**Resident Assistant secondary trauma and burnout associated with student nonsuicidal self-injury**

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**ABSTRACT**

**Objective:** To determine whether or not encountering students struggling with nonsuicidal self-injury (NSSI) put Resident Assistants (RAs) at greater risk of burnout or secondary traumatic stress.

**Participants:** 155 RAs at three Midwest public university campuses between March and April 2016.

**Methods:** RAs participated in an anonymous online survey that collected demographics, information on RAs’ experiences and thoughts related to their work, RAs’ exposure to NSSI struggle of a resident, and measurements of compassion satisfaction, burnout, and secondary traumatic stress.

**Results:** RAs who encountered resident NSSI demonstrated significantly higher levels of burnout and secondary traumatic stress than RAs who did not encounter resident NSSI.

**Conclusion:** College student struggle with NSSI can significantly affect the people around them. Residence life administration and college counseling centers should provide training, support, and supervision to RAs in a way that addresses and reduces the RAs’ potential distress.

Keywords: mental health, community health, college counselling
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INTRODUCTION

Nonsuicidal self-injury is demonstrated when a person intentionally damages their own tissue without intending lethality, commonly enacted by cutting or picking at one’s own skin.1 Research has found correlations between NSSI and emotional dysregulation, identity disruption, and insecure attachment styles.2,3 Individuals struggling with NSSI often have co-occurring diagnoses of depression, anxiety, or eating disorders, and may have histories of abuse or trauma.2,4-6 Individuals who use NSSI are more likely to make a suicide attempt than those who do not.2,5 NSSI is a clear indication that a person is suffering and at risk of being emotionally overwhelmed. Nonsuicidal self-injury (NSSI) has become an important issue that affects many college campuses, with past year college student use of NSSI at rates between 3.6% and 15%,7,8 which equates to hundreds of thousands of students.9

Research on witness responses to NSSI largely focuses on social contagion, therapist reactions, and efforts to assist the individual who is self-injuring.10-13 The social contagion potential of NSSI documented in adolescent populations14,15 could also occur in the college setting.16,17 College students who use NSSI are more likely to know other people who struggle with NSSI18 and more likely to disclose this to friends and family than to college health care providers or counselors.19 College peers want to be helpful upon encountering an individual using NSSI, but often do not know how to be.10 However, what has been minimally explored in either the college specific or general NSSI literature is the effect on a non-clinically trained individual who witnesses or cares for someone who self-injures.
Part of the organizational structure of most residential colleges is a network of student leaders who live with their peers in the residence halls, while serving as employees of the university: Resident Assistants (RAs). RAs support student development, foster community, and help ensure a safe environment. Often RAs can recognize student distress and intervene, which serves both the student and the entire college. College administration policy may include RAs as points of identification and initial intervention on this issue of NSSI, under the direction of professional residential life staff.

RAs are a prime group to consider when exploring how NSSI might affect witnesses. RAs face academic, social, and family challenges similar to their residents, while also carrying the responsibility of supporting the students on their floor. RAs are routinely encouraged to speak to their supervisors when concerned for a student around issues such as self-injury. RAs may feel some responsibility for students who use NSSI, yet in their semi-professional role, they lack the same safeguards that a therapist has (education, supervision, legal authority, limited office or work hours) to negotiate emotional stress.

Understanding how resident NSSI affects RAs’ emotional stress has not been previously explored in the literature. Encountering NSSI might increase RAs’ susceptibility to burnout and secondary trauma. Alternately, if RAs experience gratification from assisting someone in need, they might have more Compassion Satisfaction. This study explores the differences in Compassion Satisfaction, Burnout, or Secondary Traumatic Stress for RAs with or without experiences with a resident’s NSSI.

METHODS

Participants
Participants were RAs who lived on one of three campuses associated with two collaborating public Midwest universities. This study was approved by the Human Subject Review board as well as the residence life administrators at each campus.

**Study Design and Procedures**

Residence Life administrators at each campus sent an email to all RAs in March 2016, inviting them to complete a survey that investigated their experiences with resident NSSI. The administrators sent one reminder email a week later to their respective RAs. RA Participants indicated consent by clicking on the survey after reviewing the Study Information Sheet which included information about local supportive services.

The electronic survey included demographics, questions about their experiences as RAs, and the Professional Quality of Life 5 (ProQOL) assessment\textsuperscript{25} described below. RAs who identified having a resident struggle with NSSI were asked additional questions. This is a cross-sectional study. The timing of survey delivery between Spring Break and the end of the term allowed the RAs to reflect upon the majority of their past year experience, but also came when RAs can be fairly busy.

**Measures**

**Demographics**

RAs were asked to self-identify around gender, race, ethnicity, and home location prior to college.

