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Understanding How Healthcare Social Workers Respond To Adult Medical Trauma

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
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Abstract

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MSW, Norfolk State University, 2016

BSW, Norfolk State University, 2013

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Medical trauma in the hospital is a growing health disparity often accompanied by social determinants. Assisting in alleviating disparities and social determinants is a standard of care embedded in social work practice. This research was conducted to examine healthcare social workers' experiences responding to and managing the psychosocial impacts of adult medical trauma in an acute inpatient environment. The goal of the research was to identify if a need exists for trauma-informed training among healthcare social workers. The research question examined how healthcare social workers respond to medical trauma. The model of case management, trauma-informed care, and systems theory were used to establish an understanding of healthcare social workers' experiences in providing trauma-informed care. In a qualitative research study, interviews were conducted with 11 qualified healthcare social workers from Virginia, Maryland, North Carolina, and Washington, D.C. Data were analyzed and coded using secure qualitative coding software. The findings showed that education, training, and overall experience of healthcare social workers varied among participants, indicating a need for trauma-informed care training for clinical social workers in the acute care setting. Healthcare social workers would benefit from trauma-informed training, and further studies and evaluations are needed on the effectiveness in implementing this approach. Social workers establishing a consistent identity in practice approaches can promote an environment of positive social change in which social workers are operating at the top of the profession and can improve perceptions of social workers by other interdisciplinary team members. Creating a more cohesive environment among interdisciplinary team members can lead to more holistic treatment for patients and improved health outcomes.

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Dedication

To all healthcare social workers trying to identify themselves as a practitioner. To the healthcare social workers who are relentless in advocating for knowledge and training needed to meet the current needs of their patient population. To the healthcare social workers who come together for peer support to assist in guiding each other's practice. Thank you for what you do, and your constant selfless acts in caring for such a vulnerable population.

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I want to start out with acknowledging my Lord and Savior Jesus Christ. With him, I can do all things in him that strengthens me. The spiritual guidance and support brought me to this day. I want to acknowledge the faculty members within the Ethelyn R. Strong School of Social Work at Norfolk State University for providing a strong foundation in my academic career. To the faculty of the Barbara Solomon School of Social Work and Human Services for advancing and enhancing my academic career to becoming an advanced practitioner. Lastly, I want to acknowledge my family members, and friends for their ongoing support in helping me reach this point in my academic career. Thank you, everyone!

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Section 1: Foundation of the Study and Literature Review

Introduction

Trauma induced in a medical setting is encountered widely, but often misunderstood, misdiagnosed, and underreported. This experience is a source for acute stress disorder and posttraumatic stress disorders (PTSDs) that are accompanied by events and circumstances that promote fear, terror, and helplessness. When the experience goes unidentified, this can deprive patients and family's access to psychological and or social services related needs while inpatient during hospitalization. The social worker is an integral member of the integrated care management team and may contribute to this practice problem due to their responsibilities of having to adhere to the healthcare delivery system known as the case management model. This healthcare delivery system may confine the professional practice of the social worker in their ability to recognize and appropriately respond to the psychological effects of medical trauma.

The social workers role within this model adopts task-oriented practice behaviors. These practice behaviors can inhibit the healthcare social worker's ability to assess and provide for interventions related to treating and managing medical trauma (Janssen, 2020). Medical trauma responses can be both psychological and physiological (Janssen, 2020). These responses can have a debilitating impact on a patient's overall mental and physical well-being (Janssen, 2020).

In this study, I used a qualitative research design to explore the experiences of healthcare social workers in managing the psychosocial impacts of adult medical trauma in an acute inpatient environment. Identifying social workers' experiences with trauma -informed care can lead to understanding whether there is a need for additional training. I attempted to enhance the professional practice knowledge, and skills of social work in healthcare to prevent retraumatization. In this study, I provide a foundation of the study with a literature review, a

description of the research design with data collection details, and applications to the professional practice to include implications for social change.

Problem Statement

How social workers respond to psychological responses to medical trauma in an acute inpatient environment is questionable as the profession of social workers within the healthcare environment has undergone some identity crisis (Ashcroft, R., & Ambrose-Miller, 2016). The social work profession has undergone some practice restraints since being integrated in care management. Healthcare social workers are more oriented with tasks than working as clinicians (Ashcroft & Ambrose-Miller, 2016). The functionality of their clinical capabilities has been minimized to functions that may include clerical-related roles, roles that oversee volunteers, nurse task roles, and whatever department-related goals needed to ensure care for the client has been adequately coordinated and that promotes continuous care (Badger et al., 2008). The clinical capability of the healthcare social worker if able to function at the top of their clinical capabilities includes counseling and support, discharge planning, psychoeducation, solution focus, assisting with accessing benefits along with community resources, resolving behavioral-related concerns that can pose as a contraindication to the plan of care, and assisting with emotional issues (Beckett et al., 2014).

The profession of social work over the years in the acute inpatient environment has been perceived as stagnant, as the roles and functionality have been dictated by hospital administrative staff that lack knowledge of social work practice (Heenan & Birrell, 2019). The profession has been departmentalized, potentially causing limited social work training and professional growth in efforts of identifying and meeting the needs of individuals and families who have experienced catastrophic events that have been medically traumatizing (Fraser & Curtis, 2006). Social workers in the acute inpatient setting having served as a separate entity from other healthcare specialists

such as mental health professionals, could aid as a first responder to this growing identifiable need of support to medical trauma (Mersky et al., 2019).

