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The impact of severe mental health on peers in supporting roles: A look at secondary trauma and college students

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THE IMPACT OF SEVERE MENTAL HEALTH ON PEERS IN SUPPORTING
ROLES: A LOOK AT SECONDARY TRAUMA AND COLLEGE STUDENTS

An Abstract of a Thesis
Submitted
in Partial Fulfillment
of the Requirements for the Degree
Master of Arts

Courtney Tripp-Stuck
University of Northern Iowa
May, 2020

ABSTRACT

Evidence indicates directors of college counseling centers and those in student affairs roles have observed a steep increase in the number of severe mental health crises on their campuses, thereby also impacting student leaders and those in helping roles as counseling centers try to adapt to the influx of need (Kitzrow, 2003; CAS, 1999). Additionally, there is evidence to support students are more likely to turn to peers first when experiencing mental health crises than they are to seek out professional help (Drum, Brownson, Burton-Denmark, Smith, & Roberts, 2009; Gallagher, 2013). The goal of this study is to examine whether or not students experiencing traumatic mental health events cause secondary trauma to their peers who are supporting them during and after the traumatic episode. This study utilizes mixed quantitative and qualitative measures to gather data, including Bride, Robinson, Yegidis, and Figley's (2004) Secondary Traumatic Stress Scale (STSS) and in-person individual interviews with the researcher. Ultimately, there were several factors that contributed to the experiences of secondary trauma including engaging in dependent relationships, having feelings or responsibility and guilt, triggering of past mental health concerns, desensitization to mental health crises, and a lack of boundaries.

Keywords: secondary trauma, college students, suicidality, peer support, mental health

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This Study by: Courtney Tripp-Stuck

Entitled: The Impact of Severe Mental Health on Peers in Supporting Roles: A Look at
Secondary Trauma

has been approved as meeting the thesis requirement for the
Degree of Master of Arts

Date

Dr. David Schmid, Chair, Thesis Committee

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Dr. Jennifer Waldron, Dean, Graduate College

DEDICATION

Maya Angelou said, “There is no greater agony than bearing an untold story inside you.” This research is dedicated to all the college students holding on to their stories of secondary trauma, not even realizing they have a story to tell. You are not alone, and what you are experiencing is real. To Aria, Mia, Grace, Emma, Micah, Genevieve, Brett, and Veronica: thank you for letting me tell your stories and may you have found a little more peace and healing through this process. It has truly been an honor to know you even for a brief moment.

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CHAPTER 1

INTRODUCTION

The understanding of college student mental health and its effects on students in helping roles has begun to take shape in research literature when looking at both peer mentors and resident assistants (Kitzrow, 2003; House, Lynch, & Bane, 2013; Swanbrow Becker & Drum, 2015; Lynch, 2017). It has been shown that directors of college counseling centers and those in student affairs roles have observed a steep increase in the number of severe mental health crises on their campuses, thereby also impacting student leaders and those in helping roles as counseling centers try to adapt to the influx of need (CAS, 1999; Kitzrow, 2003). Additionally, there is evidence to support students are more likely to turn to peers first when experiencing mental health crises than they are to seek out professional help (Drum et al., 2009; Gallagher, 2013). This trend leads to increasing impact on both students in designated helping and leadership roles, as well as untrained friends and classmates of convenience with whom the student has built a relationship (Kitzrow, 2003). The goal of this study was to examine whether students experiencing traumatic mental health events cause secondary trauma to their peers who take on supporting roles during and after the traumatic mental health crises and episodes.

When a mental health crisis occurs on a college campus, the instinct of administrators, student affairs staff, and students in leadership positions is to provide resources and support to triage the situation for the student directly experiencing the crisis. Oftentimes, the students who were in an unofficial support role (roommates, close friends, significant others) providing peer-to-peer support are not contacted or provided

the level of support they need after the emotional labor they have performed by caring for, and at times intervening in crisis, with the victim. This lack of support may be from the triage mentality that exists as a result of the overflow of students utilizing campus mental health resources. There is also difficulty in identifying the key players in the crisis, as students may not recognize they are in need of help. Specifically, this study seeks to center students who may be experiencing trauma as a result of their close friends' own mental health concerns and crises, specifically suicidality.

This study is significant because much of the research on secondary trauma in college students is centered on those in social work and counseling programs who are interacting with clients regularly, and students in leadership roles such as Resident Assistants (RAs) and peer mentors. While these groups of people are important to understanding the impact of secondary trauma on students providing peer-to-peer support, these students and leaders, either through their coursework or employment training, are taught how to address mental health crises and are given immediate resources they must contact in emergency situations (House et al., 2013). Not only do these students have at least basic training on mental health and emergency response, but they have mentors or supervisors who are typically on call and available to take over or help in a crisis, and subsequently process with the student after the event has ended. Trained student leaders are more prepared to handle these situations and are given plenty of ongoing professional support following their interactions with critically mentally ill students (House et al., 2013). Although other students not in leadership positions still have access to the emergency resources, they are neither required to seek them out, nor

may they be as comfortable utilizing them. Additionally, they may not receive the same level of follow-up care from on campus professionals due to their focus on the primary student of concern.

Trained student helpers are also often not emotionally connected to the people they are working with and supporting. Students who are in counseling and social work programs are working with clients and patients with whom they must keep strict emotional boundaries. Furthermore, student leaders also must maintain some semblance of boundaries in order to enforce policy and gain respect. The experiences of untrained students providing peer-to-peer support for their close friends, roommates, or significant others, sometimes for months at a time, fall into a category entirely their own which lacks depth of research and action plans to improve their experiences and support.

Additional factors are also at play, including the shift in generational characteristics of today's college students. As college students move from the cusp of the Millennial generation to the beginning of Generation Z, help-seeking behavior and communication has impacted what resources these students need and are most comfortable utilizing. With the changes in the modern college student, many student affairs professionals and college administrators have been slower to adjust their crisis response procedures, referral resources, and follow-up support practices. As research unfolds providing insight into Generation Z's characteristics, motivations, and needs, student affairs response and support will also need to adjust to provide the best care to untrained students providing peer-to-peer support for other Generation Z students.

Statement of Problem

As the literature will show, secondary trauma is the result of being exposed to trauma indirectly through the sharing of experiences by the person who experienced the trauma firsthand. The literature supports the concept that students with severe mental health concerns are more likely to seek out peers before professional help. Students tend to be in those informal helping or peer-to-peer supporting roles for weeks or months before the student of concern will begin to seek out professional help. However, there is limited research available on the connection of secondary trauma and students placed in informal peer-to-peer helping roles by their friends and significant others with severe mental health concerns. For this reason, the following are the research questions this study addresses:

1. Do students with severe mental health concerns, namely those who express suicidality, contribute to symptoms of secondary trauma in the untrained peers they confide in and use for support?
2. What effects do the students providing peer-to-peer support for their peers expressing suicidality notice impacting their functioning academically, personally, and socially both at the time of the traumatic incident and after it has concluded?
3. How long do students providing peer-to-peer support tend to serve in those roles before feeling their responsibility has been sufficiently alleviated by another party such as a professional counselor, student affairs professional, or guardian?

4. What interventions from on campus staff, faculty and administrators were helpful or not helpful, and are there different types of support or interventions which could have provided a higher quality level of support for the student in the helping role?

CHAPTER 2

LITERATURE REVIEW

Increase in Mental Health Concerns on College Campuses

According to the Council for the Advancement of Standards in Higher Education [CAS] (1999), “The mission of university and college counseling centers is to ‘assist students to define and accomplish personal, academic, and career goals by providing developmental, preventive, and remedial counseling’” (p. 67). College and university campuses have seen a shift in the use of on campus counseling resources from developmental and goal-related needs, to clinical and severe psychological counseling needs (CAS, 1999; Kitzrow, 2003).

CAS (1999) acknowledges, “the role and function of college counseling centers continues to evolve and change in response to a variety of social, political, and economic factors” (p. 67). Those factors can include “the momentous changes in the demographics of today’s college student population,” which is cited as the “greatest change in higher education in recent years” (Kitzrow, 2003, p. 646). With these demographic and social changes occurring, the mental health needs of college students would also change and evolve simultaneously (Kitzrow, 2003). Specifically, college counseling services are moving from a prevention-based program to an intervention-based program as a way to mitigate the negative effects of students who possess diagnoses for severe psychiatric conditions (Owen & Rodolfa, 2009).

One salient demographic shift includes the changes associated with generational shifts from the Millennial generation to Generation Z, today’s current traditional college

students. According to the American Freshman National Norms Survey: Fall 2014 (Eagan et al.),

In 2014, students' self-rated emotional health dropped to 50.7%, its lowest level ever ... Additionally, the proportion of students who "frequently" felt depressed rose to 9.5%, 3.4 percentage points higher than in 2009 when feeling "frequently" depressed reached its lowest point. Self-rated emotional health and feeling depressed are very highly correlated. (p. 13)

Further, this trend continues in the American Freshman National Norms Survey: Fall 2016, with 10.7% of participants reporting a psychological disorder, and "just over half (51.8%) ... frequently [feeling] depressed in the past year" (Eagan et al., 2017, p. 12). Similarly with depression, Eagan et al. (2017) found participants in the American Freshman National Norms Survey: Fall 2016 who reported a psychological disorder were 79.5% more likely to report feeling anxious.

Additionally, Kitzrow (2003) states "many psychological disorders such as depression, bipolar disorder, and schizophrenia first manifest themselves in late adolescence or early adulthood" (p. 650). For traditional-aged college students, the late adolescent and early adulthood life stages overlap with their time in college, meaning these disorders may only begin to present themselves while the students are in college (Wilcox et al., 2010). This, when coupled with the general trends in low emotional health and high depression and anxiety self-reporting, indicates the need for a shift in mindset from the CAS view of counseling centers based around student development, to a clinical

and crisis-oriented model (Eagan et al., 2017; Eagan et al., 2014; Kitzrow, 2003; CAS, 1999).

Another possible cause for the “marked increase in both the number of students with serious psychological problems on campus and the number of students seeking counseling services” (Kitzrow, 2003, p. 647) can be attributed to the strides being made with the creation and de-stigmatization of psychiatric medication (Daddona, 2011, p. 31). Students who previously would not have been “psychologically healthy enough” (Daddona, 2011, p.31) to gain entrance to higher education, let alone thrive in a campus setting, are now much more able to gain a higher education due to their access to medication (Center for Collegiate Mental Health [CCMH], 2017; Howe & Strauss, 2003). Many students are coming to college with previous treatment plans and prescriptions for psychiatric drugs already in place (CCMH, 2017; Howe & Strauss, 2003; Kitzrow, 2003). This access supports the reported increases in students with severe mental health concerns, as has been noted by both directors of counseling centers and student affairs professionals who are triaging and referring students.

Counselors are reporting seeing higher numbers of students seeking psychiatric care at on campus counseling facilities (Kitzrow, 2003). Specifically, counselors have seen an increase in students “consistently present[ing] with severe concerns including suicidality, substance abuse, history of psychiatric treatment or hospitalization, depression and anxiety” (Eagan et al., 2017; Eagan et al., 2014; Levine & Cureton, 1998, p. 387). Of these specific conditions, this study looks specifically at suicidality, defined

as the presence of thoughts, ideation, planning, hospitalizations, and attempts relating to suicide.

Prevalence of Suicidality on College Campuses

According to the Suicide Prevention Resource Center (2014), “suicide is likely the second leading cause of death for youth ages 10-24 years of age, with an estimated 1,088 suicides occurring on campuses each year,” (p.4) with 80% of students completing suicide never being treated by the counseling centers on campus (Gallagher, 2013). There are many reasons these students do not make it to the counseling center, including not being aware of the resources, being reluctant to use the resources because of stigma associated around mental illness or help-seeking behavior, or being scared to tell university officials for fear of being involuntarily hospitalized or forced to leave the institution (Kitzrow, 2003; Drum et al., 2009; Daddona, 2011). In a study examining the ways in which college campuses identify students at risk for suicide, as well as work to prevent suicide once indicators are present, Drum et al. (2009), found the following statistics:

Over half of college students reported some form of suicidal thinking in their lives. When asked whether they had “ever seriously considered attempting suicide,” 18% of undergraduates and 15% of graduate students endorsed this item. Among those who had seriously considered attempting suicide, 47% of undergraduates and 43% of graduate students had three or more periods of this serious ideation, suggesting by the time students undergo suicidal crises in college, they are likely to have significant previous experience with suicidality.

Additionally, 8% of undergraduates and 5% of graduate students reported having attempted suicide at least once during their lives. (p. 215)

See Table 1 for exact percentages.

Table 1 Thoughts and Attempts of Suicide

	Undergraduate Students	Graduate Students
Students who ever seriously considered attempting suicide	18%	15%
Students who experienced three or more periods of serious suicidal ideation	8.46%	6.45%
Students who have attempted suicide	8%	5%

Additional statistics from this study purport more often than not students who express thoughts of suicide also have thoughts of how they would complete the suicide. Per Drum et al. (2009), “among students who seriously contemplated suicide in the past 12 months, 92% of undergraduates and 90% of graduate students either considered some ways of killing themselves or had a specific plan” (p. 216). Additionally, 37% of undergraduate students who had considered committing suicide in the last 12 months had taken one or more actions towards preparing for ending their life (Drum et al., 2009). Perhaps the most concerning statistic from Drum et al. (2009) indicates “23% of undergraduates and 27% of graduate students who attempted suicide within the past 12 months reported that they were currently considering making another suicide attempt” (p. 216).

