnings that their paraprofessional counseling and intervention may negatively impact RAs' well-being (Lynch, 2017; Owens, 2011; Sorenson, 2018; Stoner, 2017), there is a dearth of empirical investigation that explores how trauma support and intervention is related to RA development of secondary traumatic stress. Through this investigation I sought to better understand how RA work environment factors related to self-reported symptoms of

secondary traumatic stress. Results were significant in that they provided evidence that the types of trauma support in which an RA engages, as well as the duration of their support, play a meaningful role in their self-reported levels of secondary traumatic stress. In particular, supporting residents experiencing suicidal ideation was found to have the most significant impact on RA self-reported levels of secondary trauma. Given that suicide continues to be a leading cause of death on college and university campuses (Suicide Prevention Resource Center, 2014) and that RAs are often expected to act as a resource for residents experiencing suicidal ideation (Grosz, 2008; Taub & Servaty-Seib, 2011), it follows that this type of support may be of particular concern for RA supervisors and housing leaders. Additionally, supporting students who witness a traumatic event or experience severe mental health issues, the death of a loved one, or an eating disorder was also found to impact self-reported secondary trauma.

Given that suicide continues to be a leading cause of death on college and university campuses and that RAs are often expected to act as a resource for residents experiencing suicidal ideation, it follows that this type of support may be of particular concern for RA supervisors and housing leaders.

Overall, the findings of this study extend the work of Owens (2011) and Sorenson (2018) by exploring secondary trauma using specific symptomologies and environmental factors such as trauma type and time spent engaging in trauma support work. Findings also extend research focused on the negative impact of RA work, particularly burnout (Hardy & Dodd, 1998; Paladino et al., 2005; Stoner, 2017), by framing secondary trauma as another potential outcome. It is worth noting that no relationship existed between secondary trauma and diversity of training types, length of RA service, number of residents, or average amount of time spent on-call. This finding may underscore the importance of trauma type, cumulative trauma exposure, and trauma support duration as factors to focus on when investigating or addressing this issue among RAs. Additionally, this finding highlights the ubiquitous nature of secondary trauma given the lack of concentrated reports in senior RAs versus new RAs or among RAs with varying amounts of on-call responsibilities.

Practical Implications

Findings from this study may have significant implications for RA training and RA supervision.

Resident assistant training. Scholarship in other helping professions has demonstrated that training focused on building awareness of secondary traumatic stress can help to mitigate the development of this phenomenon (Bercier, 2013). Leaders in housing and residence life who are involved with RA training initiatives should incorporate sessions focused on secondary trauma during summer and winter RA trainings, as well as in-service trainings throughout the year, in order to promote the

. . . greater attention should be given to tracking RA interactions with residents experiencing trauma. . . . Items that may be tracked include number of student trauma cases, the type of trauma support in which the RA is engaged, and estimated amount of daily or weekly time devoted to trauma support work.

well-being of their RA staffs. Trainings may focus on building awareness of the impact of trauma; trauma events associated with higher reports of secondary trauma; boundary setting, particularly for RAs who may engage in higher levels of trauma support; clear expectations regarding the emotional labor components of the RA position; and resources available for student staff experiencing negative impacts related to trauma support work.

Results of this study indicated that an RA's length of service did not relate to self-reported symptoms of secondary trauma; therefore, only training new RAs may not be enough to ensure that RAs do not develop secondary trauma. Instead, trainings may be differentiated based on new and returning RA needs. New RA training may focus on the theory and symptomology of secondary traumatic stress, while also creating personal wellness plans (Sansbury, Graves, & Scott, 2015) to combat the development of secondary trauma. Training for returning RAs should briefly review topics covered in new RA training but focus more on

debriefing them in terms of their past experiences supporting students through trauma and revising personal wellness action plans.

Finally, in-service interventions may take the form of support groups or debriefing sessions for RAs who have found themselves supporting residents through traumatic life events, particularly those identified in this study as having differential impacts on the development of secondary trauma. While support groups need not be led by certified mental health counselors, group facilitation trainings or partnerships with other offices such as the college counseling center should be considered before engaging in such activities.