Healthcare social workers, as independent care managers, frequently see patients who have not yet been identified as having experienced medical trauma within the first 48 hours of admission (Wiggall, 2017). The healthcare social worker sees these patients to assist with identifying needs related to the plan of care (Wiggall, 2017). The provider being independent and not embedded within another specialist group may lead to a lack of clinical expertise. Lacking some clinical expertise may create for a barrier in a patient's plan of care (Wiggall, 2017). Providers not seeing mental health related signs or signs of trauma will likely not identify a need in which a referral would be initiated. This inhibits patients from receiving all required services. A social worker working as a care manager must anticipate the needs of the patient population being served (Wiggall, 2017). Without the clinical expertise and skill set, a provider may pose as a barrier more so than a solution to patient treatment-related needs (Wiggall, 2017).

The social worker's role in an acute medical hospital when working among the trauma population can create an experience that can be complex and emotionally intense (Cowgill & Petrakis, 2018). This population can create an environment that may be fast-paced and require the provider to be readily prepared for any situation (Cowgill & Petrakis, 2018). Situations can include psychological implications depending on the patient's response to their perceived trauma (Cowgill & Petrakis, 2018). Social workers working with trauma often use trauma-informed care (Polmanteer et al., 2019). This treatment approach is often used by social workers within this specialization when in comparison to those not within this specialization ((Polmanteer, Keefe, & Brownstein-Evans, 2019). The social workers that manage this population outside of this specialization as an independent provider in care management has a clinical expertise that may very well cause the approach to be less uniform (Wiggall, 2017).

Trauma-informed care within the practice of social work provides for client safety, trustworthiness, and client self-determination, while being culturally sensitive (Varghese et al., 2018). The underlining principles of trauma-informed care aligns with the social work values and provides for empathy, empowerment, and a strengths-based approach (Rhodes, 2019). Trauma-informed care is an approach that can be integrated into existing models of evidence-based services including the medical environment (Beckett et al., 2014). Trauma-informed care can strengthen the therapeutic alliance between the client and members of the interdisciplinary team and facilitate posttraumatic growth (Mersky et al., 2019). This treatment approach is easily adaptable in a variety of settings and promotes client engagement (Leveson, 2017).

Purpose Statement and Research Questions(s)

The purpose of this study was to identify if an actual practice problem exists in how social workers respond to psychological responses to medical trauma in a hospital setting. The current responses of social workers vary in nature and could have a retraumatization impact (Rikard et al., 2015). Care in a medical environment is rarely perceived as being harmful and traumatizing to patients and their families (Hall & Hall, 2016). Research is just developing, and the experience is subjective, which creates responses that are less uniform across multidisciplinary teams in the hospital setting. The practice of social work, along with other interdisciplinary teams, in the hospital setting does not identify with the term *medical trauma* (Hall, & Hall, 2013). A term more highly known associated with trauma for adults in a medical setting is *trauma medicine* (Hall, & Hall, 2013); this term is associated with experiences outside the hospital setting.

The experience of trauma medicine and medical trauma are similar. Medical trauma results from a direct encounter between a patient and a medical environment that is perceived as traumatic (Hall & Hall, 2016). This experience results from an interaction within the medical

setting, by way of staff support professionals and experiences related to procedural and/or diagnostic encounters (Janssen, 2020). A patient's psychological response to this encounter is intense, causing strong emotional psychological interpretations of the event. The traumatic event can be experienced by the patient or a patient's family, friend, or support professional (Hall & Hall, 2016).

In this research, I sought to set forth an understanding of how healthcare social workers are managing the psychosocial impacts of adult medical trauma in an acute inpatient environment. The practice focus research question is: What are the experiences of the healthcare social workers in managing adult medical trauma in an acute inpatient environment? The practice of social work in a hospital-based setting and managing any form of trauma can be complex and involve emotional intensity (Hall & Hall, 2016). That high risk can predispose social workers to vicarious trauma and further exacerbate the psychological responses of those having already been exposed to medical trauma (Hall & Hall, 2013).

The practice of social work must include approaches that integrate both various medicine programs and practices within the social work framework (DiLauro 2018). Such an integrated approach suggests a holistic approach to meet the needs of diverse clients. With healthcare constantly changing, creating an approach that continues to be comprehensive and empowering is important in addressing the psychological and medical needs of the current patient population (DiLauro, 2018). Social workers in a hospital-based setting encounter many clients, representing diverse experiences and backgrounds. Having an approach that is multidimensional allows social workers to identify areas of needs for clients, acknowledge their strengths, and apply interventions for restoration versus retraumatization (Rikard et al., 2015).

Trauma-informed care is a multidimensional approach used as a strength-based approach and can be applied to patients of all ages. The approach is diverse in nature, promotes cultural

sensitivity, and can be applied in any setting (Mersky et al., 2019). This approach is commonly used by social workers for trauma; however, the experience among social workers varies. According to Mersky et al. (2019), social workers entering the work force have a limited basic understanding of trauma and treatment modalities. The thought process among social workers is limited regarding how prevalent trauma is and some consequential effects if trauma is not treated appropriately (Mersky et al., 2019). In addition, some discrepancies exist in how trauma is treated among the practice of social work in a hospital-based setting. For example, trauma-informed care being is a preferred treatment regimen for trauma, and social workers may use this approach without a proficient knowledge base for insight, evidence, and shared understanding (Mersky et al., 2019).