**Resident Struggling with NSSI**

To measure NSSI, RAs were asked if they ever had “a resident who you believed was using nonsuicidal self-injury?” This was a categorical, yes or no, independent variable. A follow up question asked RAs to identify the number of students in their care who struggled with NSSI.
The ProQOL 5 assessment tool\textsuperscript{25} is comprised of three scales, one for \textit{Compassion Satisfaction}, one for \textit{Burnout}, and one for \textit{Secondary Traumatic Stress}. Each scale consists of 10 questions measured on a 5-point Likert scale. The assessment tool subscales have been validated across helping populations with psychometrics indicating these are three distinct concepts.\textsuperscript{26} The ProQOL 5 subscales are standardized with a mean of 50 and standard deviation of 10.\textsuperscript{26} Compassion satisfaction is the gratification individuals experience through assisting someone effectively within their role.\textsuperscript{26} The Compassion Satisfaction scale has a Cronbach’s alpha scale reliability of .88.\textsuperscript{26} Stamm states burnout is “associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively.”\textsuperscript{26} The Burnout scale has a Cronbach’s alpha reliability of .75.\textsuperscript{26} Stamm describes secondary traumatic stress as “work-related, secondary exposure to people who have experienced extremely or traumatically stressful events.”\textsuperscript{26} Secondary Traumatic Stress looks at how caregivers who empathically engage with a traumatized person begin to experience symptoms of trauma related distress themselves such as hypervigilance, or a constricted worldview. Secondary Traumatic Stress scale has an alpha scale reliability of .81.\textsuperscript{26} Each of these scales represented a unique continuous dependent variable.

\textbf{Data Analysis}

The data was analysed using IBM SPSS version 24. When no more than one question was missing in each subscale, then the average score for that subscale was used and the surveys were retained, as recommended.\textsuperscript{26} The independent variable was RA group membership (addressing resident NSSI or not) related to the dependent variables of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. A two-group MANOVA was used to assess group differences in RA ProQOL 5 scores based on
whether or not they encountered NSSI amongst their residents. The value of using a MANOVA was its ability to account for possible relationships between the dependent variables (Compassion Satisfaction, Burnout, Secondary Traumatic Stress) when evaluating the presence of group differences.  

Assumptions for the MANOVA were met for all dependent variables (independence of observations, sufficient normality, minimal impact of outliers and multivariate outliers, the presence of linearity, nonsignificance of covariance, equality of variance, absence of multicollinearity) except that Levene’s test of equality of variance was found to be significant for Burnout at $p=.05$. Due to the violation of the equal variance assumption for Burnout, a non-parametric Mann Whitney U tests was used to compare the two groups of RAs by Burnout scores, with a Bonferroni correction to $p = .17$, which confirmed the MANOVA results.

**RESULTS**

Respondents fully completed 155 surveys, reflecting a 29% response rate from the entire pool of RAs at the three campuses. Eleven of the 166 surveys were excluded due to data missing in the ProQOL 5 assessment. The Fisher’s exact test suggested that males ceased responding more frequently than females, but other demographic differences could not be identified. Approximately two thirds of the sample identified as female and 84% reported the Midwest as their home. With 73% identifying as Caucasian, the sample was slightly more diverse than the populations at these universities which ranged from 77-80%.

Thirty of the 155 RAs encountered resident NSSI, which represents 19.4% of the RAs, half of whom reported two or more residents using NSSI.  

**RA Risk of Burnout and Secondary Traumatic Stress**
The MANOVA revealed significant differences in the overall model between RA groups, with Wilks’ $\lambda = .895$, $F(3, 151) = 5.922$, $p = .001$, partial $\eta^2 = .105$. There were significant differences for Secondary Traumatic Stress, but not for Compassion Satisfaction, with the Bonferroni correction adjusted $p$ value of $0.05/3 = 0.017$. RAs with a resident who struggled with NSSI ($M = 56.473$, $SD = 11.194$) had significantly higher levels of secondary traumatic stress than the RAs who did not have a resident struggle with NSSI ($M = 48.447$, $SD = 9.073$) at $F(1, 153) = 17.228$, $p < .001$, partial $\eta^2 = .101$.

The non-parametric Mann Whitney U test identified that there was a significant difference in Burnout scores $U = 1321.000$, $Z = -2.512$, $p = .012$, $r = .201$ between RAs who had a resident struggle with NSSI ($Mdn = 52.790$, IQR = 45.91-61.68), and RAs who did not ($Mdn = 49.408$, IQR = 43.27-55.54). This confirmed the informal MANOVA that identified Burnout scores being significantly different between the two groups of RAs.

Table 1 demonstrates the parameters and test statistics of the three scales compared by whether or not an RA knew they had a resident struggle with NSSI.

**COMMENT**

This study demonstrates that RAs who encountered NSSI were significantly more likely to have higher levels of secondary traumatic stress and burnout than RAs who did not. While many RAs may never encounter NSSI, other RAs are encountering this issue repeatedly and the personal impact may be just as variable. Residence Life supervisors should consider these negative effects and initiate reliable methods for addressing the needs of the RA. Normalizing this challenge and facilitating discussion could encourage RAs to take stock of their own wellness and evaluate what is realistic in terms of role expectations. Due to the nature of some extended resident NSSI struggles, supervisors should monitor RA wellness and involvement throughout the
RA DISTRESS AND STUDENT NSSI

term. RAs come to the work with varying familiarity and understanding of mental health concerns, so training about self-care as well as NSSI, and routine access to knowledgeable and supportive supervision could help RAs to engage and set healthy boundaries with residents. Alternately, a formal protocol could be implemented, such as Critical Incident Stress Debriefing which outlines strategies to process immediate distress and make referrals for additional support.\(^{29}\) In emergency rooms, CISD and has been found to reduce a person’s experience of being stressed after encountering a traumatic incident.\(^{30}\) Effective applications of CISD require consideration of the culture and specific needs of the organization.\(^{31}\) Any application of CISD in the residence hall to address this issue should maintain an awareness of the nonclinical role of the RAs, the 24/7 nature of the RA-resident relationship, and the variations in NSSI severity and usage which might complicate or extend how the ‘crisis’ is defined.