Additionally, according to the American Association of Suicidology's official 2017 data, for every completed suicide by a young person (ages 15-24), there are 100-200 unsuccessful suicide attempts (Drapeau & McIntosh, 2018). When looking at the greatest stressors or causes of suicidal ideation, Drum et al. (2009) found the three most salient factors cited by students for their suicidal ideation were "(1) wanting relief from emotional or physical pain, (2) problems with romantic relationships, and (3) the desire to end one's life" (p. 217). Finally, Center for Collegiate Mental Health's 2016 annual report expressed that 44.4% of college students who self-disclosed having attempted suicide had done so in the last 1-5 years. Beyond that, 14.8% of college students who self-disclosed having attempted suicide had done so in the past year (CCMH, 2017). This data shows that not only are students experiencing suicidal thoughts and actions before coming to college, but some may be attempting suicide or experiencing these severe mental health crises while in the college setting.

In a more recent study conducted by Farabaugh et al. (2012), college students who tested higher on the Beck Depression Inventory (BDI) also were more likely to endorse experiences of suicidal ideation. Additionally, Farabaugh et al. (2012) found students who reported higher levels of hopelessness and lower quality of life were more likely to report experiencing suicidal ideation. Both confirming and expanding the findings of Farabaugh et al. (2012), Cukrowicz et al. (2011) found evidence to support "the association between subclinical depressive symptoms and suicide ideation ... these results indicate that clinically important suicide ideation may emerge for students with milder depressive symptoms on college campuses" (p. 580). Even students who are not

clinically depressed based on DSM criteria, still may experience suicidal ideation which puts them at risk for not being identified as in need of support by mental health and other professionals on college campuses (Cukrowicz et al., 2011). Rather than just considering the rise in clinical depression in college students, professionals also need to consider the impacts of sub-clinical depression on a rise in suicidal ideation in students.

Changes in Student Help-seeking Behaviors

Traditional resources provided to students for mental health crisis intervention include crisis hotlines and text lines. While there is plenty of research to support high use of crisis hotlines as well as effectiveness in adults, this trend is changing with youth and adolescents (Budinger, Cwik, & Riddle, 2015). Research conducted by Budinger et al. (2015), showed of youth ages 10-17 who participated in their study about mental health crisis help-seeking behavior, only 30.4% of participants were aware of suicide hotlines, with only 3.0% of participants having utilized a suicide hotline. Further, Seemiller and Grace (2015) found Generation Z students (current college students) to be highly averse to phone calls and utilizing the phone to talk verbally to others. Many crisis hotlines are executed via the phone. Specifically, “Sixty-five percent of Generation Z students in [the] study said they dislike or only somewhat like making voice phone calls” (Seemiller & Grace, 2015, p. 59). Gould, Greenberg, Munfakh, Kleinman, and Lubell (2006) found the preferred method of help-seeking by today’s adolescents is through trained professionals or virtually over the internet.

Particularly because the definition of ‘physical space’ has been expanded due to the internet and social media access, college students tend to utilize personal technology

to reach friends and family with ease and virtually instant response times (Owen & Rodolfa, 2009; Seemiller & Grace, 2015). This can also alleviate the need to physically speak to someone. Rather, students can now electronically message on social media sites or widely post their concerns and receive support. Naslund, Grande, Aschbrenner, and Elwyn (2014) found adolescents and young adults identifying with a mental illness reported seeking support and comfort through social media usage, specifically YouTube videos from people sharing similar experiences. In several cases, participants created friendships that extended beyond the bounds of YouTube and continued contact with each other as a form of mental health support (Naslund et al., 2014; Seemiller & Grace, 2015).

Seemiller and Grace (2015) found in their extensive study about Generation Z college students, having grown up in the digital age it has been normalized for them to build, strengthen, and essentially create relationships online with people they have never met in person. Generation Z college students can easily establish groups of support around any topic or hobby. It makes sense that this extends to the mental health and help-seeking behaviors as well whether via YouTube as with the Naslund et al. study (2014) or with other platforms like Reddit or even Pinterest (Seemiller & Grace, 2015). Beyond the general support students receive through digital connection, they can also maintain a sense of anonymity and privacy while disclosing vulnerable information. One of Generation Z's priorities and values is safety online and privacy. Social media disclosure allows students to feel safe and connected with their friends while seeking help from their mental health (Seemiller & Grace, 2015).

The research of Budinger et al. (2015) also showed students were unlikely to reach out to a crisis hotline primarily due to stigma and self-shaming (Vogel, Bitman, Hammer, & Wade, 2013). Gould et al. 2006, found that one of the main reasons participants noted not reaching out via a crisis hotline was because they felt more comfortable seeking help from a peer. Similarly, in Budinger et al. (2015), participants did mention they would be more willing to call a hotline if they confided their crisis in a peer or trusted parent and they encouraged them to call (Budinger et al., 2015). This shows a trend toward confiding in known peers and guardians before confiding in other resources previously seen as well-known and effective crisis-management tools. In addition, Howe and Strauss (2003) address the changes in trends with millennials moving towards confiding stress and mental health concerns to parents and friends due to the decrease in stigma. This trend may continue to the current college students who are a transitional generation from Millennials to Generation Z.

Effects of Mental Health and Suicidality on Campus Stakeholders

Another study conducted by Brackney, Karabenick, and Hill (1995) suggests academic performance could be impacted significantly by extreme levels of psychological distress. In support of this relationship, Alonso et al. (2018) studied the relationship between types of stress and student role impairment. Student role impairment is defined as a student's ability to be successful in "four role domains (1) home management/chores, (2) college-related and other work, (3) close personal relationships, and (4) social life" (Alonso et al., 2018, p. 804). In cases where participants tested positive for Generalized Anxiety Disorder or Major Depressive Disorder, there was

substantial role impairment. In addition, generalized anxiety disorder and major depressive disorder tend to appear comorbidly and are extremely prevalent in the college-aged population (Alonso et al., 2018; Morrison & O'Connor, 2005). This indicates these mental illnesses not only have an impact on the social functioning of students, but also academic success as well. The combination of these two indicate potential concerns regarding student retention (Kitzrow, 2003).

Another group of individuals who are impacted by the rise in suicidality and severe mental health concerns on campus are the student leaders who are placed in helping roles (Kitzrow, 2003). In an attempt to open up counseling center resources to the overwhelming number of students requesting them, student leaders and staff members often serve as a resource and support system for students experiencing mental health concerns (Kitzrow, 2003). According to Swanbrow Becker and Drum (2015), “when [resident assistants] intervened with their residents, the resident assistants experienced average or moderate stress with these interventions [...] When resident assistants did intervene, they tended to stay engaged for a month or more” (p. 82). Beyond just serving as a one-time referral source, resident assistants were noted as being involved in ongoing cases of mental health management. The same can be said for peer mentors who are engaging in personal communication with students experiencing transition and stress in college (Erdur-Baker, Aberson, Barrow, Draper, & Kenkel, 2006).

To this point, research indicates students placed in official helping roles through their jobs tend to be on the front lines of mental health crisis response with the students with whom they work. This may be in part due to seeming approachable, having

established relationships, and generally not being viewed as a “real” university official (Erdur-Baker et al., 2006, Drum et al., 2009). As explained by Lynch (2017), “repeated exposure to those experiencing trauma can have deleterious effects on those who provide help and support” (p. 12). When student helpers are put in this position, there can be effects on their own mental health.

Secondary Trauma

One effect students with mental health concerns may have on other students designated as helpers includes secondary trauma (Lynch, 2017). As defined by Figley (1999), secondary trauma is “the natural, consequent behaviors and emotions resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person” (p.10). Figley (1999) states, “simply learning about traumatic events carries traumatic potential” (p. 6). Further, “secondary traumatic stress was operationalized as intrusion, avoidance, and arousal symptoms resulting from indirect exposure to traumatic events by means of a professional helping relationship with a person or persons who have directly experienced traumatic events” (Bride et al., 2004, p. 28).

The understanding of secondary trauma originated with the experiences of counselors working with clients, the spouses and children of combat veterans, and those experiencing compassion fatigue and job burnout such as professionals working for long periods of time in the social work field (Cieslak et al., 2014; Fowler, 2015; Herzog, Fleming, Ferdik, Durkin, & Bride, 2016). Specifically, the criteria for secondary trauma as defined by Motta, Kefer, Hertz, and Hafeez. (1999) and Bride et al. (2004) in their

secondary trauma measurement tools has been based off of the Post Traumatic Stress Disorder (PTSD) criteria in the fifth edition of the Diagnostic Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013).

Although the term ‘secondary trauma’ has historically been used to refer to those in the social work and counseling fields, it has begun to be used to refer to more general populations. Studies indicate resident assistants do experience secondary trauma when aiding their residents in mental health (or other) crises (Bride et al., 2004; Lynch, 2017). Some of the trauma resident assistants hear about the most from their residents include “(1) death of a loved one (56.7%), (2) family issues (46.2%), (3) suicidal ideations, attempts, or completions (43.3%), (4) and severe mental health episodes (36.1%)” (Lynch, 2017, p. 19). Of those four categories, two of them are related to mental health or suicidal ideation/actions.

Secondary Trauma in Peer Relationships

As has been established, students with mental health concerns have been shown to inflict secondary trauma onto designated student leaders and helpers (Lynch, 2017). This study considered whether or not students who are not designated helpers also experience secondary trauma from assisting their peers with psychological trauma. Although students with mental health concerns tend to contact designated student helpers before professional help, evidence indicates they reach out to general students at the institution, including friends, classmates, roommates, or significant others before their designated student helpers (Drum et al., 2009). According to a study by Seemiller and Grace (2015) on Generation Z college students, this generation highly values their peers’ opinions and

will seek out this support whether via in person or online relationships. Drum et al.

(2009) states:

To better understand student patterns of informal help seeking, we asked students who seriously considered attempting suicide in the past 12 months if they told anyone about their suicidal thoughts. We found that 46% of undergraduate and 47% of graduate students chose not to tell anyone about their suicidal thoughts...However, 52% of students who confided in other people reported that telling the first person was helpful or very helpful in dealing with the suicidal thoughts. Two thirds of those who disclosed their suicidal ideation first chose to tell a peer, such as a romantic partner, roommate, or friend. (p. 218)

As established earlier, student leaders who act in helping roles with mental health crises report being engaged with students for a month or more in the helping role (Figley, 1999), and “when a person is in continued close contact with trauma survivors...[they] may experience considerable emotional disruption and may become indirect victims of the trauma themselves” (Swanbrow Becker & Drum, 2015, p. 82). The impact of friend’s needs on college students has been documented via the American College Health Association-National College Health Assessment (2008) in which students mentioned feeling affected academically and personally by the need to care for their friends.

Finally, students who live residentially in on-campus housing facilities, are likely to be further impacted by trauma occurring to their peers than commuter students, due to residential students creating stronger community and social bonds with each other (Pascarella, 1984; Graham, Hurtado, & Gonyea, 2018). Pascarella (1984) finds in their

comparison study of commuter and residential students, “living on-campus had its strongest influence in the areas of fostering interaction with peers and faculty” (pg. 257).

Therefore, residential students are establishing more robust and intimate social relationships with their peers. From the research of Marino, Child, and Campbell Krasinski (2016), people are most likely to self-disclose lived experiences associated with mental health when they feel safe and secure in their surroundings and social context. Because residential college students may be establishing those more intimate social connections, they may be more willing to self-disclose about mental health struggles, crisis and trauma (Marino et al., 2016).

CHAPTER 3

METHOD

Participants

The participants of this study were gathered through the distribution of a survey to students living in intentionally selected residential housing facilities on campus at the University of Northern Iowa (UNI), a population of 2,977 students. In order to ensure enough qualifying participants, the survey was also distributed to students living in intentionally selected residential housing facilities on campus at Wartburg College.

Although specific demographic information was not collected, according to the 2017-2018 institutional factbook created by the office of University of Northern Iowa Institutional Research and Effectiveness (n.d), the general makeup of the graduate and undergraduate UNI student population can be found in Table 2.

Table 2 UNI Student Demographics

Demographic	Demographic Sub-category	Total Students
Enrollment		
	Total Student Enrollment	11,907 students
	Undergraduate	10,005 students
	Graduate	1,902 students

(table continues)

Demographic	Demographic Sub-category	Total Students
Gender*		
	Female	7,139 students
	Male	4,768 students
Age		
	24 years and younger	9,176 students
	25 years and older	829 students
Race/Ethnicity		
	American Indian/Alaskan Native	36 students
	Asian	146 students
	Black/African American	317 students
	Hispanic	431 students
	White	9,685 students
	International	547 students
	Native Hawaiian/Pacific Islander	7 students
	Two or More	221 students
	No Response	517 students
*No data available for transgender, agender, or nonbinary identifying students		

From the demographics in Table 2, the researcher concluded the likely demographics of the UNI participants in this study would mirror those of the larger UNI population (Institutional Research & Effectiveness, n.d). The majority of participants were likely going to be between the ages of 18 and 24 years old and white identifying (Institutional Research & Effectiveness, n.d). Beyond these demographics provided, the population of students at UNI typically come from rural, and midwestern towns, specifically from Iowa. Many UNI students are also religiously affiliated with a sect of Christianity, as is demonstrated by the presence of 13 recognized campus ministries connected to Christian-based organizations. There are zero listed campus ministries related to other religious affiliations available on the University of Northern Iowa Student Life website (n.d.).