Social workers as an integrated part of case management in a hospital setting intervene on a case alongside the nurse case manager to ensure an inpatient hospitalization stay is of quality while preserving hospital resources (Fraser & Curtis, 2006). The applied case management model for this population promotes the use of the social worker to be interpersonal and knowledgeable and to have clinical expertise with managing trauma along with other critical care needs (Fraser & Curtis, 2006). Members of the case management team for a trauma population need to be more dedicated to the improvement of the trauma system and the overall care needs of this population (Fraser & Curtis, 2006). Patients not having identifiable traumatic experience nor classified under trauma services will likely not obtain related specialty services. This population will likely remain under general services under integrated care management where the specialization and clinical expertise will likely vary.

This doctoral study is needed to identify best practice approaches used by practicing social workers in the hospital environment. I attempted to increase the data that exist on medical trauma and promote for awareness. In this study, I attempted to identify gaps in social work

practice related to healthcare social workers' experiences in responding to medical trauma. I attempted to enhance the professional practice knowledge within the social work profession while adhering to the core values of the social work profession. In this research, I attempted to implement a more uniform approach across disciplines to enable the treatment regimen to be more holistic.

Nature of the Doctoral Project

I applied a basic qualitative design to inform and establish understanding of healthcare social workers' experiences in providing trauma-informed care. Applying a qualitative research design promotes for an explanation that addresses multifactorial frameworks that exist in an institutional setting such as the hospital. The hospital is made up of different systems with various organizational designs and models embedded within each organizational structure. The qualitative design promotes for a framework that enables a design choice to be explored, while creating an understanding of its impact within the environment among this trauma patient population (Hall & Hall, 2016). This qualitative design acknowledges factors embedded in the experiences of healthcare providers and patients to the extent of being able to identify practice approaches that would likely meet the needs of those impacted by medical trauma (Hall & Hall, 2016). Having a qualitative research design can promote explanations that are comprehensible and easily identifiable to various members of interdisciplinary teams that work alongside the practice of social work in the hospital setting. The knowledge and data achieved can be made useful in predicting and identifying alternative practice approaches among other professions in managing medical trauma (Hall & Hall, 2016). A qualitative research design allows phenomena to be understood through responses to open-ended questions.

Significance of the Study

The results of this qualitative research study may provide insights on current responses to medical trauma within the inpatient setting and explore the need for trauma-informed training among healthcare social workers. In this study, I attempted to identify trauma-informed care as an informed holistic evidence-based practice approach for tackling disparities in health and well-being within healthcare (Bent-Goodley, 2019). The social work profession's contribution would allow this phenomenon to be acknowledged through various lenses specific to each practice approach. Once acknowledged in various lenses, a more world view approach will be ignited, warranting additional research and an array of interventions that meets the needs of all patient populations (Hall & Hall, 2016). This research contributes to the development of more optimal interventions that lead to more holistic treatment regimens. These holistic treatment regimens can lead to more positive outcomes for patients to alleviate the revolving door of high readmission rates.

This research study is significant for the field of social work practice because it relates to ethical responsibility of colleagues and the patient population being serviced. The social worker as a member of an interdisciplinary team has the ethical responsibility to contribute to the decisions that impact the overall well-being of patients and their families. The profession of social work allows such decisions to be drawn from their perspectives as they relate to experiences and values. This research allows for social workers to identify current experiences and ensure that the profession is following their ethical duty as it relates to the profession's code of ethics.

Implications for positive social change can result from the study related to the identity of social work's professional practice in the hospital setting. Social change can persist in how social workers identify themselves in the hospital, how other members of interdisciplinary teams

perceive social workers and identification of practice roles. Roles include competencies, trainings, and the ability to be subject matter experts within a profession. The profession of social work being compartmentalized within other professions promotes identity crisis, role confusion, and inability to own professional subject matter expertise. Reidentification, competencies, and adequate training will promote an optimal social environment to allow the social work profession to work at the top of their license and adequately meet the service needs of the patient population with regards to identifying and treating medical trauma.

Theoretical/Conceptual Framework

Medical trauma with a theoretical underpinning such as systems theory shows how several factors can be influential on the patients' and family members' experiences in the acute inpatient environment (Hall & Hall, 2016). These experiences can be impacted by the cohesiveness among members of the treatment team and the treatment plan of care (Hall & Hall, 2016). From an ecological perspective, a patient's individual traits, environment, and medical history can influence an interpretation of their medical experience (Hall & Hall, 2016). Similarly, healthcare social work professional traits, professional skills, and training can influence the social worker's interpretation of how to anticipate patient needs or perceive the medical experience of the patients and their families (Hall & Hall, 2016).

Applying systems theory as a theoretical framework for this research allowed me to identify patients and families, the healthcare social worker, and the inpatient environment as an organization with open social systems that must interact with their environments to survive (Graham et al., 2009). This theoretical framework gauges the rationale of the healthcare social workers' responses to the psychological impacts of medical trauma and the rationale of the perceived healthcare experience by the patient and their family members. The healthcare social worker as a member of a multidisciplinary team works together with other individuals from other

disciplines to deliver care and services both systematically and theoretically to patients related to their social, psychological, cultural, environmental, and financial situations (Graham et al., 2009). How a social worker responds to medical trauma is impacted by social systems. How a patient receives the care from a healthcare social worker is also impacted by social systems. Both the healthcare social worker and patient are part of the social system.