Resident assistant supervision. Previous scholarship has indicated that positive supervisory relationships are related to reduced reports of secondary trauma in RAs (Sorenson, 2018). The results of this study may assist supervisors, and departmental leadership, in identifying specific ways they may provide support to RA staff. Perhaps most importantly, greater attention should be given to tracking RA interactions with residents experiencing trauma. Given that a number of work-related factors were demonstrated to be related to self-reported symptoms of secondary trauma, tracking trauma support engagement may provide supervisors with real-time information to make proactive interventions. Tracking may occur in a variety of ways, from formal surveys of RAs to informal inquiries during individual or group meetings. Items that may be tracked include number of student trauma cases, the type of trauma support in which the RA is engaged, and estimated amount of daily or weekly time devoted to trauma support work.

Supervisors may also engage RAs in regularly scheduled coaching conversations regarding boundary setting for those who have higher caseloads of students experiencing trauma or work with a greater sum of trauma types. Departmental leaders should consider creating or revising policies regarding RA caseload and support of students experiencing trauma. Policies may include mandatory screening by the campus counseling center, or contracted counselor, for RAs who engage in certain types of trauma support or reach a particular threshold of time spent supporting students.

Future Scholarship

This study focused on a limited number of work environment factors that may influence development of secondary trauma. Other work factors including level of supervision, perceived organizational support, and organizational culture may be considered in future studies. Additionally, scholars have suggested that personal characteristics, including race, gender, and sexual orientation, play a role in stress responses in other helping professions (Adams, Boscarino, & Figley, 2006; Connally, 2012; Sorsoli, 2007). Future research may consider how personal factors, in addition to work environment factors, may impact development of secondary trauma in RAs.

Furthermore, RAs are often part of larger teams who work together to provide student support in terms of community development. One outcome of secondary trauma is a sense of isolation or lack of social support (Hensel et al., 2015). Scholars have also demonstrated the positive impact of normalizing negative feelings associated with trauma support work through peer and professional support interventions (Bercier, 2013). Future studies may focus on the impact of secondary trauma within the context of RA teams, investigating the impact of secondary trauma on team dynamics or vice versa.

Limitations

This study is not without limitations, and results should be considered in light of these constraints. Most notably, this study was conducted using a relatively small sample size, potentially restricting generalizability of findings. This limitation is also compounded as there is no recorded description of the national population of college and university resident assistants for comparison. Additionally, the instrument used in this investigation, the *Secondary Trauma in Resident Assistants Scale*, is limited in that it is *not* meant to diagnose secondary trauma; and the prior existence of other mental health disorders, such as depression and anxiety, may have impacted responses to specific items. The STRAS is also restricted in the ability to analyze specific aspects of training or types of trauma, which may have impacted responses on the survey. Finally, while this study suggests a relationship between trauma support work and secondary traumatic stress in RAs, this study was not designed to infer causative relationships.

CONCLUSION

Supporting students who have experienced trauma has increasingly become a part of student support roles in the U.S. (Lynch, 2017; Lynch & Glass, 2018; Read et al., 2011). Often viewed as paraprofessional helping staff, RAs are given tremendous responsibility, yet, as students themselves, they may experience harm as a result of their duties. Other helping professions have indicated how trauma support work may lead to potentially hazardous out-

comes, including secondary traumatic stress. The results of this study explored secondary traumatic stress as one potential outcome of RA trauma support work, as well as how work environment factors may impact self-reported symptoms of secondary trauma. As RAs increasingly engage in trauma support work, it is imperative that scholars and practitioners understand how to equip RAs with the tools to manage their own trauma as they seek to be a resource for their residents.

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. doi: 10.1037/0002-9432.76.1.103

American College Health Association (ACHA). (2015). *Fall 2015 reference group executive summary: National College Health Assessment.* Hanover, MD: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

Association for University and College Counseling Center Directors. (2017). *The Association for University and College Counseling Center Directors annual survey.* Indianapolis, IN: Author.

Baird, K., & Kracen, A. (2006). Vicarious traumatization and secondary traumatic stress: A research synthesis. *Counseling Psychology Quarterly, 19*(20), 181–188. doi: 10.1080/09515070600811899

Bercier, M. L. (2013). *Interventions that help the helpers: A systematic review and meta-analysis of interventions targeting compassion fatigue, secondary traumatic stress and vicarious traumatization in mental health workers* (Unpublished doctoral dissertation). Loyola University Chicago, Chicago, IL.

Boone, K. B. (2018). Resident assistant workplace motivation. *The Journal of College and University Student Housing, 44*(2), 28–43.