Wartburg College did not have extensive online publications of student demographics. The Wartburg College Fast Facts website (n.d.) provided the following information available in Table 3.

Table 3 Wartburg Student Demographics

Demographic	Demographic Sub-category	Total Students
Enrollment		
	Total Student Enrollment	1,505
Gender*		
	Female	813
	Male	692
Race/Ethnicity		
	White	1,193
	American Multicultural Students	189
	International Students	123
*No data available for transgender, agender, or nonbinary identifying students		

From the demographics listed in Table 3, it can be assumed that the participants involved in the study were primarily white students and a fairly even split between male and female.

These populations of students at both UNI and Wartburg College were chosen based on the relationships residentially housed students create with the other peers living on their floors and in their buildings. The students living on campus also live in close

proximity with many other students, often times being on floors of between 30 and 60 residents and living with roommates, suitemates, or apartment mates. As the residence halls are intentioned to foster and build community, students will likely have created friendships with those on their floors and have built a base level of trust. Beyond this, students living in residence halls are likely to hear each other's conversations and experiences by overhearing their neighbors or those walking in the hallway and seeing concerning behavior in common areas like bathrooms or lounges. This makes on campus residents good candidates to have the experiences needed to participate in this study. The specific housing facilities chosen for survey distribution encompass traditional and apartment-style buildings as well as first year, transfer, and upper division students.

The participants were screened via the survey tool in order to ensure they fit the requirements for the study. The researcher hoped to have at least 150 students who fit the criteria for participation. From this pool, the researcher conducted in-person audio-recorded interviews with eight students. The participants chosen for the interview were based off of the seriousness of their experiences described in the questionnaire, specifically the cumulative score from the Secondary Traumatic Stress Scale (Bride et al., 2004).

Informed Consent

The informed consent fits basic parameters letting the participant know the purpose of the study, the basic risks, benefits, how to opt out of the study, where to direct questions, and clarifying the voluntary nature of the research. The complete online informed consent document can be found in Appendix A. Because the study addresses

trauma and serious mental health concerns, participants were provided a list of free on campus and digital resources for coping with emotional triggers and mental health crisis, should discomfort result from the topics discussed in the survey. Those resources include the University of Northern Iowa's Counseling Center (which also includes on call crisis counseling available 24/7), Crisis Text Line (a texting service which responds to students in crisis and will perform rescues if necessary), and both the call and text options of the Trevor Project as an inclusive hotline for LGBT+ identifying individuals.

The informed consent form was completed electronically before the survey. Participants were only able to continue on with the survey if they selected "yes" stating they have read and understand the document. If participants selected "no," they were taken to the end of the survey without completing the questionnaire.

A similar second informed consent document was created for use with in person interviews. The participants were given a copy to read and sign if they chose to participate. Participants received a signed copy of the informed consent, and the researcher kept a copy of the document for record. Additions to this document included information about how to discontinue the interview, as well as information about audio recording. Students wishing to not participate in the interview were able to return the informed consent document unsigned to the researcher. The complete in person interview informed consent document can be found in Appendix B.

If a student participating in an in-person interview expressed thoughts of hurting themselves or others, the researcher planned to either call campus security or walk the student over to the UNI counseling facility depending on the severity of the concern.

Similarly, if a student were to become overly distressed even without the presence of suicidal ideation or intent, the same protocol was followed.

Instruments

This study utilized mixed quantitative and qualitative measures (quan→QUAL) to gather data. First, participants were screened to ensure they have engaged in the experiences required to qualify for the study. Once the screening was completed, students were contacted to set up an in-person audio-recorded interview with the researcher. At that time, the participants were asked a predetermined set of questions, with additional follow-up questions as needed.

Participant Screening

Participants were screened for several qualities in order to ensure they fit the researcher's questions for the study accurately. The qualities and experiences necessary for a participant to be eligible to participate in the study included (1) being a current UNI student, (2) serving in a supporting or helping role for another current UNI student experiencing a severe mental health crisis, specifically relating to suicidality, and (3) the supporting student identifying the peer in need of support as either a close friend, roommate, or significant other.

The first initial screening question asked: Has a UNI student disclosed any of the following to you (select all that apply)? Participants were able to select all that applied: (1) Thoughts that their family would be better off without them, (2) Thoughts of ending their life, (3) Plans to commit suicide, (4) Description of a suicide event either recently or

in the past, (5) Described or shown you a suicide note (6) I have never been told any of the above by a UNI student.

The second initial screening question asked: Have you ever had to take any of the following actions to intervene with a UNI student (select all that apply)? Participants were able to select all that applied: (1) Stay with a student because they were afraid they would hurt themselves if they were alone, (2) Stay with a student because you were afraid they would hurt themselves if they were alone, (3) Confiscate an item (medication, knife, razor, or other object of intent) the student planned to use to harm themselves or end their life, (4) Call a university official, UNI PD, someone else, or dial 911 because you feared they would take steps to end their life, (5) Call a university official, UNI PD, someone else, or dial 911 because they had already taken steps to end their life, (6) I have never intervened in the above ways with a UNI student.

If participants selected “I have never been told/intervened in the above ways by/with a UNI student,” for both of the first two initial screening questions, they were taken to the end of the survey and did not complete the questionnaire. Their lack of experience dealing with examples of suicidality in other UNI students disqualified them as participants in the study.

The third screening question was used to ensure participants were identifying the above experiences from relationships beyond acquaintances with students at UNI. This was important to the study because the research was focused on UNI students helping other UNI students with whom they have established relationships. The question was as

follows: Was the UNI student, or at least one of the UNI students you referred to above a close friend, roommate, or significant other?

If the participants selected “no” they were taken to the end of the survey and did not complete the questionnaire. The lack of strong or ongoing relationship with the student of concern disqualified them as a participant in the study.

Quantitative Methods

The quantitative portion of the study utilized the Bride et al. (2004) Secondary Traumatic Stress Scale (STSS). Before completing this survey, participants were asked to briefly describe in three to five sentences one of the experiences the participant thought of in the previous survey sections. Once students had chosen a specific experience, they were asked to complete the STSS based on that specific experience. The STSS consists of 17 items that can be ranked based on a five-point scale, anchored on each number from “Never” to “Very Often.” The STSS has been empirically tested for validity and reliability (Bride, et al., 2004; Benuto, Yang, Ahrendt, & Cummings, 2018).

The original purpose of the STSS scale was to measure the presence of varying symptoms associated with secondary trauma in professionals working within the social work field. The symptoms measured by STSS include intrusion, avoidance, and arousal. This allows the researcher to identify what symptoms of secondary trauma participants are most experiencing.

Although originally created for a professional-client relationship, the survey can be adapted to utilize other language beyond the term ‘client.’ For this study, language

was adjusted respectively to refer to ‘peers’ and ‘experience’ rather than ‘clients’ and ‘work.’ An example of the language adaptations can be seen in Table 4.

Table 4 Language Adaptation

STSS – Original Language – Item 10	I thought about my work with clients when I didn’t intend to.
STSS – Adapted Language – Item 10	I thought about my experience with my peer when I didn’t intend to.

Students who are acting in helping and supporting roles can still relate to the items included on the STSS (Bride et al., 2004). Specifically, with the students who participated in this study, they didn’t have the natural boundaries a professional-client relationship has built-in to the position, making them more susceptible to the types of symptoms measured in this survey. Ultimately the STSS was found to demonstrate internal reliability and be a valid instrument for measuring secondary trauma (Bride, et al., 2004; Benuto et al., 2018). The entire survey can be found in Appendix C.

It is reasonable to assume when interpreting the results of the survey, the higher a person’s aggregate score on items of each category, the more of an effect the experience has had on them and the more likely they are to have experienced symptoms of secondary trauma. For more specific information on which survey items relate to each category of secondary trauma phenomena, see Table 5.

Table 5 Survey Item Correlation

Intrusion	Items 2, 3, 6, 10 & 13
Avoidance	Items 1, 5, 7, 9, 12, 14, & 17
Arousal	Items 4, 8, 11, 15, & 16

To analyze the data from this survey, the researcher created a percentile rank of all of the scores and discern which participant experiences were in the top third, middle third, and bottom third percentiles.

The final section of the survey asked participants if they would be willing to talk more about the experiences described in the survey. If so, participants needed to self-identify by including their first name, last name, and email address in the spaces provided. This section was not required. If participants did not want to be contacted or self-identify, they were able to leave this section blank and continue to the end of the survey.

Qualitative Methods

The qualitative portion of the study came from in-person, audio recorded interviews with the participants who noted a willingness to talk further. During those interviews, the participants were asked to describe the experiences they had in the helping or support role, as well as talking about how these experiences affected them academically and socially, both in the moment and in the present.

Participants for in-person interviews were chosen based on the severity of their aggregate Secondary Traumatic Stress Survey scores. In order to include both

experiences which support and negate the researcher's hypothesis, the researcher conducted interviews with four individuals who score higher on the STSS instrument, and four individuals who score lower. All participants were contacted via email inviting them to talk further and to respond to the email if willing to participate in a 30-45 minute audio-recorded interview.

All interview participants were asked the same questions about their experiences supporting their peers, the emotions they felt during that time, the duration of support, and resources that would have helped them be more successful. The complete questions asked of participants can be found in Appendix D. Depending on what was shared during each interview, different additional follow up and clarification questions were included. Each participant was also told that they could skip questions they did not wish to answer, ask for a break if needed, walk out of the room or ask to end the interview, or ask to change subjects at any time. Additionally, the general purpose of the research was shared with each participant and a period of trust building took place during which the researcher shared a bit about their personal life and asked the students about their experience at UNI and their future plans.

Interviews were transcribed by the researcher and a copy of the transcribed interview were sent via email to the participant in order to provide the opportunity for member checking and the accuracy of the participants' experiences. They were given the opportunity to make any redactions they wished to the interview. Any of the portions that the participant asked to be redacted were blacked out on the transcript and not utilized in either the data coding and analysis process or the written document. At this time,

participants were also given the opportunity to provide an alternate first name for use in the written document. The name of the participant was also changed in the transcript prior to coding. If the participant did not respond to the email or give the researcher an alternative name option, the researcher provided their own alternative name for the participant. The researcher chose an alternative name for any other names mentioned in the interview, specifically students of concern, friends, family members, etc. that was utilized in the written document and the interview transcript.

Once the transcript had been approved by the participant and all names had been changed to reflect the chosen aliases, the researcher coded the data based on patterns and themes that emerged from the interviews. These themes were used as the main determinant of the impact these experiences had on the participants in the study.

CHAPTER 4

RESULTS

In total, 1,930 surveys were sent via email to housing residents at both Wartburg College and the University of Northern Iowa. With 532 students responding to the survey, there was approximately a 28% response rate.

There were 335 participants who took the survey from the University of Northern Iowa distributions. Of those 335 participants, 227 were screened out based on their lack of experience regarding supporting peers with suicidal-driven mental illness concerns. Of the 108 remaining participants, 12 were screened out based on their experiences described being with peers not currently enrolled at the University of Northern Iowa. In total, 96 participants qualified to complete the Secondary Trauma Questionnaire portion of the study. Of the 96 participants who completed the entire survey, 17 of them chose to disclose their names and email addresses, consenting to personal email contact from the researcher inviting them to do an in-person audio-recorded interview.

There were 197 participants who took the survey from the Wartburg College distributions. Of those 197 participants, 110 were screened out based on their lack of experience regarding supporting peers with suicidal-driven mental-illness concerns. Of the 87 remaining participants, 13 were screened out based on their experiences described being with peers not currently enrolled at Wartburg College. In total, 74 participants qualified to complete the Secondary Trauma Questionnaire portion of the study. Of the 74 participants who completed the entire survey, nine of them chose to disclose their

names and email addresses, consenting to personal email contact from the researcher inviting them to do an in-person audio-recorded interview.

Once collection and analysis of all survey data was completed, the following were the types of information disclosed to participants from both institutions: Thoughts of ending their life; Descriptions of a suicide attempt either recently or in the past; Thoughts their family would be better off without them; Plans to commit suicide; Described or were shown a suicide note. Specific data regarding number of students reporting each type of disclosure can be found in Table 6. Some participants may have peers who disclosed multiple types of information throughout the duration of their support role.

Table 6 Disclosure Topics Reported

Topic of Disclosure	Number of Participants Reporting
Thoughts of ending their life	124
Descriptions of a suicide attempt either recently or in the past	107
Thoughts their family would be better off without them	101
Plans to commit suicide	34
Described or were shown a suicide note	15

These disclosures were then connected to the following topics of distress the participants' peers were experiencing: Suicidal Thoughts or Actions; Depression; Suicide

Attempt; General Mental Health; Romantic Relationship or Breakup; Substance Use or Abuse; Home Life; Academics; Anxiety; Assault or Abuse; and Isolation. Specific data regarding number of students reporting each topic of distress can be found in Table 7.