Bronfenbrenner's ecological system theory is known to be comprehensive and conceptualizing within the clinical environment (Campbell & Khin, 2020). This theory acknowledges the impact of environmental factors, also known as ecological systems, on an individual's experiences and overall development (Campbell & Khin, 2020). The systems theory is known for four ecological impacts: (a) microsystem, (b) metrosystem, (c) ecosystem, and (d) macrosystem. The microsystem is the interaction between the individual's direct surroundings. The mesosystem creates a description of the interaction within the microsystem. The ecosystem is the societal or environmental factors that may indirectly impact the individual. Lastly, the macrosystem includes location geographically, government systems, ideology from communities and organizational perspectives, and factors that impact the individual from a societal perspective (Campbell, & Khin, 2020).

In viewing medical trauma with respect to systems theory, the ecological perspective is best to gauge the experiences of patients, hospital staff, diagnoses, along with procedures within a hospital (Hall & Hall, 2016). How staff and patients perceive a medical encounter, along with its various systems, dictates if it has an association with being traumatic or not. Systems theory as it relates to this research problem, questions, and the purpose of the study helped to identify the research need and how problematic this need is or can be. Systems theory highlights how not managing the phenomena can impact other systems and other parts of the social system.

Values and Ethics

When responding to the psychological impacts of medical trauma, the healthcare social worker must behave in a manner that adheres to the social work code of ethics. When responding or interacting with this population, a social worker needs to demonstrate the ethical principles based on social work's core values of service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence (Council of Social Work Education [CSWE], 2015). The principles include helping people in need to address social problems, challenge social injustice, respect the inherent dignity and worth of the person, recognize the central importance of human relationships, behave in a trustworthy manner, and practice within their areas of competence and develop and enhance their professional expertise (CSWE, 2015). The clinical social problem related to healthcare social workers' response to managing the psychological impact of medical trauma is related to all social work core values and related principles (CSWE, 2015).

Healthcare social workers' response to the psychological impacts of medical trauma need to reflect ethical value service and the principal to help people in need, which can include addressing social problems that involves a social worker pulling from their values, knowledge, and skills to help those in need. While implementing this service, social workers actions are elevating service to others above their own self-interest (CSWE, 2015). The value social justice and related principle to challenge social injustice involves social workers implementing social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people (CSWE, 2015). The value dignity and worth of a person includes the ethical principle of respecting the inherent dignity and worth of the person (CSWE, 2015). A social worker adheres to this value and principle by treating everyone in a manner that is both caring and respectful,

while being mindful of individual differences related to their cultural and ethnic diversity. Overall, social workers promote self-determination of patients and their families (CSWE, 2015).

The ethical value of importance of human relationships includes the ethical principle of recognizing the central importance of human relationships (CSWE, 2015). A social worker implements this approach by demonstrating an understanding that the importance for change originates through relationships between and among people. A social worker engages people as partners in the helping process, including the patient and members of the interdisciplinary team (CSWE, 2015). Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities (CSWE, 2015). The value integrity and competence mean social workers have an ethical principal to behave in a trustworthy manner, practice within their areas of competence, and develop and enhance their professional expertise (CSWE, 2015). Social workers adhere to these values and principles by acting responsibly, while being honest when promoting ethical practices within their areas of competencies on the part of the organizations within the hospital (CSWE, 2015). A social worker demonstrates such acts while developing and enhancing professional expertise.

Review of the Professional and Academic Literature

The overarching goal of a literature review is to provide for a broad base perspective of the research. To obtain sources for this literature review, I used scholarly databases such as Google Scholar, ResearchGate, the Walden University Library, and other related academic libraries. The main search engine used was Google Scholar. Key terms commonly searched were *medical trauma, trauma, trauma in the hospital, hospital trauma, trauma-informed care, case management model, trauma-informed care education, healthcare social workers,* and *medical social workers*. Preference was given to articles published within the past 10 years, mostly from

scholarly researchers, social work journals, and anecdotal data relevant to the research problem. These articles provide relevant content that helps create a clear picture of the research problem. The literature review is organized into themes including history of hospital-based social work, integrated care management, medical trauma, trauma-informed care, and competencies of social work practice, among others.

History of Hospital-Based Social Work

The history of hospital social work services in the United States began with Ida Cannon. She was known as the founder of medical social work; she assisted in the establishment of the first department of social work service in the United States within Massachusetts General Hospital in early 1905 (Praglin, 2007). At that time, social workers helped patients through various problems. Those problems included social workers helping patients through the nonavailability of other support services such as facilities, medications, and overall recovery from illnesses (Praglin, 2007). Social workers enabled patients to navigate through health systems with their continued guidance and support while advocating and ensuring they were being afforded their rights (Praglin, 2007). Social worker support extended to the nurses and physicians during times of need for their patients (Praglin, 2007).

Social work service in the hospital has progressively grown in the 1930s, to where Janet Thornton broke ground in efforts to provide support for practice-based research (Sedgwick, 2012). A grant of 10,000 dollars was provided from the Auxiliary of Vanderbilt Clinic at Columbia Presbyterian to improve the work of the Social Service Department (Sedgwick, 2012). The grant sponsored Thornton's research study into the connection between social disorders and medical problems (Sedgwick, 2012). The title of the study was *The Social Component in Medical Care, A Study of One Hundred Cases from the Presbyterian Hospital in the City of New York* (Sedgwick, 2012). The outcome demonstrated a prevalence of social problems that impact health.

Thus, Thornton created awareness after this study and promoted for the need of departments of social work services in hospitals across the country (Sedgwick, 2012). Overall, Thornton wanted to communicate how social factors impact medical issues and how applying measures to highlight patient strengths can assist in decreasing debilitating factors affecting patients (Sedgwick, 2012).