While working with students who struggle with NSSI is associated with higher levels of secondary trauma and burnout in RAs, this study cannot confirm that exposure to resident NSSI is the causal phenomena. It is alternately possible that certain RAs are more attuned or approachable, so they are not only more likely to hear about NSSI, but also other difficult resident situations, leaving them more vulnerable to burnout and secondary trauma due to the number of stories they hear.

**Limitations**

Measurement error might have limited the effect size of these results\(^{32}\) in three ways. The ProQOL 5 tool asks RAs about their previous 30 days experience.\(^{25}\) RAs were not asked to identify how recently they had encountered this issue, so many of the RAs might have worked with the resident in question a month or a year earlier. It is possible that the burnout and secondary traumatic stress levels might have been even more pronounced if the scales were completed while they were actively working with
the distressed resident. Since the question asked RAs if they had a resident use NSSI, RAs might have responded negatively if they had a resident who thought about using NSSI, which can still be a burden on an RA. Additionally, RAs likely had residents using NSSI without their knowledge, which could alter the observed effect.

A limitation worth noting in any investigation of college NSSI is that the perspective of the most vulnerable people involved, those students struggling with NSSI, was not explored.

Conclusions

This research identifies a population at higher risk of secondary trauma and burnout. While each student struggling with NSSI has their own story and network of people involved or affected, this research suggests that NSSI should be considered a community health issue. On campus, students live in close proximity to each other and are subject to each other’s private behavior. Precise delineations between individual distress and community hardship are not always easy to make, and recognizing the complexity of students’ interdependence can encourage campus leaders to more holistically address nonsuicidal self-injury in the residence hall.

Future research could differentiate risk and protective factors that serve to increase or alleviate secondary trauma and burnout in RAs addressing NSSI (personal trauma history, mental health familiarity, coping strategies, supports system, academic or family stresses and experience of support and RA role expectations). Better understanding how supervisors and residence life protocols effectively support RAs and how witnesses experience peer NSSI is also worth exploring.

Deepening understanding of RA exposure to NSSI can better inform administrative protocols for addressing an individual student’s NSSI struggle, college mental health outreach services’ efforts to focus prevention efforts, and residential life
practices to support RAs and residents. Without this knowledge, the full implications of NSSI cannot be appreciated and additional students may be at risk.
References


23. Foubert, J. *Lessons learned: how to avoid the biggest mistakes made by college resident assistants.* New York, NY, Routledge; 2014


Table 1. Statistics for Dependent Variables Based on Having a Resident with NSSI (n=155)

<table>
<thead>
<tr>
<th></th>
<th>RA without resident with NSSI (n = 125)</th>
<th>RA with resident with NSSI (n = 30)</th>
<th>Test Statistic</th>
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</thead>
<tbody>
<tr>
<td><strong>Compassion Satisfaction</strong> a</td>
<td>Mean (SD)</td>
<td>50.513 (9.801)</td>
<td>47.862 (10.697)</td>
</tr>
<tr>
<td><strong>Secondary Traumatic Stress</strong> a</td>
<td>Mean (SD)</td>
<td>48.447 (9.073)</td>
<td>56.473 (11.194)</td>
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<tr>
<td><strong>Burnout</strong> a</td>
<td>Mean (SD)</td>
<td>48.861 (9.083)</td>
<td>54.744 (12.223)</td>
</tr>
<tr>
<td><strong>Burnout</strong> a</td>
<td>Median</td>
<td>49.4083</td>
<td>52.790</td>
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<th></th>
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<th>95% CI</th>
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<tbody>
<tr>
<td><strong>Compassion Satisfaction</strong> a</td>
<td>48.750 - 52.276</td>
<td>44.263 – 51.460</td>
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<tr>
<td><strong>Secondary Traumatic Stress</strong> a</td>
<td>46.766 – 50.127</td>
<td>53.042 – 59.904</td>
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<tr>
<td><strong>Burnout</strong> a</td>
<td>47.138 – 50.585</td>
<td>51.225 – 58.263</td>
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<td><strong>Compassion Satisfaction</strong> a</td>
<td>43.27-55.54</td>
<td>45.91- 61.68</td>
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<tr>
<td><strong>Secondary Traumatic Stress</strong> a</td>
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<tr>
<td><strong>Burnout</strong> a</td>
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a Standardized mean across populations is 50  
b $p< .017$  
c $p< .05$