Some participants may have been supporting peers through multiple types of experiences simultaneously or throughout the duration of their support role.

Table 7 Distress Types Reported

Type of Distress	Number of Participants Reporting
Suicidal Thoughts or Actions	55
Depression	28
Suicide Attempts	19
General Mental Health	18
Romantic Relationship or Breakup	11
Substance Use or Abuse	9
Home Life	6
Academics	4
Anxiety	4
Assault or Abuse	3
Isolation	3

As a result of these supports, the following include the types of support given to the participants' peers: Stay with someone because you were afraid they would hurt

themselves if they were alone; Stay with someone because they were afraid they would hurt themselves if they were alone; Confiscate an item; Call a college official, Wartburg Security, someone else, or dial 911 because you feared they would take steps to end their life; Call a college official, Wartburg Security, someone else, or dial 911 because they had already taken steps to end their life. Specific data regarding number of students engaging in each type of support can be found in Table 8. Some participants may have been providing multiple types of support simultaneously through the duration of their support role.

Table 8 Support Type

Type of Support Provided	Number of Participants Reporting
Stay with someone because you were afraid they would hurt themselves if they were alone	120
Stay with someone because they were afraid they would hurt themselves if they were alone	83
Call a college official, Wartburg Security, someone else, or dial 911 because you feared they would take steps to end their life	16
Call a college official, Wartburg Security, someone else, or dial 911 because they had already taken steps to end their life	4

In looking at the results of the Secondary Trauma Questionnaire, the maximum score a participant could self-report was 85, meaning the participant experiences all secondary trauma symptoms from the support role very often. The lowest score a participant could self-report was 17, meaning the participant never experiences any of the

secondary trauma symptoms from the support role. The higher a person's self-reported score was, the more secondary trauma symptoms had impacted that person's life since their peer support role. Of the participants completing the questionnaire portion of the survey, the highest percentile ranked participant self-reported a score of 80 indicating high numbers of negative experiences associated with their peer support role as well as a high likelihood of having secondary trauma. The lowest percentile ranked participant self-reported a score of 17, indicating zero negative experience associated with their peer support role and no symptoms of secondary trauma. Of the top 75% of participants, there was a range of scores from 48 to 80 with the following being the five top secondary trauma symptoms experienced, (1) I felt emotionally numb, (2) My heart started pounding when I thought about my experience with my peer, (3) I had trouble sleeping, (4) I expected something bad to happen, and (5) I thought about my experience with my peer when I didn't want to.

Eight in person audio-recorded interviews were completed and there was an equal balance between both institutions and secondary trauma scores. The researcher was able to meet their goal of having four interviews from the higher scoring participants and four interviews from the lower scoring participants. The following are the participants who were interviewed as well as the scores they received on the Secondary Trauma Questionnaire and the institution they attend respectively: Mia (80 - University of Northern Iowa), Veronica (70 - Wartburg College), Aria (65 - University of Northern Iowa), Emma (62 - Wartburg College), Grace (28- University of Northern Iowa), Brett

(27 - University of Northern Iowa), Genevieve (22 - Wartburg College), and Micah (22 - Wartburg College).

Within the coding of qualitative data from the interviews, it is evident how participants with the higher secondary trauma scores tended to have similar experiences, as did those with lower secondary trauma scores. For this reason, the results have been divided between the groups to better address the patterns found in helping behavior and impact on the helper.

High Secondary Trauma Scores

Mia

Mia's peer support role involved a close friend, Josh, who had undiagnosed mental health concerns. Mia supported Josh for a year and a half progressing from just texting and checking in periodically to calling crisis lines, taking him to the hospital, and staying with him for nights at a time. Mia's experience with Josh also triggered her own past mental health concerns involving suicidal thoughts and hospitalization which resulted in a resurfacing of her previously well-controlled OCD (Obsessive Compulsive Disorder) compulsions.

Mia felt a dependency had developed between herself and Josh when she believed she was having to help Josh manage his own emotions and find ways to cope. Mia described her relationship with Josh as being a mothering role, "It was more like I was a mom just making sure 'are you doing your homework,' 'is your homework getting done,' ...and making sure he was going to classes." As time went on, Mia became further involved in Josh's life and her helping role also changed to a more laborious one, "and

then next year was more like ‘okay, you need someone to be with you so I’m going to stay with you until you’re okay.’” Finally, Mia shared how eventually the frequency of her support transitioned from her checking in or staying with Josh weekly to doing so every night.

Mia also disclosed her mental health diagnoses. When Mia was in high school, she was diagnosed with depression, anxiety, and OCD. Mia was hospitalized twice during her high school years for suicidal thoughts and actions. Mia’s last hospitalization was four years ago in the spring of 2015. Since then she has been seeing a counselor and has a regulated treatment plan with a psychiatrist. Until this point, Mia had her compulsions and mood under control. Mia felt her support role with Josh triggered her in multiple ways across her diagnoses.

When Mia watched Josh go through the in-patient hospitalization process she struggled to see him go through similar experiences as she had. Mia also felt obligated to comfort Josh’s mother and explain that process to her.

I stayed with him until he was put into an outpatient facility and then I was like ‘oh my gosh’ everything just came flooding back and I just wish I could be in his position instead of him being there because...yeah everything was familiar.

As Mia worked through her experiences with Josh, she noticed her compulsions began to resurface both in trying to care for others but also in concerns about faucets being off and doors being locked. Mia identified herself as a mom multiple times throughout the interview and explained how that is a role she naturally plays in her friend groups. At the point of impact for Mia she began to re-experience symptoms of her

mental illness she had not struggled with since coming to college. For her, counseling is now a regular part of her life as she works to regain the progress she feels she's lost.

In Mia's experience she was working with Josh for an extended period of time. She was the one calling crisis lines and encouraging Josh to get help via the hospital and in-patient programs. It felt to Mia like her job was his safety and she eventually felt relief when she was able to get Josh connected with professional resources and ensure his safety beyond her staying with him. Specifically, Josh was having suicidal thoughts and a crisis line suggested Mia take Josh to the hospital. When Josh was released Mia felt uneasy about the next steps.

[Josh] was there for a couple days and then they let him out and I was like, 'hm, interesting,' so I was with him for a couple more days and I noticed his mood just drastically changed for the worse so then I...got him with the crisis line again for him to text and communicate with so that um...it wasn't all on me.

Mia felt relief when she realized she didn't have to be the sole person for Josh to talk to and process with. Connecting him with the crisis line and him eventually going to the hospital for a more extended stay helped Mia feel like she could step back and that Josh would get the care and help he needed. It allowed Mia to remove some of the responsibility from herself.

Ultimately, Mia felt the effects of her support role with Josh primarily in her social life rather than within her academics. Mia described having to balance her own help-seeking and processing with the privacy she wanted to provide Josh as he navigated his recovery process. As previously mentioned, Mia saw an uptick in her OCD and began

to feel the urge to consistently care for everyone in her life and make sure everyone she cared about was safe and taken care of.

I think it affected more my personal life with friends, because they're very much like 'I don't know what's going on' and I was like 'I do know what's going on' so it was a little push and pull with that...I was just making sure everything was okay, like playing the mom again, like 'are you okay, are you okay, do you need help, here are resources.'

Mia experienced social struggles because she was trying to balance the line between supporting Josh's privacy and having other mutual friends who were asking lots of questions. Josh has a right to not have his personal mental health information shared without his consent, however this also put Mia in a difficult position both in the way her roommates responded to her not giving them information and her inability to seek any level of support from her friends.

Mia's also explained how her relationship with Josh has changed dramatically since his hospitalization. For a while, it was difficult for Mia to maintain the same level of friendship with Josh as thinking about the situation was bad for her mental health:

I know right after that happened it was more prominent like every day I would think about it and now it's more of, if it passes my mind it's like 'oh wow that was really scary,' but um I do sometimes still worry about him.

Mia described the current relationship with Josh as complicated. Specifically, Mia explained how their roles and relationship dynamics had been so focused around mental

illness and supporting each other that once Josh began to become more independent and able to control his mental health, they weren't sure what their friendship looked like.

It's not as close as we were. But we um, we're working on that actually. We have a group therapy appointment tomorrow to kind of work through it...Now because he's healthy in his own way and he doesn't need someone to help him through that all the time, and now it's like I don't need to take care of that, so our friendship has kind of changed dramatically in a 'what are our roles in this friendship now' thing.

Mia's support of Josh has caused her to reevaluate what relationships are based on healthy connection and which ones are being created based on a dependent need or mental illness.

Mia also confided in her voice lesson teacher and was able to get a lot of faculty support throughout her time helping Josh. Mia felt this allowed her to have more understanding and grace when it came to her academic life. Beyond that, Mia's music faculty were described as "super close and if one person knows something they all know it." Mia said all of her faculty are very involved in the personal lives of their students and wanted to help Mia as much as they could. All of this academic support allowed Mia to succeed despite the other barriers that were in her way due to her focus on Josh and his mental illness.

Emma

Emma was in a relationship with her boyfriend, Jason. As their relationship transitioned to the college setting Emma became the sole caretaker for Jason and he was

dependent on Emma for performing many basic life functions. Eventually Emma became so burdened by her care for Jason that she ended the relationship resulting in Jason's suicide attempt. Emma described the dependency as her becoming a caregiver:

Like [Jason] was so at the point of not functioning that I would go over there and help him like shower, like it was that bad I would just be like you need to clean yourself like...so yeah I just like took up the caretaker position and was just always there and [made] sure he would eat.

Emma felt a shift in her and Jason's relationship from being a girlfriend or partner to someone who was responsible for the well-being and hygiene of her peer. As Emma said, she was "always there."

Shortly after this Emma had a realization about her care for Jason, "one day it just hit me...I can't do this. Cause first of all I'm not taking care of myself anymore." After Emma's understanding of how Jason was impacting her own health and well-being she deleted him off of all social media and stopped answering his phone calls or texts. It was at this point Emma described feeling free; like she could start "finding [her] way up from there."

Emma also shared about her OCD diagnosis in high school and how she had managed to control her disorder with medication until she came to Wartburg for the Fall 2019 semester.

When I got here a lot just kind of hit me again and then I self-harmed again and so I relapsed. I'd been clean for like five years and I just really beat myself up about it because like five years down the drain.

Later in the interview Emma also shared how she thought her experience supporting her boyfriend played a significant role in her mental health decline, “I think it did trigger it a little bit...it was also just the feeling of ‘I can’t fix him’ so...I was just pretty hopeless about it all and felt really shitty about it.” Until Emma’s relationship transitioned to college, she had been coping with her cutting and suicidal thoughts successfully and in healthy ways.

Additionally, Emma engaged in a longer-term support role with Jason and began to feel guilty for both breaking up with him while he was experiencing severe depression and also for feeling like she couldn’t keep taking care of him. Emma ultimately broke up with Josh because “it really wasn’t a healthy relationship” however she also still “feels guilty about it because of just like the break up was happening at the same time...and part of me feels like I was what kept him together and took care of him.” Despite Emma’s belief that she made the right decision in ending her relationship with Jason, Emma also felt pressure to return to help him at times due to her guilt. “I felt so guilty I actually like, he was so at the point of not functioning.”

During and after Emma’s support of Jason, she felt the largest impact on her personal and social life. Emma described how her coping became unhealthy both based in her support role of Jason but also as a result of their breakup. As their relationship ended and Emma also felt she needed to still help him, she coped by going out and sleeping with other people.

Socially I found it difficult to be around people I knew he was friends with...I let myself spiral out of control; I have slept with 6 guys, all football players, of

course. Just shitty guys...I just kind of let myself go and just really stopped respecting myself...But yeah it was like probably the toughest thing I'm still processing, like why, and why I did that. I don't know.

In Emma's attempt to cope with her frustration of caring for her ex-boyfriend, Emma found herself responding to the hurt and stress she was feeling by using sexual relationships. Emma also mentioned being "sick if you know what I mean" and having lots of heavy social repercussions because of how she physically coped with her stress. Emma felt this didn't align with who she was as a person. Due to that pattern however, Emma created a reputation for having one-night stands making it difficult to meet new people without that being attached to who she is. Further, Emma insinuated having gotten an STI from one of the men she slept with. This likely caused further stigmatization of her as a friend and partner across campus.

Aria

Aria's experience with supporting her friend Meredith was fairly short-term support, however involved her directly and physically intervening in a suicide attempt. Aria not only experienced events which contributed to her beginning to relive her own past mental health crises, but also resulted in a relationship where Meredith asked for continuous support in ways Aria could not provide due to her past experience and present need to care for herself.

Aria did feel like she was able to distance herself from Meredith's needs and requests, however that was still a very difficult process for her and contributed to negative feelings towards her relationship with Meredith.

I stayed in contact with her a little bit um but...I was the main person she was reaching out to for the most part um which is fine but like it got to a point where she was calling me a lot...and leaving voicemails and like I just was not in a place where I could be supportive and she kind of knew why I wasn't visiting in the hospital and she knew kind of where I was at and so it was like it became kind of frustrating to me that she wasn't respecting the fact that I needed space...and that was probably the hardest part cause it's like I don't want you to feel more alone.

Aria did successfully exit the dependent relationship however that came from, in her words, "a lot of like a lot of help from the staff from the college ministry and other students and stuff too."