Over various decades of having social work service departments in the hospital, the profession has adapted the practice to continuously meet the growing care delivery changes with the healthcare sector (Muskat et al., 2017). Encounters occurred in which departments of social work services faced increased shortages of funding, which included caps on spending. In addition, hospitals where facing patient conditions that were becoming increasingly complex and chronic (Muskat et al., 2017). While hospitals were facing those changes, the social environment had endured an influx in environmental-based illnesses. These rapid changes in the environment were in addition to pressures on hospitals to measure healthcare delivery outcomes (Muskat et al., 2017). The practice role of healthcare social work had grown to be in acute and chronic care sectors of hospitals. The practice of social work had instituted an approach that allowed for social workers to provide support perceived as instrumental and emotional to patients (Muskat et al., 2017). Other supportive care included linking patients to support-related services that were internal and external to the hospital setting.

Healthcare eventually adopted measures that enabled healthcare delivery outcomes to be measured through cost containment models (Judd & Sheffield, 2010). As a result, social work practice was decentralized and placed under case management, causing changes in standardization of care. These changes changed the functional role of social work services within the hospital systems both in the United States and Canada (Judd & Sheffield, 2010). The process of decentralization of social work practice in the hospital resulted in trends that shifted supervisory responsibilities for social work staff to those with other areas of professional

expertise and resulted in the initial erosion of social work leadership (Judd & Sheffield, 2010). In many hospitals, social workers' roles are frequently questioned, including how essential they are or if their services are even necessary (Judd & Sheffield, 2010).

Many interdisciplinary team members are still unclear of what medical social workers are and how social work practice contributes to the medical environment (Short et al., 2016). This uncertainty and deficits in knowledge of social work practice prompted an identity crisis, forcing social workers to define their roles. This initiative began to promote awareness about social work practice in a hospital-based setting and the contribution this practice makes to patients and social workers as members of the interdisciplinary teams (Nelson & Merighi, 2003). Frequent practice changes and role identity changes can impact a healthcare social worker in a manner that causes negative responses by social workers, including emotional negativity, job-related burnout, and loss of commitment to the job and the profession (Nelson & Merighi, 2003). This response can cause a residual effect in how a social worker appropriately responds to all patients' experiences, including psychological responses of traumatic experiences in the hospital environment (Nelson & Merighi, 2003).

Integrated Care Management

According to the National Association of Social Workers (NASW), the social work profession and the practice of case management began in the late 19th century and early 20th century (Judd & Sheffield, 2010). The relationship emerged due to social problems such as poverty, urbanization, industrialization, immigration, and growth of populations throughout the United States. In the first half of the 20th century, social work began to integrate perspectives that reflected an approach that was psychodynamic in nature. With hospitals adopting models of cost-containment approaches, the department of social work services and nursing case management

became under one umbrella, which is the integrated care management services department (Judd & Sheffield, 2010).

Integrated care management is identified as being a program that is strength based, voluntary, and family focused (Judd & Sheffield, 2010). This case management approach involves an independent facilitator who collectively brings members to a table that serves as relevance for patient-related care needs (Judd & Sheffield, 2010). The members include providers, family members, and additional hospital-based support personnel. The hospital personnel operate as a team where the members work as a partnership to establish a comprehensive plan that addresses the needs of patients and family members while containing costs of the hospital environment (Daniels, 2011). The system allows the nurse to work at the top of their license and social workers to work with families, providing support through counseling, finding resources, and other related encounters the hospital perceived as fitting for the profession of social work (Daniels, 2011). A registered nurse most commonly performs triage and initiates the services of social work for cases the nurse believes are most fitting based on the knowledge they have (Daniels, 2011).

Challenges often emerge primarily around the discharge processes and how the teams work together for patient discharges (Heenan & Birrell, 2019). An agreement persists that the development and implementation of discharge plans has become a primary focus of hospital-based social work practice, which poses an adverse impact on other traditional practices of social workers (Heenan & Birrell, 2019). Pressure has arisen for social workers to discharge patients and much of the managerial focus within the department of care management targeted the ability to measure output while jeopardizing the holistic assessments and needs of vulnerable patients, which social work practice was initially known for (Heenan & Birrell, 2019). This adverse

component became known as the best practice to meeting the cost containment of healthcare in the hospital environment (Heenan & Birrell, 2019).

Many social work professionals perceived that their role in hospital discharge is important, but they no longer had time to build relationships or give emotional support with people and gain their trust because they were preoccupied with completing other assessments (Heenan & Birrell, 2019). These kinds of approaches changed the practice of social work in the hospital; discharge management has grown to be the therapeutic role of the healthcare social worker (Heenan & Birrell, 2019). These restrictions and role changes, including social workers becoming too busy to build relationships, build trust, and provide for emotional support, raised concerns on how social workers could respond to the traumatic experiences, including identifying psychological responses to medical trauma.

Medical Trauma

Adult medical trauma can best be described as a set of psychological and physiological responses of adults and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences (Hall & Hall, 2013). Medical trauma can be a single event or result from multiple medical events (Broad & Wheeler, 2006). A healthcare social worker must be able to identify signs of medical trauma for the response to be appropriate (Badger et al., 2008). Not identifying signs can impact the overall treatment plan (Coyle et al., 2019). Inappropriate responses to medical trauma can lead to repetitive traumatization (Rikard et al., 2015). Medical trauma can be perceived as subjective, as it is the experience of the person who endured the event or events (Hall & Hall, 2016). Medical trauma is more predominantly identified among the pediatric population; however, life-threatening experiences can occur among any patients or within any part of a patient's hospital treatment (Broad & Wheeler, 2006).