Canto, A., Cox, B., Osborn, D., Becker, M., & Hayden, S. (2017). College students in crisis: Prevention, identification, and response options for campus housing professionals. *The Journal of College and University Student Housing, 43*(2), 44–57.

Center for Collegiate Mental Health. (2017, January). *2016 annual report* (Publication No. STA 17–74). Retrieved from https://sites.psu.edu/ccmh/files/2017/01/2016-Annual-Report-FINAL_2016_01_09-1gc2hj6.pdf

Cieslak, R., Shoji, K., Luszczynska, A., Taylor, S., Rogala, A., & Benight, C. (2013). Secondary trauma self-efficacy: Concept and its measurement. *Psychological Assessment, 25*(3), 917–928. doi: 10.1037/a0032687

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

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

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

Dickey, J. (2016, May). The revolution on America's campuses. *The New York Times.* Retrieved from http://time.com/4347099/college-campus-protests/

Figley, C. R. (1999). 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* (2nd ed., pp. 3–28). Lutherville, MD: Sidran.

Fisher, B., Cullen, F., & Turner, M. (2000). *The sexual victimization of college women* (NCJ 182369). Retrieved from https://www.ncjrs.gov/pdffiles1/nij/182369.pdf

Gallagher, R. P. (2014). *National survey of college counseling centers*. Alexandria, VA: The International Association of Counseling Services, Inc.

Grosz, R. (2008). Suicide: Training the resident assistant as an interventionist. *Journal of College Student Psychotherapy, 4*(3–4), 179–194. doi: 10.1300/J035v04n03_11

Hardy, S. D., & Dodd, D. (1998). Burnout among university resident assistants as a function of gender and floor assignment. *Journal of College Student Development, 39*(5), 499–501.

Harper, S. R., Davis, R. J., Jones, D. E., McGowan, B. L., Ingram, T. N., & Platt, C. S. (2011). Race and racism in the experiences of Black male resident assistants at predominantly White universities. *Journal of College Student Development, 52*(2), 180–200.

Hensel, J., Ruiz, C., Finney, C., & Dewa, C. (2015). Meta-analysis of risk factors for secondary traumatic stress in therapeutic work with trauma victims. *Journal of Traumatic Stress, 28,* 83–91. doi: 10.1002/jts.21998

Koch, V. A. (2016). Current practices in resident assistant training. *The Journal of College and University Student Housing, 42*(3), 80–97.

Locke, B., & Stauffer, A. (2015). *Center for Collegiate Mental Health (CCMH) 2015 annual report* (Publication No STA 15-108). College Station, PA: Pennsylvania State University.

Lynch, R. J. (2017). The development and validation of the Secondary Trauma in Resident Assistants Scale. *The Journal of College and University Student Housing, 44*(1), 10–29.

Lynch. R. J., & Glass, C. R. (2018). The development of the Secondary Trauma in Resident Assistants Scale (STSAP). *Journal of Student Affairs and Practice*, *56*(1), 1–18.

Manata, B., DeAngelis, B., Paik, J., & Miller, V. (2017). Measuring critical aspects of the resident assistant role. *Journal of College Student Development, 58*(4), 618–623. doi: 10.1353/csd.2017.0046

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

Newell, J. M., & Nelson-Gardell, D. (2014). A competency-based approach to teaching professional self-care: An ethical consideration for social work educators. *Journal of Social Work Education, 50*(2014), 427–439. doi: 10.1080/10437797.2014.917928

Onofrietti, J. M. (2000). *Resident assistant stress, job satisfaction, and persistence* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (DAI-A 61/02)

Owens, E. (2011). *The resident assistant as paraprofessional counselor and crisis interventionist: A study of lived experience* (Unpublished doctoral dissertation). Duquesne University, Pittsburgh, PA.

Paladino, D. A., Murray, T. L, Newgent, R. A., & Gohn, L. A. (2005). Resident assistant burnout: Factors impacting depersonalization, emotional exhaustion, and personal accomplishment. *The Journal of College and University Student Housing, 33*(2), 18–27.