Aria felt personally impacted by her support of Meredith partially because Meredith was creating a dependent relationship, but also because of Aria's own previous mental health crises. During the interview, Aria shared the ways in which her support of Meredith impacted her steps to recovery after several hospitalizations eight months prior to Meredith's suicide attempt:

[Meredith's attempt] was just something that I was really struggling to not think about and not let replay over in my head and um I think part of it was also me being anxious about ending back up in the hospital and not being okay. And so, I think there was an increase in anxiety and depression just as a result of everything that happened. So, like I just started not really eating well and sleeping well and that became a concern because like I lost a lot of weight really fast and...it was

very very difficult to stay out of that darker place when I kind of started having those thoughts again.

Throughout the interview with Aria, she mentioned multiple times about her experience with hospitalization earlier that spring and the significant triggers she felt from caring for Meredith. The entirety of Aria and Meredith's relationship impacted Aria's mental health. From Meredith expressing suicidal thoughts to her attempt and even further to her hospital stay, Aria shared how she continually felt she had to worry about being re-hospitalized and losing her mental health progress. After months of hard work, Aria explained "It was very difficult to stay out of that darker place...like it was very discouraging to me and very devastating because I'd been doing so well."

Aria having an intimate understanding of how Meredith may have been feeling and what she may have been experiencing made the struggle to separate herself from the relationship much more difficult. There was a dichotomy between Aria wanting Meredith to feel supported and also wanting to ensure her own mental health and sanity throughout that helping time period. Aria described feelings of guilt for not being able to fully support Meredith in the ways she needed and wanted Aria to.

[Meredith] really wanted me to visit her and that was really hard because I knew that like I wasn't in a position to um to visit her especially cause the hospital she went to was the hospital I did not have a good experience at...so that was probably the hardest part was not being able to be like as supportive as she needed me to be at that time.

Although Aria said throughout her interview she was able to understand why she couldn't support Meredith in the ways she wanted, Aria also acknowledged over and over how the hardest part of the experience was not being able to support Meredith the way Aria wanted to be supported when she was in the hospital. Aria not being able to go to the hospital and visit Meredith was the peak of where her guilt came from.

Finally, Aria felt her academics were impacted the most as she navigated the support of Meredith and processing her own emotions and thoughts about everything that had happened in their relationship. Aria shared that although she did explain to her professors that there was something personal going on, she didn't give explicit details so as not to be seen as making excuses for her performance. Aria also believed her professors would be supportive, especially with her social work major, but was still concerned because there's no guarantee they will be understanding,

It's just kind of one of those things...you don't know exactly how supportive the professors are going to be and how understanding they're going to be and um part of it is also I don't want them to think I'm like making excuses for um my performance in school either.

Only at the time of the interview did Aria feel that her academics were getting back to normal and she was able to make more forward progress with her own mental health. "I'm just now starting to get back to sleeping semi-normally and eating semi-normally . . . um I think like it definitely has made it difficult to stay focused on school."

Veronica

Veronica was a new first year student who had been placed in a helping role by Cherelle, a friend she met at orientation. Veronica received a phone call about Cherelle cutting. With very little information, Veronica immediately called campus security and ran over to Cherelle's room. Veronica went with Cherelle to the emergency room and stayed with her until late into the morning before returning safely to campus. After that night, Veronica worked through how to process her support role with Cherelle as well as how to move forward successfully as a new first year student in college.

Veronica did not feel as though a dependent relationship developed between herself and Cherelle, however there were still feelings of responsibility for her peer's safety due to her knowledge of one specific and isolated event. She was not drawn into the supporting role based on a well-established relationship and she also felt little guilt in stepping away from the relationship when she needed to process her own experiences. Veronica also shared how she felt comfortable ending relationships if she felt she was put in an uncomfortable helping position in the future.

I did think about it the other day and realized almost all of the people I first met on campus I've had to support, or give a lot to so I'm giving them all another chance because I just met them, but I know that I can't like do that again so if it gets close to that then I'll deal with the situation then cut off the relationship just cause I know I can't do that again.

Specifically, Veronica shared she “didn’t really talk with Cherelle at all,” and allowed herself time to slowly process. It was only recently Veronica and Cherelle had a conversation and were able to work towards reinstating the friendship.

Unlike the other three high-scoring participants, Veronica had not previously been diagnosed with any mental illnesses or disorders. Veronica shared that her mom is a health coach and has been able to help her process her experiences in healthy ways. The few times Veronica felt she was in a more difficult spot with her mental health she “would pull [herself] out of it and get the help [she] needed.” Veronica credited her ability to do that both to her own genetic luck of not having any obvious signs of mental illness but also to her mom’s encouragement of self-care and healthy practices.

In Veronica’s case, her grades suffered due to her inability for her to focus on schoolwork. Even in the short term, Veronica explained “one assignment could change your grade, so I turned in a couple that I wasn’t super proud of and I had to work harder now to get to a good spot.” Ultimately Veronica’s grades will recover but they were affected and caused more stress as the semester went on in order for her to successfully finish the semester. Veronica described her immediate response to her experience supporting Cherelle and how that impacted the days following.

When I got back to campus I kind of just like fell into my bed and fell asleep with all of my clothes on, um and so the morning was kind of a way for me to start dealing with what happened, so I was just very mentally shut off and I, when people would try to talk to me it was like I couldn’t hear them, they would have to

like tap on me for me to even know that they were there. So, I was just very disconnected.

Veronica explained how supporting Cherelle impacted her focus and motivation to stay caught up with homework and to attend class. Veronica also noted how when she was offered an excuse from class the next day, she wished she had chosen to take it. Despite the offer to contact her teachers and give her an excuse based on her involvement in the incident, Veronica insisted on going to class. "I didn't take classes off even though [unnamed] offered it to me, but I do wish I did that. So, I probably would. I like hate missing classes; I haven't missed a single class." Although a small decision by Veronica, looking back she felt she would have been better able to focus and avoid getting behind. When asked why she chose not to take the day off, Veronica explained how she didn't want to get any extra attention or have people inquiring as to why she missed class. While Veronica was physically there, she still wasn't mentally able to process the interactions she was having with her faculty members or peers.

Veronica explained how looking back on the experience she can see how "it like traumatized me a little bit because I just like had been so focused on [Cherelle's] wellbeing that I hadn't even thought about mine." Veronica felt an impact in her grades because with only a few missing assignments she had to work even harder at the end of the semester in order to catch up.

Low Secondary Trauma Scores

Brett

Brett has had many experiences throughout their time at UNI where they have taken on a supporting role. Brett describes themselves as the person everyone comes to for support. "I'm kind of like the mama bird of the group." Through these experiences Brett described a desensitization to working with peers experiencing destructive and suicidal thoughts. "I don't know. I feel like lots of times people come to me like 'hey I think I'm going to cut myself, hey I think I just want to end it, I think I'm going to get back into insert self-destructive behavior' and then I'm the one who like coaches them through." Brett also explained their own help-seeking patterns and how avoidance of their own emotions has impacted their ability to cope with the heavy situations they intervene in.

Brett shared several times during their interview about the frequency with which they had taken on these helping roles with peers in severe and high-risk situations. Specifically, while at UNI Brett shared how they had helped peers through suicidal thoughts and cutting caused by alcoholism, abusive relationships, general mental illness, academics, and other topics. Brett shared about these situations as a part of their regular routine "it always happens at like one or two or three AM, so I always try to stay awake until you know, I know no one's going to message me."

Brett having these frequent experiences embedded in their weekly routine suggests they may be desensitized to the kind of help they are providing. Brett specifically talks in the interview about how their response to their peers and the way they enact their helping role has changed over time.

I feel like I've done it so many times now that it doesn't affect me like it used to. Before it was definitely like the next day I would be very worried about them, I'm very concerned, I'm not going to classes. I'm not doing anything because I have to make sure this friend or whoever is okay. Now it's more of calling them in the morning, checking up on them, making sure they're okay, that nothing's happened, following up with the roommate, and making sure that my phone is at least fully charged so they can contact me and I can get in contact with them. Um but it doesn't stop me from going to classes anymore or anything like that.

Brett demonstrated how the more times they engaged in the peer helping role, the less they felt an effect on them academically and socially. Brett still took steps to be the helper after the initial crisis moment, however those steps have changed. Brett now accounts for the needs of others into their daily routine and preparation. Brett described contacting roommates and ensuring their phone is charged. This has just become taken for granted as a necessary task for the day and has been absorbed into Brett's life showing a desensitization to the impact of each of these isolated incidents.

Brett's interview demonstrated a lack of healthy boundaries or coping mechanisms as they discussed avoiding and not processing the thoughts and emotions related to the helping roles they take on. When asked directly how Brett takes care of themselves and their own mental health when supporting peers, Brett said "Good question. I kind of don't." Specifically, Brett described their brain as a "big storage shelf, you know like library shelves and there's a bunch of boxes on the shelf and I just pick up whatever I'm feeling and I put it in the box, and put the box on the shelf." Rather than addressing

the experiences Brett had with their peers or reaching out for help, even at the peer level they chose to not even address what they were feeling. Sometimes this philosophy for coping was to the detriment of Brett and their own mental health,

Most of the time like I've suffered with these things before like suicide, wanting to commit suicide and wanting to hurt myself um so lots of times when other students come to me with that, it's hard to keep myself from then falling back into old habits.

As discussed with Brett's desensitization, they were involved in these helping relationships consistently throughout, and before their college years. In all of that time, boundary setting appears to be limited as peers will call Brett about any topic, at any time of day, and will even do so after having taken steps to end their own life. Furthermore, Brett has an entire protocol for how these conversations occur and the steps they take. There is never a question of whether Brett will take the call or pass off the responsibility. Brett's thought process is encompassed by what helping action comes next, rather than deciding if they are the correct person to be helping at all.

Micah

Micah was a new first year student who during orientation met another student, Maren, who began oversharing about her previous traumatic experiences with her home life as well as some current suicidal ideation. Micah spent months trying to help Maren reach out to counseling or find a different outlook on life, however once Maren realized Micah was not interested in a romantic relationship, she stopped communicating with him. Micah also set very clear boundaries with Maren and refused to take on her

problems as his own. With Micah's goals of being a counselor, he was also comfortable reaching out to counseling himself both to refer Maren and as a way to cope with his everyday stresses and own mental illness.

Micah described having mass amounts of experience helping peers with their own mental illness throughout high school and now into college. During the interview, Micah portrayed himself as the person everyone comes to for support whether "they're 800 miles away or if they're a couple doors down" the hallway from him. This is a role Micah plays often and a situation he has found himself in countless times.

Micah's ability to set boundaries comes from past experience and learning the importance of saying no and setting limits about what he can and cannot do for a person. He described experiences from high school where he had lost friends to suicide and had worked hard on helping his friends utilize the school's anonymous reporting system. Micah invested a lot of his personal time into working in the mental health field. Micah explained how he "learned very quickly that people like to come talk to [him] about stuff." Micah also shared that he previously didn't handle these situations well. It's through his life experiences that Micah has begun to recognize how important having personal boundaries is to him and his mental health.

Now I know my boundaries and...I've learned 'no' is my favorite word um and I will find time for this later but I can't do it right now and so it was learning boundaries and that's my coping mechanism.

Micah also recognized the scope of his ability to help and then was able to look for a referral resource. He did not try to take on the support role for Maren on his own.

Micah attempted to refer her to counseling and to also reach out to counseling to ask them to do a wellness check from their end. Micah was also able to rationalize his emotions about his role in supporting Maren by remembering the importance of the boundaries he had set. Micah explained he “feels a little morose and it eats at [him] like on the inside because [he doesn’t] check in as much as often because [he] set a boundary very hard with her.” Although Micah may still think about Maren and feels bad about not checking in, he is still able to maintain a safe emotional distance from her situation.

Finally, Micah explained how support roles like these naturally attract him as he is both a double major in psychology and neuroscience. Micah wants to become a therapist and tends to look at everything from that point of view. Specifically, Micah described making sure he is only listening and not putting himself in his friends’ shoes or trying to give advice. It appears that Micah emotionally separates himself from the helping role naturally but also as part of a future job expectation he is practicing.

Genevieve

Genevieve found out from a mutual peer that her friend Gabby had gone to the hospital for trying to overdose. Genevieve took on a helping role when Gabby returned to campus, helping Gabby through some of her anxiety. Genevieve identifies as an empath and someone who takes on others' emotions very easily. However during this time, Genevieve also advocated for her own needs and felt comfortable asking Gabby for some space and alone time to recharge.

In Genevieve’s experience, she described having become very self-aware of what she needs in order to keep herself in a healthy place mentally. In Genevieve’s identity as

an empath, she feels lots of emotions very intensely and when someone is continuously expressing emotions like anxiety and depression it's easy for her to take them on as well. Genevieve says "if [Gabby's] feeling super anxious she'll come talk to people and if she talks to me I kinda start feeling...I can feel what she feels."

Genevieve's awareness of her strong empathy came from supporting lots of peers and friends on the internet through their own mental health crises. Genevieve would talk with people on Tumblr who shared similar mental health concerns as her and that's how she first started getting into the role of listener. From that point she's been able to identify both when she is starting to take on too much as well as how to get herself out of that role and into a healthier mindset. This is especially evident in her support of Gabby. Genevieve will say "okay I need to go home and color for a little bit cause that's how I destress."