Factors related to medical trauma are the patient, diagnoses and procedures, medical staff, and the medical environment (Hall & Hall, 2016). The patient factor of medical trauma is commonly depicted as the patient's interpretation of medical trauma. Some components are the patient's past hospital experiences, other mental health or related personality disorders, or even social determinants the patient has been exposed to, all of which can cause a patient to perceive their hospital encounter as being traumatic (Hall & Hall, 2016). A diagnostic or procedure as a component of medical trauma can be related to a patient's planned hospital procedure going differently than the patient planned or expected, causing the patient to endure near-death experiences, loss of limbs, or some other traumatic outcome (Hall & Hall, 2016).

A life-altering diagnosis or procedure is a factor of medical trauma that can impact patients' lives and their psychological well-being. An emotional construct can put these patients in a state of fear, not knowing if they will ever get out of such a dark place, and their sense of normalcy can be altered (Hall & Hall, 2016). These experiences related to a diagnosis and procedures can lead to medical emergencies that can be traumatic in nature and life altering. Patients with such experiences may develop PTSD, depression, and related anxiety disorders (Hall & Hall, 2016). The medical environment and the staff can exacerbate the experience because they play a central role in the patient experience. Ongoing communications and the relationships built between patients and hospital staff can impact patient outcomes (Hall & Hall, 2016). Basic communicative skills can affect how patients understand their experiences (Hall & Hall, 2016). The basic time of building relationships and gaining the trust of patients can help patients put into perspective their experiences (Hall & Hall, 2016). Hospital staff who are emotionless or not gentle in their patient care approach can solidify to the patient that they are having a horrible experience, which could cause them to believe if they stay where they are or continue to go through the experience, they could die (Hall & Hall, 2016). Other encounters

include lack of bedside manners in which patients feel violated when people enter their room at any given time and any given manner (Hall & Hall, 2013). How abrupt they may assess the patient and the forceful tones of their voice may mimic another perceived experience (Hall & Hall, 2013). The hospital environment if endured adverse experiences, or witnessed by others on a daily basis, may cause that environment to be adversely known from the previous adverse encounter.

Trauma-Informed Care

Healthcare social workers, applying a trauma-informed care approach as a response to the psychological impacts of medical trauma demonstrates a way of thinking that promotes for strength (Hall & Hall, 2016). This practice approach allows for coping mechanisms, behaviors, and traumatic experiences to best be understood by the individual (Coyle et al., 2019). Instituting trauma-informed care allows practitioners to adequately provide care to individuals who has encountered violence, experienced being a victim, and having gauged traumatic experience (Bent-Goodley, 2019). Care is provided adequately when instituting trauma awareness within the systems and other related service provisions to best accommodate the member as being a survivor while promoting a healing process, and a haven that promotes safety to best promote for recovery (Bent-Goodley, 2019).

Trauma-informed care is known for its 6 principles: safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and being responsive to cultural, historical, and gender issues (Beckett et al., 2014). The most important component in this care approach is the safety principle as it initiates grounding for the patient while practitioners promote a safe environment from a physical and a psychological perspective (Beckett et al., 2014). The practitioner makes the patient feel comfortable and does his or her best to alleviate environmental triggers that will cause the patient to feel unsafe or have

repetitive experiences of trauma. The approach under trauma-informed care gives the patients some form of predictability while being engaged in the helping process (Beckett et al., 2014). This approach allows the patients to feel like they have some form of control, while the practitioner is creating a trusting relationship. This approach provides tools and resources to the survivor to enable them to build resilience that will promote for peer support, collaboration, and the ability to learn from the supportive members of their treatment team (Bent-Goodley, 2019). By learning from the supportive members of their treatment team, the patient is empowered, validated, and experiences encouragement to endure and be part of their treatment regimen (Bent-Goodley, 2019). Trauma-informed care can be implemented in any practice. It promotes for cultural awareness and is perceived to be comprehensive where partnerships are developed. This approach too, enables the social worker to utilize multiple social work skills that are at the core values of the social work principles, and values (Bent-Goodley, 2019).

Competencies of Social Work Practice

The competencies of the healthcare social workers responding to the psychological impacts of adult medical trauma in an acute inpatient environment comes from the CSWE. According to the CSWE, the competencies of the social worker come from the ability to integrate and apply social work knowledge, values, and skills to practice situations in a purposeful, intentional, and professional manner to promote human and community well-being. The CSWE adopted a competency-based framework Educational Policy and Accreditation Standards (EPAS) to ensure the competency level of the profession of social work (CSWE, 2015). This competency-based education has a shared view as it relates to being competent in the professional practice. EPAS has a defining view of competence that is holistic in nature where it is informed by knowledge, values, skills, cognitive and affective processes. This level of competency is manifested in the social workers ability to critically think, respond affectively, and exercise

appropriate judgments to unique practice situations CSWE, 2015). Overall professional competence is multidimensional and composed of interrelated competencies. The social workers level of competency can be described as dynamic, developmental, and ever changing (CSWE, 2015). In consideration of the practice of social work within EPAS, the social workers competencies derive from nine interrelated competencies and component behaviors that consist of knowledge, values, skills, and cognitive and affective processes (CSWE, 2015).

Although the practice of social work has these nine interrelated competencies and component behaviors, accredited institutions can add to the already existing 9 competencies or choose how to integrate the competencies within their educational platform to be consistent with their mission and goals (CSWE, 2015).