Read, J. P., Ouimette, P., White, J., Colder, C., & Farrow, S. (2011). Rates of DSM-IV-TR trauma exposure and posttraumatic stress disorder among newly matriculated college students. *Psychological Trauma: Theory, Research, Practice, and Policy, 3*(2), 148–156. doi: 10.1037/a0021260

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. doi: 10.2202/1949-6605.6016

Rzeszutek, M., Partyka, M., Golab, A. B., & Ronald, T. (2015). Temperament traits, social support, and secondary traumatic stress disorder symptoms in a sample of trauma therapists. *Professional Psychology: Research and Practice, 46*(4), 213–220. doi: 10.1037/pro0000024

Sansbury, B. S., Graves, K., & Scott, W. (2015). Managing traumatic stress responses among clini-

cians: Individual and organizational tools for self-care. *Trauma, 17*(2), 114–122.

Schaller, M. A., & Wagner, R. (2007). Indecision and an avalanche of expectations: Challenges facing sophomore resident assistants. *NASPA Journal, 44*(1), 32–56. doi: 10.2202/1949-6605.1754

Shoji, K. M., Smoktunowicz, E., Bock, J., Luszczyn-ska, A., Benight, C., & Cieslak, R. (2015). What comes first, job burnout or secondary traumatic stress? Findings from two longitudinal studies from the U.S. and Poland. *PLoS ONE, 10*(8), 1–15. doi: 10.1371/journal.pone.0136730

Siegfried, C. B. (2008). *Child welfare and secondary traumatic stress*. Los Angeles, CA: The National Child Traumatic Stress Network. Retrieved from http://www.nctsnet.org/nctsn_assets/pdfs/CWT3_SHO_STS.pdf

Silverman, M., & Glick, R. (2010). Crisis and crisis intervention on college campuses. In J. S. Kay & V. Hoboken (Eds.), *Mental health care in the college community* (pp. 157–178). Hoboken, NJ: Wiley & Sons, Ltd.

Sorenson, E. A. (2018). *Situational stress factors and secondary traumatic stress among resident assistants* (Unpublished doctoral dissertation). Miami University, Oxford, OH.

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. doi: 10.1300/J146v14n01_06

Stoner, J. C. (2017). Revisiting resident assistant burnout: Functions of gender, community com-position, choice to continue employment, and job satisfaction. *The Journal of College and University Student Housing, 44*(1), 30–47.

Suicide Prevention Resource Center. (2014). *Suicide among college and university students in the United States*. Waltham, MA: Education Development Center, Inc.

Taub, D. J., Johnson, R. B., & Calhoun, D. W. (2016). Introduction–Resident assistants in college and university housing. *The Journal of College and University Student Housing, 42*(3), 8–11.

Taub, D. J., & Servaty-Seib, H. L. (2011). Training resident assistants to make effective referrals to counseling. *The Journal of College and University Student Housing, 37*(2), 10–24.

Taub, D. J., Servaty-Seib, H. L., Miles, N., Lee, J., Wachter-Morris, C. A., Prieto-Welch, S. L., & Werden, D. (2013). The impact of gatekeeper training for suicide prevention on university resident assistants. *Journal of College Counseling, 16,* 64–78.

Thombs, D. L., Gonzalez, J. M., Osborn, C. J., Ross-heim, M. E., & Suzuki, S. (2015). Resident assistant training program for increasing alcohol, other drug, and mental health first-aid efforts. *Society for Prevention Research, 16,* 508–517. doi: 10.1007/s11121-014-0515-x

U.S. Department of Education. (2016). *Campus safety and security*. Retrieved from https://ope.ed.gov/campussafety/Trend/public/#/answer/2/201/trend/-1/-1/-1/-1

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Discussion Questions

1. From this paper, what can you conclude is the greatest contributor to secondary trauma in RAs?

2. How might efforts to hire and retain RAs be affected if they had advance knowledge of the effects of secondary trauma?

3. In what ways does the surrounding community (other floors or residents from other buildings) add to the demands of an RA in relation to secondary trauma? Should an RA's personal and academic workload be considered when scrutinizing these data and developing interventions?

4. Once an RA has experienced secondary trauma, will that RA be more or less likely to leave their position immediately or the following year?

5. In what ways is trauma support work hazardous for the well-being of the campus population of student leaders and student affairs professionals?

6. We know that the need for trauma support is outpacing campus counseling centers' ability to serve students. What are some ways that residence life/housing, student affairs, and higher education personnel can combat this problem? What other campus services should be involved?

Discussion questions developed by Olivia Chandler, Jennifer Cole, Jacklyn Erb, Hannah Hench, and Kyle Kern, graduate students in the College Student Affairs program at Bloomsburg University of Pennsylvania, with assistance from Denise Davidson, associate professor