Furthermore, Genevieve described a time at Wartburg when she took initiative in her own moment of crisis and could identify when was appropriate to process and cope by talking to friends and when she needed "a therapist, a real certified person." After having several breakdowns that day Genevieve chose to reach out to the campus counseling center and receive professional help rather than just "ranting to [her] friends." Additionally, Genevieve shared the mental and emotional work she had done in the past before college to discover her coping mechanisms and put plans in place for her moments of stress and breakdown. Ways Genevieve described coping independently of friends or certified professionals included time alone, coloring, spending time in nature, photography, singing, and art in general.

Although Genevieve appears to have a strong understanding of her own needs and takes the initiative to advocate for and enforce her own boundaries, she also appears to have become desensitized to the support role she has found herself playing in Gabby's life as well as her other friends from home and at Wartburg. Genevieve at one point discussed becoming a therapist because she had "talked a lot of people out of committing suicide and just making them believe that they're worth living, they're worth the air they breathe, cause sometimes that's what they don't feel like." Even in Genevieve's experience on Tumblr she would create community based around the suicidal experiences of others and then would become the helper in all of those relationships.

Grace

Grace shared how she has been in both short-term and long-term helping relationships with her peers. During her first year at UNI Grace's neighbor in the residence hall was experiencing suicidal thoughts and Grace took action to stay with her overnight so she wouldn't attempt to hurt herself. Currently Grace is supporting one of her roommates through the process of mental illness diagnosis and engaging in conversations about starting medication.

During her interview, Grace said she tends to "attach [herself] to people that have similar issues...like [she has], Bipolar Disorder." Later in the interview Grace returns to the idea of connecting with others who share her experiences with mental health. Specifically, when Grace began supporting her friend during her first year at UNI she recalled a time when the peer was in crisis.

I have a similar issue, so we were just like talking about how I used to deal with it because I had a pretty bad episode in high school. And she um she'd had issues before but never to the point where it was really that bad and we just talked about how I dealt with it and how I could help her if she was willing to.

Grace having had these college experiences as well as her desire to connect specifically with people who have diagnosed mental illnesses shows a desensitization.

Grace believed she was able to manage her boundaries sufficiently, as she would take breaks from being in the support role and would vocalize her need for space or time to work on her own homework and personal life, "I try to be there for her as much as possible, but sometimes I'm like 'okay dude I gotta go.'" Grace also talked in her interview about how she never felt like she had to respond to a peer unless they were talking about actually committing suicide. Other times when they just needed to talk, Grace felt like although she may want to be able to help, she knows there's times when she can't, and has become okay with advocating for that.

I do want to support her that's what I want to do but sometimes I have stuff going on and I really can't be there for her um which makes me feel terrible because sometimes I'm like 'sorry, I have homework I gotta do.'

Although Grace largely was able to enforce her own personal boundaries, there were times when she admitted to feeling pressure or responsibility to be there for her peers. Grace shared that during her first year at UNI her next door neighbor struggled and "her roommate wasn't really there for her...so [Grace] was pretty much the only person in the

building she thought she could really talk to.” Grace appreciated this friendship and also believed it had to be her to help her peer with her suicidal thoughts and actions.

Qualitative Data Summary

Ultimately, there were clear similarities between the experiences of the high scoring participants and low scoring participants. All high scoring participants described some level of a dependent relationship and feelings of responsibility for their peer or guilt when unable to provide the support their peer desired. Mia, Emma, and Aria all experienced triggering of their own past mental health concerns during the time of supporting their peers. All participants also discussed their coping mechanisms whether healthy or unhealthy for working through these roles and supporting themselves in the process.

CHAPTER 5

DISCUSSION

As the results show, the participants in this study were able to note several key impacts on their lives while serving in these helping and support roles for their peers. Below is a review of the previously stated research questions for this study followed by a more in-depth explanation of key themes and patterns identified throughout the data analysis.

In review, the research questions guiding this study included: (1) Do students with severe mental health concerns, namely those who express suicidality, contribute to symptoms of secondary trauma in the untrained peers they confide in and use for support? (2) What effects do the students providing peer-to-peer support for their peers expressing suicidality notice impacting their functioning academically, personally, and socially both at the time of the traumatic incident and after it has concluded? (3) How long do students providing peer-to-peer support tend to serve in those roles before feeling their responsibility has been sufficiently alleviated by another party such as a professional counselor, student affairs professional, or guardian? (4) What interventions from on campus staff, faculty and administrators were helpful or not helpful, and are there different types of support or interventions which could have provided a higher quality level of support for the student in the helping role?

Question 1

Do students with severe mental health concerns, namely those who express suicidality, contribute to symptoms of secondary trauma in the untrained peers they confide in and use for support?

The results and the trends of those who rated high secondary trauma coinciding with their peer experiences, implied there is definitely an impact on the participants own well-being. The type of secondary trauma experienced and the severity with which it affects students varies based on a number of factors discussed below including the presence of dependent relationships, feelings of responsibility or guilt for their peers, having past mental health concerns triggered by their support role, ability or inability to create healthy personal boundaries, and a desensitization to mental health crisis situations. Specifically, when considering experiences of several participants, the support role they played had a negative impact on their mental health due to the feeling of reliving their own unhealthy and traumatic life experiences. Further, several participants began to worry about their peers outside of when they were being contacted in the support role. The participants began to proactively look for ways to ensure their peers safety out of a feeling of responsibility.

Question 2

What effects do the students providing peer-to-peer support for their peers expressing suicidality notice impacting their functioning academically, personally, and socially both at the time of the traumatic incident and after it has concluded?

Participants noted seeing an impact on both their academic and social lives at

the time of their peer support role as well as after. Specifically, the high scoring participants noted higher levels of impact both socially and academically, however they typically noted only being impacted either socially or academically, not both.

The participants feeling impacted academically discussed missing assignments or being unable to focus in class due to intruding thoughts about their peer or the feelings of responsibility for not leaving their peer alone. Those who felt impacted socially described more experiences of isolation and depression. Emma noticed her social change due to the way she was coping with her experiences with her peer. Aria noted a social impact because her friend group became very anxious and she wasn't able to share with them any of the information she had about Josh's situation regarding his mental health.

Question 3

How long do students providing peer-to-peer support tend to serve in those roles before feeling their responsibility has been sufficiently alleviated by another party such as a professional counselor, student affairs professional, or guardian?

Through the analysis of the qualitative data there was no clear timeline for serving in the peer support role, as all participants noted varying relationship lengths and support timelines. The majority of the high scoring participants did engage in longer relationships with their peers from two to three months all the way to multiple years. Even once another professional or responsible party takes over the care of their peer, it took time for some of the participants to step away and let go of the urge to help and take responsibility for their peer.

Aria for example could rationally see Meredith being taken care of in the hospital and by other staff from within her campus ministry, however, it took her time to be able to actually step away from her relationship with Meredith. Aria felt pulled back into the relationship every time Meredith would reach out and felt manipulated back into the helping role. Ultimately Aria did leave the relationship, but it took great amounts of mental and emotional energy to rationalize leaving and stepping out of the support role. Aria continually described it as “the hardest part” of being friends with Meredith and trying to support her. From Aria’s experiences, there was guilt letting go of the dependent relationship regardless of the supports put in place to better serve Meredith in the long run.

In other cases, participants who understood the importance of boundaries were able to more easily step away and recognize when their helping role needed to end. Specifically with Micah, he reached out for additional support with Maren fairly early on in his support role. Within two weeks, Micah disclosed his concerns to a counselor and was able to relieve some of the feelings of responsibility coming from Maren’s dependency. Micah’s self-awareness and ability to step away and set boundaries served him well in getting him out of his peer support role sooner than other participants.

Question 4

What interventions from on campus staff, faculty and administrators were helpful or not helpful, and are there different types of support or interventions which could have provided a higher quality level of support for the student in the helping role?

As discussed in more detail under further implications, participants largely cited feeling as though faculty and staff support was lacking or they could have done more and noticed signs of distress sooner. Participants also mentioned the importance of further on campus resources being available. Overall, staff and faculty could do a better job of recognizing student needs and distress. When Emma shared about Jason missing class and failing classes, she mentioned that she had no idea how none of the faculty or staff noticed his absence and declining performance. Similarly, she wondered how her professors didn't notice her own behavior changes.

The most commonly cited way of improving support involved, at some level, better counseling resources and support. Some participants felt counseling availability made it difficult to process, while others struggled financially with having to pay for counseling after a certain number of sessions. One participant had a unique idea of including a partnership between counseling and offices receiving reports of high impact mental health incidents so a referral system could be created. See below in further implications for more ways in which support for secondary trauma could be improved within their college experiences.

Thematic Patterns

According to previous research conducted by Drum et al. (2009) and Gallagher (2013), students have become much more open to discussing mental health and more likely to seek support from friends and family rather than professional counselors or therapists. Drum et al. (2009) found that students were more likely to reach out to peers

not associated with leadership roles within the institution. The results of this study clearly support these and other assertions by studies regarding secondary trauma.

Specifically, the high-scoring participants, Mia, Aria, Emma, and Veronica had several similarities in their experiences supporting their peers. The participants discussed one or more of the following topics; feeling pulled into an ongoing dependent helping relationships with a peer, having a personal mental illness behavior triggered by their experience with their peer, expressing feelings of responsibility for their peer and guilt for their actions or stepping away from the relationship, and an impact on their own life either socially or academically.

The low-scoring participants, Micah, Genevieve, Brett, and Grace had several similarities in their experiences supporting their peers, specifically the participants discussed one or more of the following topics; desensitization to hearing about and supporting peers through mental health and suicidal-based trauma, ability to set healthy and clear boundaries in peer and helping relationships, positive and effective coping mechanisms, and clear but unhealthy coping mechanisms.

Key reoccurring themes which have emerged from the qualitative data analysis include: the presence of dependent helping relationships; feelings of responsibility and guilt associated with their helping relationships; being presented with experiences which triggered past mental health concerns in themselves; and the impact of boundary setting, coping mechanisms, and desensitization to mental illness interventions. Through the analysis of the experiences of both high and low-scoring participants' experiences, these

themes help illuminate traits of people and relationships that correlate with high and low secondary trauma responses.

Dependent Relationships

Of the high-scoring participants, Mia, Emma, and Aria all became involved in a dependent relationship with the peer they were supporting. Much of this may be attributed to the nature of the relationships prior to the participants taking on the support role. All three of these participants were in a long-term helping relationship of some kind with their peers. Mia supported Josh for over two years and had known him for several years before that. Aria had known Meredith for several months and was pulled into the relationship for several weeks after the initial crisis. Emma was supporting her long-term boyfriend for several months before getting help. With the closeness and length of the relationship, there may be more feelings of loyalty. Because the relationships continued during the support role, there was potential for the dependency to grow as the peer showed more need, and the participant provided more support.

Of the low-scoring participants, Micah was the only participant engaged in a dependent relationship. Although Brett, Genevieve, and Grace were involved in support relationships, their peers did not rely on them to complete daily functions. In Brett's case, although he was providing interventions during crisis, it does not appear to be one consistent relationship he is supporting. Micah however was supporting Maren consistently for a couple weeks and was involved in several extensive interventions related to her suicidal thoughts and actions. The main difference between their relationship and the relationships from the high-scoring participants was the length.

Micah and Maren's relationship was not as long term and he was able to set boundaries quickly after his first serious intervention.

There appears to be two different ways in which the dependency begins. The start of the dependency for Mia and Emma did look different from Aria, and Micah's. For Mia and Emma, their helping roles were not based on explicit requests from their peers. The roles were taken on by Mia and Emma because they saw a need and lack of support so they offered to fill it. From there, the dependency began and the peers became less and less able to cope without their presence. With Aria and Micah however, their experience with dependency began when their peers frequently reached out to them asking to talk, texting back and forth, and requesting interventions or hospital visits.

With three of the dependent relationships being the high-scoring participants, this suggests that when students are engaged in a dependent helping relationship, they may be more likely to be engaged in the relationship longer and to self-report higher scores of secondary trauma.

Feelings of Responsibility & Guilt

Both within and outside of dependent relationships, the participants largely had feelings of responsibility for their peers or guilt when they couldn't produce the kind of support their peer needed or was asking for. All participants described the feeling of responsibility for their friends at some level; the main difference was how each participant chose to respond to those impulses.

This phenomenon is also represented in literature concerning counselors impacted by vicarious trauma symptoms as a result of the clients they are working with. In an

article by Trippany, White Kress, and Wilcoxon (2004), counselors may begin to struggle in their personal lives based on feelings of guilt in relation to their clients. Trippany et al. (2004) suggests counselors may also experience feelings of grief when thinking about the circumstances of their clients; trauma.

Oftentimes participants who showed high levels of guilt identified themselves as “the mom” or “the therapist.” Veronica shared how she handles crisis situations in the moment “Whenever I am in a situation like that I just kind of go into like mom mode basically, so I just shut off whatever I’m feeling and focus on how I can make them okay.” Veronica feels she is responsible to the point of having to push aside her own needs and emotions in order to take care of the person in trouble. Mia shared similar sentiments “I was just making sure everything was okay, like playing the mom again, like ‘are you okay, are you okay, do you need help, here are resources,’” Similarly, Brett explained, they are “basically the mom/therapist of the group.” Brett’s feelings of responsibility also come out in how they will stay up until 3:00am at times until they are certain no one will call them with a crisis. The need to care for and support their friends has been incorporated into Brett’s routine and how they live their life.