As intuitions missions and goals vary, so does the delivery of social work education. The delivery of social work education can impact the training and preparation of healthcare social workers when interacting, gauging, and responding to the psychological impacts of medical trauma with the inpatient environment (Kawam, E., & Martinez, 2016). Although the platform varies, social workers at minimum still have the nine interrelated competencies and components of behaviors (CSWE, 2015). Some healthcare social workers may have obtained training and education in trauma-informed care, and others, if not reflective of their institutions mission and goals may have not gotten the same training (Kawam & Martinez, 2016). In consideration of the different levels of training and development amongst healthcare social workers, it is important to get a consensus of the healthcare social worker response to the psychological impacts of medical trauma in efforts to promote continuity of care, prevention of retraumatization, and prevention of vicarious trauma (Levenson, 2017). Trauma-informed social work practice is not among the necessitate social work practice requirements. Many institutions remain on the defense due to the potential trauma related background of their students (Levenson, 2017). In defense to that notion,

many students represent all aspects of the population that the practice of social work serves. There are pros and cons to every population that the students represent, however the student will still need to know how to manage their own trauma perceptions while learning to identify and meet the needs of other (Short et al., 2019).

Origin of Trauma-Informed Social Work Practice

The practice of social work, and its interaction with trauma has grown since hospital based social workers originated (Bent-Goodley, 2019). The EPAS, provided for updates on the trauma-informed social work practice as the practice of social work had continued interaction with the trauma population. The practice recommendation can be applied to all types of trauma that the practice of social worker gauges in, to include that of medical trauma. The updates came about in 2015, when EPAS expanded the nine competencies for the social work profession. In doing so, allowed for the competencies to be adequately applied to practices beyond generalist, however, to include and specialized (CSWE, 2015). Select institutions have chosen to integrate program specialization at their institution, as it relates to their intuitions mission and goals. The 2015 EPAS included a Specialized Practice Curricular Guide for Trauma-Informed Social Work Practice. The hope for this expansion was to aid as an invaluable resource to field instructors, along with faculty members to ensure they were adequately educating students to work effectively in trauma-informed social work practice (CSWE, 2015). Educating students in Trauma-informed social work was aimed to prepare students through research and best practice standards when working with individuals, families, groups, organizations, and communities (CSWE, 2015). Standards for competent practice in response to trauma are an ethical obligation of the profession because the likelihood of encountering survivors of trauma in every practice setting is very high (CSWE, 2015). Additionally, trauma-informed social work education recognizes the importance for students to understand the impact of the work on self, colleagues,

the organization, and the system (CSWE, 2015). Understanding the impact of secondary traumatic stress, vicarious traumatization, vicarious resilience, and posttraumatic growth is critical to professional growth and development (CSWE, 2015).

Trauma-Informed Education and Training

The healthcare social worker having trauma-informed education, and training reduces re-traumatization, and vicarious trauma when able to identify and appropriately respond to the psychological impacts of medical trauma. According to EPAS, the trauma-informed social workers recognize the following: the inherently complexity of trauma and traumatic experiences, specific challenges to trauma recovery, and how trauma informs organizational practices (CSWE, 2015). The trauma-informed trained social worker has an understanding that trauma occurs in a broad context that includes individuals' personal characteristics, life experiences, and current circumstances (CSWE, 2015). The social worker is knowledgeable of the intrinsic and extrinsic factors that can influence individual's perception of the experience and to the extent in how the patients rates his or her experiences (CSWE, 2015). How the patient rates the experience promotes for an environment where expectations vary as it relates to one's expectations regarding danger, protection, and safety; and the course of post trauma adjustment (CSWE, 2015).

The trauma-informed social worker has an understanding that the experiences that is perceived as traumatic can pose as a challenge when providing treatment to what is expected by the patient, family, and the society (CSWE, 2015). The society figures can be related to the social roles the patient and/or family members are related to or influenced by. In addition, the trauma-informed social worker has the understanding that in working with trauma-exposed clients can evoke distress in providers that makes it more difficult for them to provide good care (CSWE, 2015). From that, the importance of proper professional development and self-care are among the

important parts of providing high-quality care and of sustaining personal and professional resources and capacities over time (CSWE, 2015).

According to EPAS, the trauma-informed social worker has an understanding whether recognized or not, that trauma can shape the organizational culture of all service providing systems. The organizational practice of social work had adopted to reflect that the U.S. Substance Abuse and Mental Health Services Administration statement reflects understanding of the vulnerabilities and triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be more supportive and avoid re-traumatization (CSWE, 2015).

Description of a Competent Trauma-Informed Social Worker

The description of a competent trauma-informed social worker that is able to respond appropriately to the psychological impacts of medical trauma in an acute inpatient environment is one that can adhere to the ethical responsibility to represent themselves as competent only within the boundaries of their education, training, supervised experience, or other relevant professional experience (CSWE, 2015). They are knowledgeable about the impact of personal and collective, secondary, and vicarious exposure to trauma. The social worker recognizes the importance of attending to organizational dynamics that contribute to traumatic stress (CSWE, 2015). They demonstrate ethical behavior by developing and maintaining professional development activities at the micro, mezzo, and macro levels (CSWE, 2015). They engage in ethical decision making that addresses the potential risk for harm and re-traumatization in the helping relationship. These competent social worker with regards to being trauma-informed is to be able to understand their own trauma-related history, clients' experience of trauma, and their positionality as it relates to issues of diversity (CSWE, 2015). They recognize the impact of historical, collective, global, secondary, and vicarious exposure to trauma and the resulting cognitive shift in worldview.