Mia, Emma, Aria, Micah, and Genevieve had feelings of guilt based on their inability to fully support their peer or for stepping away from their relationships. Aria described repeatedly how one of the hardest parts of this entire experience supporting Meredith was when she realized there was nothing more she could do, and that Meredith wouldn’t understand that. Aria also described how the relationship she had with Meredith was enabling her, and the only way to help Meredith was to exit the situation. This was

especially hard for Aria based on her own experiences with mental illness and hospitalization. Aria's empathy with Meredith may have accounted for her intensified feelings of guilt when creating more space in her helping and personal relationship with Meredith.

It was just kind of um really hard to be able to separate myself like knowing I couldn't be what she needed and wanted at that time because she needed a lot more than any of us could give and she wasn't going to get the help she really needed unless we stepped back.

In Emma's interview, she talked through how she had broken up with Jason but would still return to help him perform daily tasks and keep him safe. Emma described how volatile she felt her breakup was, "It was a really bad breakup. Like 'fuck you, go be a whore' type thing and still like tweets about me like subtweets and it's just really nasty." Despite those intense feelings about her relationship, Emma continued to follow-up with Jason and said she "instantly, like felt so guilty," because she had broken up with him during his mental health crisis.

Even Micah who set healthy boundaries with Maren experienced felt guilt about taking less initiative to help her cope. Micah shared, "I feel a little morose and it eats at me like on the inside because I don't check in as much as often." Micah can acknowledge he can't be everything to Maren and how he is not the person who should be helping her, however it still contributed to those feelings of responsibility and guilt.

Triggering Experiences

Three out of four high-scoring participants denoted past mental health concerns being triggered due to their experiences in their helping roles. This is consistent with a study conducted by Hensel, Ruiz, Finney, and Dewa (2015), which looked at what factors impact the presence of secondary trauma in professionals working with their clients. Specifically, this study noted that professionals with previous trauma were likely to be triggered when working with clients expressing similar direct traumatic experiences. This demonstrates a parallel between the professionals working with clients, and the college students within this study working with their peers.

With the exception of Veronica, all three high-scoring participants had previously diagnosed mental illnesses or disorders and had an established treatment plan with a professional. All three of these participants had also had their symptoms under control until they began their support role for their peer. During that time, Mia, Emma, and Aria all experienced upticks in their mental illness symptoms and in some cases experienced new symptoms not previously seen.

Mia was diagnosed with OCD and during her time working with Josh she saw not only her old compulsions relating to making sure her loved ones were safe intensify, but began seeing new ticks related to turning off faucets and locking doors. Mia did not see a return of her previous suicidal thoughts, however she did feel heavily burdened by trying to explain the hospitalization process to Josh's mom, as it felt like she was reliving her own hospitalization experience again.

Emma was also diagnosed with OCD in high school. She also was a cutter and had suicidal thoughts. Before coming to college, she had her disorder under control and had the appropriate resources for success. Once Emma started trying to support Josh, she notes that she wasn't caring for herself anymore. She was cutting for the first time in five years and had her friends confiscate her sharp objects. As a cutter, Emma had previously been very proud of her progress and the amount of time she had been clean. Her experience with Jason however triggered her past enough that her friends became the caretaker for her, and she relapsed back into cutting.

Through both Emma and Mia's re-triggering of their own mental illnesses there is evidence to suggest how engaging in these roles can impact a person's own mental health. Even when a student has worked through their own diagnoses with a professional counselor, students watching and supporting their peers through parallel mental illness experiences serves to bring back past feelings and unhealthy behaviors. For both Mia and Emma, their unhealthy and obsessive coping mechanisms began again when they re-encountered the same experiences with their peers as they personally did previously in their own life. As Mia said,

It wasn't really triggered until he went to the hospital and I stayed with him until he was put into an outpatient facility and then I was like everything just came flooding back and I just wish I could be in his position instead of him being there because...yeah everything was familiar.

Boundaries, Coping, & Desensitization

The topic of boundaries was discussed in almost every interview with a range of thoughts on the subject and self-reported ability to set them. It appears that a student's ability to recognize and enforce healthy boundaries is related to their level of secondary trauma. Mia, Emma, and Aria all described having a lack of boundaries in their relationships. They would communicate as often as their peers needed and consistently stay with them to keep them safe.

Micah and Genevieve demonstrated the clearest examples of boundary setting in order to preserve their own mental health. In both of these instances, the participants talked about being self-aware of when they've hit their capacity for peer support. Micah, Genevieve, and Grace were all excellent at setting boundaries and could easily articulate what they were and were not willing to do in a helping relationship. Micah shared, "I know my boundaries and it's kind of saying 'okay, and I can help you with this and I can't help you with this.'" Micah has learned from previous counseling relationship and experiences how important it is to have boundaries and be able to advocate for himself.

Micah also explained how his experience with counseling and the commitment to his treatment plan and coping mechanisms contributed to his success and mental health while engaged in these peer support roles. When asked how he learned so much about healthy self-care Micah said, "five years of therapy man, it'll do it for you." Micah also described how his experience would have been different if he didn't set the boundaries he had, "previously if this was a first experience, I would have probably divulged too much time and like engaged in a support role that was like a relationship aspect." Micah

recognizes it is his emotional separation and ability to say ‘no’ that has helped him maintain his own mental health and not get sucked into a dependent relationship.

Micah described a common concern when first interacting with people who are experiencing trauma. When a peer wants to help it can be easy to remove boundaries that have been in place or have never been pushed back on. Trippany et al. (2004) addressed the ways in which professional counselors can be tempted to compromise their professional boundaries with clients and start to take on the vicarious trauma symptoms.

Genevieve also clearly articulated the importance of boundaries in her relationships and how she was able to continue to support her friend Gabby because she would vocalize her need to take breaks and step away to take care of herself. Genevieve has worked through on her own what coping looks like for her and it committed personally to using those skills. “I always know that’s what’s happening, so I’m like ‘okay I need to go home and color for a little bit’ cause that’s how I destress.” Genevieve sees mental health in highly destigmatized way and is willing to talk about suicide and other heavy topics frequently. Genevieve is also willing to seek help and step away from conversations when she realizes she needs a break. This is part of how she is able to continue to have these conversations in the future and continue to support her friends who are sharing heavy emotions and thoughts with her.

This is consistent with a study completed by Lynch (2019) in relation to resident assistants experiencing symptoms of secondary trauma through interactions with their peers in their job settings. A suggestion provided based on Lynch’s study was to help resident assistants set healthy boundaries. Without boundaries in place, resident assistants

with high numbers of students experiencing trauma were more likely to report symptoms of secondary trauma (Lynch, 2019). Trippany et al. (2004), also shared how encouraging healthy boundary setting with professional counselor helps mitigate the risk of developing symptoms of vicarious trauma.

Three of four high-scoring participants struggled with boundary setting and three of the four low-scoring participants had an understanding of boundaries and a self-awareness of what their coping plan is related to their mental health. The only low-scoring participant who did not describe healthy boundary setting was Brett who described staying up extremely late to be there to support their friends and always being the therapist and mom for whoever needs it. Brett appears to be an outlier who scored low for secondary trauma but has experienced the most consistent and intense crisis response situations and had the least professional support. Brett also did not have many of the resources like self-awareness, coping skills, professional counseling support, or ability to recognize and set appropriate helping relationship boundaries.

Due to Brett's consistent relationship with supporting those in mental health crisis, rather than setting boundaries and having positive coping mechanisms, their inability to process their experiences may have led to a desensitization when confronting the topic of suicide. Brett still struggles with their own suicidal thoughts yet also actively engages in these helping roles. Brett even described how their response to a mental health crisis has changed over time and evolved from one of fixation and obsession on helping, to having a steady routine. After responding to these types of crises repeatedly, Brett now can more easily function afterwards.

I feel like I've done it so many times now that it doesn't affect me like it used to. Before it was definitely like the next day, I would be very worried about them, I'm very concerned, I'm not going to classes. I'm not doing anything because I have to make sure this friend or whoever is okay. Now it's more of calling them in the morning, checking up on them, making sure they're okay, that nothing's happened, following up with the roommate, and making sure that my phone is at least fully charged so they can contact me and I can get in contact with them. Um it doesn't stop me from going to classes anymore or anything like that.

Although Brett can now function after having provided an intervention to an extreme mental health crisis, this is not the result of healthy processing or because of hard work Brett has put in to mitigate trauma. Part of the reason Brett's suicidal thoughts are still triggered by these interventions but Brett self-reported less secondary trauma, may be because they have slowly become emotionally desensitized to this topic and have begun to experience compassion fatigue. This fatigue may also mask some of the symptoms they are feeling that are connected with secondary trauma. Because Brett can now function better after these interventions, they may be attributing some of the negative effects to other areas of their life rather than their helping role.

Based the consistency between high and low-scoring participants and Brett's outlier status, ability to set healthy boundaries, understanding of purposeful and effective coping mechanisms, and presence of frequent contact with and desensitization to the topic of suicide may be signifying themes that explains how some helping roles are related to higher secondary trauma scores than others.

Further Implications

Participants were able to identify multiple different ways in which they believe they could have been better supported as a peer helper. Participants were asked what would have helped them receive help sooner. The most common response was a wish for better mental health resources available on campus. Over half of the participants cited an improvement that could be made to either the availability of mental health resources, or function of those resources.

As explained by Kitzrow (2003), there is evidence to show how campus counseling resources have changed. As the original function of these resources evolved from a place of goal setting and discernment to ongoing professional treatment needs, wait times have lengthened. As the participants mentioned, counseling feels inaccessible based on the wait times they are seeing on their campuses and this is affecting students' willingness to try counseling. One participant, Micah, was even able to articulate the same phenomena as seen in Kitzrow's (2003) work outlining how long-term needs for care have overtaken the college counseling field and made it more difficult for those who need short term support.

So, the friend that I tried to talk into counseling she got a little angry about how long it would take because they're very busy. We have a lot of kids here who see the need and it's good and I'm glad that's a thing but you're seeing, you're seeing an issue where it's the long-term stuff.

Although there has definitely been a surge in the number of people seeking counseling support for severe mental health conditions, the resources provided to

counseling services on campus has not increased at the same rate. According to a comparison between the University of Northern Iowa 2017-2018 and 2018-2019 fiscal year budgets, there is virtually no additional resources provided (University of Northern Iowa [UNI] Counseling Center, n.d.a-b). An allocation of \$477,789 during the 2017-2018 year employed eight full time staff members and two graduate assistants (UNI Counseling Center, n.d.-a). An allocation of \$473,425 during the 2018-2019 fiscal year employed eight full time staff members and two graduate assistants (UNI Counseling Center, n.d.-b). Although the national data shows an increase of college mental health needs, the budgets don't reflect those same data.

This same participant, Micah described feeling as though he had to sacrifice his own appointments so others could get counseling. "I was like 'I'm gonna skip next month I want someone else to take the time' and that spot immediately got filled the moment I didn't take it." The shortage of availability to counseling resources makes students feel as though because others were struggling, they need to take a step back from seeking support for their own mental health. Similarly to Micah, students begin to feel responsible for their friends' health and wellbeing.

Due to the inability to receive timely counseling support, students begin to receive the message that their mental health isn't in a dysfunctional enough place to warrant taking up a space. Mia described how in her relationships with friends, the message had become that unless you're in crisis you don't need to go to counseling.

I just know there are a lot of people going through this and some people just don't know they need to talk to someone professional instead of just their friend and I

wish I could help ease that into their minds better...they're like, 'but I'm not depressed, I don't need to use it, I'm fine.' I'm like 'well sometimes you don't need to be depressed.'

Many students like Mia's friends are relying on each other at the minor end of mental health support because they don't think they are "bad enough" to need counseling.

However, the longer they wait to go to counseling, the more their mental health worsens, and they begin to burden their friends with the needed support. Rather than intervening and treating students at a lower level, it begins to look like lots of students needing major crisis intervention. This waiting period may contribute to why so many friends and peers play the support role for so long, the friends don't receive the message that they should and could be receiving professional help.

Brett explained how valuable they felt it would be if the message that help could be for anyone was more widely spread. Brett shared how in their experience, students who are helping everyone rarely believe they can reach out for the same help they provide.

I do think it would be helpful for students who do supporting to know that just because they're the support for other people doesn't mean they can't go get support themselves. Um I know I have a friend who has also been a support for a lot of people, and it took a while for her to finally start getting support for herself because it was wearing away at her. She felt like she had to hold everyone's baggage and her own.

Another way students feel they lack access to support is through the changes being made to counseling and mental health resources based on budget cuts and the decline of enrollment at various institutions, is through session limits and insurance billing. Between the 2018-2019 academic year and the 2019-2020 academic year, changes put in place regarding the counseling center included a maximum of five free on campus sessions before being referred off campus or having insurance charged (UNI (n.d.-a-b)). For students like Brett, this isn't a feasible option for more long-term care and off campus support is even more difficult without reliable transportation and inclusive health insurance policies. Specifically, when asked how to improve the support for him as a peer helper, Brett said "First of all, they'd stop with that new thing that they started this year where you get so many freebies before they start billing you. That's just...people don't have those kinds of resources always."

Beyond requesting easier and faster access to on-campus counseling resources, participants also had suggestions for different ways to reach counseling. Aria mentioned it would have been helpful for her friends if after the school was made aware of who was involved in the immediate crisis intervention with Meredith if a note or email had gone out from counseling specifically to those students. This would have allowed those students direct access to a counselor without the pressure and anxiety that may come from reaching out on their own to start that process. According to Mia, several university officials were aware of the event and would have had the ability to forward that to the counseling center or work with the counseling center directly to get the students connected. In addition, Mia shared how a crisis counselor is always on call in the UNI

counseling center. A way to remove the barrier of these students connecting with a counselor quickly would be to directly invite them to make an initial first appointment with the crisis counselor.

Micah also had an idea of a way to better protect the students having the mental health crisis in addition to the peers in the supporting role. When Micah went to the counseling center to ask if there was a way to report a concern about a peer, he was told no, and that he would need to wait for his appointment and share that with his own counselor. This was a two week wait time. Micah's idea is to create an online reporting function within both the security and counseling center web pages. This would allow students who feel stuck in the peer helping roles the ability to find alternative professional help for their peer, as well as relieve some of the feelings of responsibility and guilt.

Brett also expressed distress about how the counseling services available at UNI did not interact enough with the other functions of campus. An example they gave was in connection with Brett's request for an emotional support animal (ESA). UNI's Student Accessibility Services (SAS) office required documentation of a disability in order to provide an ESA accommodation. In Brett's case, their disability related to a mental health diagnosis which they received at UNI's psychiatric side of their health center. Although the psychiatrists at UNI can prescribe medication, diagnose conditions, and have full authority as other psychiatrists, the policy at UNI is a note verifying a student's mental illness and disability does not qualify for accommodation through SAS. In order for a student to receive the accommodation the note would have to come from an off campus

medical professional. Brett felt distressed at being asked to find another provider without reliable transportation or beneficial insurance, as well as to have to reestablish a provider-patient relationship. Brett believed it would take a very long time to develop a relationship where the provider felt comfortable enough to support the request for an ESA. For this reason, Brett explained they gave up seeking the accommodation despite their strong belief it would have helped them cope. Had the mental health resources on campus and the SAS office been able to create a better partnership, Brett may have felt better supported in one of their few attempts to seek out professional help.

Taken together, the ways in which student affairs professionals can more adequately support students in these peer helping roles is first by identifying them and connecting with them to counseling. Participants explained how the only way faculty and staff of the school reached out to them to support them is when the participant approached the university official. Although once the student initiated a conversation, the faculty and staff members continued to provide support, there were other opportunities in Mia, Aria, and many of Brett's cases for someone reach out and help them find the appropriate resources to process. This is especially true when there is a specific incident where someone from the institution would have been notified if students participated in an intervention involving hospital transportation, in patient committal, or by calling 9-1-1 for medical and mental health support.

A way this support could be put into action would be in asking faculty and staff to also aid in mental health advocacy. For example, when a report comes in like when Aria directly intervened with her peer Meredith, the report could be passed on to a staff

member who has volunteered for the advocacy role. They could set up a meeting with Aria, walk her over to counseling, work with her and her advisor or professors to advocate for any academic extensions that might be helpful, as well as connect her with other key players in her life such as her on-campus employer, Residence Life Coordinator, or coach. This person could act as a guide to the student throughout the process of getting their own help as well as helping them understand and formulate a plan for success moving forward. Ensuring a university official offers timely support may be important to limiting the overall impact of their experience on their own mental health as well as their academics and social life.

Beyond counseling, there should be more continuity between departments and offices at the university when responding to student helpers in crisis. Just as the advocacy program would help bridge gaps between students and their resources, it would be important to work to create systems that better communicate across the institution. In Aria's case, she described how the RAs were involved in the same incident as her, but no one from housing reached out to check on her, and how the campus ministry leaders were aware of what happened, but none of her faculty and staff members or offices for student support worked to contact her. A way to combat students slipping through the cracks is to create a protocol for how offices who are informed of an incident work together and ensure their processes don't contradict each other. Specifically in Brett's position, he would have benefitted if the student health center and SAS could have created a policy that allowed students to use their freely provided psychiatric care for accommodation rather than asking them to look for other off campus providers.

Limitations

One limitation to the study includes the time of year the survey was distributed to students. The researcher noticed significantly less students were qualifying for the study than they had seen previously when conducting a similar informal research project. A reason this might have occurred would be the timing of the survey. During the researcher's past study, the survey had been sent out around midterms of the spring semester, meaning the large majority of students had already been on campus for more than an entire semester. The survey for this study was distributed in the fall semester meaning students had not had as much time on campus to create friendships or to have the experiences necessary to qualify for the study. The data supports how many of these high secondary trauma relationships come from longer-term friendships and relationships. Students who have only known each other for one or two months may not have entered into a dependent relationship or have been comfortable enough to start disclosing their mental health concerns with their peers on UNIs campus.

A second limitation applies to the ability to generalize data and results beyond the institutions at which it was collected. The study would need to be repeated at many different and diverse types of institutions including public, private, public-private partnerships, mid-size, small, large, religiously affiliated, rural, urban, etc. Each region of the country and the demographic of students attending impact how mental health is viewed and treated in campus settings. There are also different cultural beliefs regarding mental health which speaks largely to Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions, and Tribal colleges.

Future Research

There are many areas to be explored within the research of secondary trauma as it relates to peer helping roles in college students. Topics including the impact of prior mental health conditions and treatment, generational help-seeking behaviors, and types of mental illnesses in peers may all have impacts on how students report secondary trauma symptoms and impacts.

One of the themes which could use more in-depth and targeted research and analysis is the look at how students with prior mental health support and coping skills in place respond to helping roles as compared to students who have not had those experiences. Further, looking at how desensitization may play a role in how students respond to subsequent mental health crisis interventions. In the case of Brett, they expressed low levels of secondary trauma related to their most recent interaction with a suicidal peer, however they have also created a lifestyle around untrained crisis intervention and shared denial-based coping mechanisms. Investigating how someone's frequency within which they serve in these roles impacts their responses, would be an interesting study.

As students continue to change over time, more information will be gathered regarding Gen Z and the ways in which they choose to seek help and the timelines within which they operate for help-seeking. As Gen. Z begins to age and a new generation of students is named, it will be important to acknowledge key patterns and changes in the ways these individuals look for support.

Finally, it appears that students who are supporting peers with more extreme mental illness disorder and symptoms like Bipolar I, Schizophrenia, and personality disorders, may have longer term support roles and experience higher effects on own mental health and secondary trauma symptoms. Looking into the support-seeking peer's own diagnoses may begin to delineate a pattern between types of diagnoses and the impact on the helper.

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APPENDIX A

ONLINE INFORMED CONSENT

Thank you for agreeing to participate in this research experience. This form details the purpose of this study, a description of the involvement required, and your rights as a participant.

The purpose of this study is:

- To better understand the connections between peer support of students experiencing suicidality, and possible secondary trauma effects of that support.
- To better understand the ways in which peer support of students experiencing suicidality affect the informal student helper academically, personally, and socially.

The benefits of the research will be:

- A better understanding of how students expressing suicidality affect their friends, roommates, classmates, etc.
- A better understanding of how student affairs professionals can offer support to students placed in these informal helping and support roles.

The method that will be used to achieve this purpose is:

- Completion of the Secondary Traumatic Stress Scale (Bride, B., Robinson, M., Yegidis, B., & Figley, C., 2004)

You are encouraged to ask questions about any concerns you may have about the nature of the study or methods I am using. Please contact me or my IRB supervisor at any time by email or phone. Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence.

Throughout the course of this study your identity and information provided including personal identifiers and your surveys will be kept private and used exclusively for research purposes only.

Possible risks of the research include triggering of past emotional trauma related to mental health. Your participation does not provide any potential benefits to you; however, your participation is helpful in providing valuable information to the university about your experience as an informal helper and how that is related to your success at the University of Northern Iowa.

Should you feel emotionally triggered or affected by this study, the following are resources you may utilize:

- UNI Counseling Center

- 319-273-2676 (Call) Press 2 to speak to a crisis counselor
- Crisis Text line
 - 741-741 (Text)
- The Trevor Project (LGBT+ Inclusive)
 - 1-866-488-7386 (Call)
 - 678-678 (Text)

Should you feel you are experiencing a mental health crisis and at risk of hurting either yourself or others, contact UNI PD at 1-319-273-2712 or call 911 immediately.

Having read this informed consent document in full and having an understanding of both the study and of your responsibility in participation, please note your willingness to participate by checking the box as indicated below.

If you are choosing not to participate, exit out of the questionnaire and close your browser at any time.

IRB Supervisor: David Schmid, david.schmid@uni.edu; 319-273-6519

Student Investigator: Courtney Stuck, cstuck@uni.edu; 254-317-4288

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I have read the informed consent above and have a full understanding of the rights, requirements, benefits, and risks of participating in the following survey. By checking the box marked, 'yes' I agree to participate in this study voluntarily and understand that I can stop at any time by closing my browser.

APPENDIX B

IN-PERSON INFORMED CONSENT

Thank you for agreeing to participate in this research experience. This form details the purpose of this study, a description of the involvement required, and your rights as a participant.

The purpose of this study is:

- To better understand the connections between peer support of students experiencing suicidality, and possible secondary trauma effects of that support.
- To better understand the ways in which peer support of students experiencing suicidality affect the informal student helper academically, personally, and socially.

The benefits of the research will be:

- A better understanding of how students expressing suicidality affect their friends, roommates, classmates, etc.
- A better understanding of how student affairs professionals can offer support to students placed in these informal helping and support roles.

The method that will be used to achieve this purpose is:

- 30-45 minute in person, audio-recorded interview with the researcher

You are encouraged to ask questions about any concerns you may have about the nature of the study or methods I am using. Please contact me or my IRB supervisor at any time by email or phone. IRB Supervisor: David "Schmiddy" Schmid, david.schmid@uni.edu, 319-273-6519 Student Researcher: Courtney Stuck, cstuck@uni.edu, 254-317-4288. Participation in research is entirely voluntary. You may refuse to participate or withdraw at any time without consequence.

Throughout the course of this study your identity and information provided including personal identifiers and your recordings will be kept private and used exclusively for research purposes only. Once the recordings are transcribed, the audio will be deleted and you will be referred to by an alias in all verbal or written documentation.

Possible risks of the research include triggering of past emotional trauma related to mental health. Your participation does not provide any potential benefits to you; however, your participation is helpful in providing valuable information to the university about your experience as an informal helper and how that is related to your success at the University of Northern Iowa.

Should you feel emotionally triggered or affected by this study, the following are resources you may utilize:

- UNI Counseling Center
 - 319-273-2676 (Call) Press 2 to speak to a crisis counselor
- Crisis Text line
 - 741-741 (Text)
- The Trevor Project (LGBT+ Inclusive)
 - 1-866-488-7386 (Call)
 - 678-678 (Text)

Should you feel you are experiencing a mental health crisis and at risk of hurting either yourself or others, contact UNI PD at 1-319-273-2712 or call 911 immediately.

Having read this informed consent document in full and having an understanding of both the study and of your responsibility in participation, please note your willingness to participate by signing as indicated below.

If you are choosing not to participate, return this informed consent to the researcher unsigned.

Participant Printed Name

Participant Signature

Date

Researcher Printed Name

Researcher Signature

Date

APPENDIX C

SECONDARY TRAUMATIC STRESS SCALE

(Bride et al., 2004)

The following is a list of statements made by persons who have been impacted by people they are supporting. Consider the experience you described above and read each statement. Then indicate how frequently the statement was true for you at the time you were in a supporting role by circling the corresponding number next to the statement.

1 - Never 2 - Rarely 3 - Occasionally 4 - Often 5 - Very Often

1. I felt emotionally numb.
2. My heart started pounding when I thought about my experience with my peer.
3. It seemed as if I was reliving the trauma(s) experienced by my peer.
4. I had trouble sleeping.
5. I felt discouraged about the future.
6. Reminders of my experience with my peer upset me.
7. I had little interest in being around others.
8. I felt jumpy.
9. I was less active than usual.
10. I thought about my experience with my peer when I didn't intend to.
11. I had trouble concentrating.
12. I avoided people, places, or things that reminded me of my experience with my peer.
13. I had disturbing dreams about my experience with my client.
14. I wanted to avoid experiences with my peer.
15. I was easily annoyed.
16. I expected something bad to happen.
17. I noticed gaps in my memory.

APPENDIX D

IN-PERSON INTERVIEW QUESTIONS

1. Talk to me a little bit about either the time you mentioned in your survey or another time where you've been supporting a UNI student with mental health or something that they've been dealing with related to mental health.\
2. During that time how did you cope, who did you talk to, who did you rely on?
3. How did this affect your academics? Your social life? How did that affect your quality of life?
4. So how are you feeling now? Where are you at now as a person?
5. Is there anything that would have been helpful to you or allowed you to get help sooner?
6. Is there anything else about this situation, or your experience or how you're doing now, that you think would be helpful that you didn't share or that I didn't ask about?