Trauma-Informed Practice Behaviors

The trauma-informed care social worker implements practice behaviors that identifies attend, and facilitate ethical considerations including maintaining physical, interpersonal, spiritual, emotional, and psychological boundaries for clients and client systems, face-to-face and virtual, and demonstrate the ability to assess and address barriers to safety for clients across the lifespan (CSWE, 2015). In addition, the social worker makes ethical decisions incorporating understanding of trauma, treatment that accommodates trauma, research, and policies along with trauma-informed organizational practice, the NASW Code of Ethics, models of ethical decision making, and relevant laws, policies, and regulations (CSWE, 2015). The social worker demonstrates behaviors that promotes understanding for their own trauma-related history and identifying potential countertransference. The social worker identifies with own positionality as well as clients' experience of trauma as it relates to age, class, color, culture, disability and ability, ethnicity, gender, gender identity and expression, immigration status, marital status, political ideology, race, religion and spirituality, sex, sexual orientation, and tribal sovereign status (CSWE, 2015). The social worker demonstrates behaviors that engage in self-reflection, self-regulation strategies, and self-care practice including reflective trauma-responsive supervision to prevent and address secondary traumatic stress, compassion fatigue, vicarious trauma, and burnout in self and organization to enhance effective practice, policies, and research that considers ethical decision making related to trauma (CSWE, 2015)

Summary

With healthcare changing, it impacts how care is delivered. How care is delivered promotes for an everlasting impact that can either be optimal or adverse (Ashcroft, & Ambrose-Miller, 2016). Some adverse responses to how care is delivered can be traumatic. Due to the traumatic experience being related to the medical environment, the medical staff, the medical

diagnosis, procedure, or overall experience makes this a medical traumatic experience (Hall & Hall, 2016). Medical trauma is predominantly known in the pediatric population. Limited research exists in the adult population. This research study hopes to promote for that awareness that this is a social problem that goes beyond the pediatric population. The resources and support that currently exists in the pediatric population can be beneficial to the adult population. Medical trauma is real, and the responses is predominantly that of psychological responses. Other than the mental health professional, the social worker in the hospital identifies with psychological concerns, and related social concerns of all patient populations (Judd & Sheffield, 2010). All patients have social, and environment experiences, due to the current systems each patient belongs too (Hall & Hall, 2016).

The practice of social work has changed and lost its voice when hospital-based settings adopted more approaches that speaks to the financial aspects of healthcare (Heenan & Birrell, 2019). This research hopes to explore the experience of the healthcare social worker while considering the core of their social work practice as it relates to building relationships, trust, and promoting adequate responses to their patients social, emotional, and psychological needs within their hospital encounter (Bent-Goodley, 2019). As the social work education varies, so does the knowledge and the experience in which the social worker draws from to promote for their practice. The hospital delivery is commonly uniform in nature, where the social worker practice and education needs to be equally as uniform. Some healthcare social workers have had the experience of being educated and trained as being trauma-informed to best identify with the trauma experienced population (Bent-Goodley, 2019). Those that lack the trauma-informed education, skills and behaviors endured an education where being experienced in this manner was not a requirement. When considering the social work practice, and the growing needs of the

current patient population, being experienced in trauma-informed care is at the heart of the social work values and ethical principles that inform the social work practice (Mersky et al., 2019).

In the upcoming section, the researcher gathers recent data to speak to the healthcare social workers experience in being under the care management model in case management, have some form of an association with the model, and how they identify their experience in managing the psychological responses to medical trauma. It is important for the experts of own practice to be the voice of their own experience and working to the top of their own practice. Gaps in literature exists in healthcare social worker implementing trauma-informed care in the hospital while being under the care management, case management model, or some form of affiliation with these models.

Section 2: Research Design and Data Collection

Introduction

In this study, I used a qualitative research design to explore the experiences of healthcare social workers in managing the psychosocial impacts of adult medical trauma in an acute inpatient environment. I identified social workers' experiences with trauma-informed care and whether it necessitates additional training. I attempted to enhance professional practice knowledge and skills of healthcare social workers to prevent retraumatization. In this section, I provide the research design and additional details of the data collection, a complete breakdown of the research design, methodology, analysis of data, and the ethical components of the ethical procedures.

Research Design

I applied a basic qualitative design to inform and establish understanding of healthcare social workers' experiences in providing trauma-informed care. Qualitative research begins with assumptions and incorporates a theoretical framework used to inform the study of the research

problem. The qualitative research design is used to address what individuals and groups ascribe to as being the social problem. Within a qualitative research design, a researcher initiates an inquiry as it relates to the social problem and begins data collection that is both inductive and deductive within the natural setting that is sensitive to people and where they study. Using this design, I established patterns and themes related to the healthcare social workers' responses to the social problem under study.

Qualitative research is conducted to address the multifactorial frameworks that exist in the acute inpatient environment. The hospital is made up of different systems with various organizational designs and models, which allowed the qualitative research to find underlining meaning of the social problem. This design acknowledged factors embedded in the experiences of healthcare providers and patients to the extent of being able to identify practice approaches that would meet the needs of those impacted by medical trauma. Having a qualitative research design can promote explanations that are comprehensible and easily identifiable to various members of interdisciplinary teams that work alongside social workers in the hospital setting. The knowledge and data can be made useful in predicting and identifying alternative practice approaches among other professions in managing medical trauma. The qualitative research design allows a phenomenon to be understood through participants' responses to the open-ended-questions.

Open-ended questions were asked during individual interviews with 11 healthcare social workers who had a minimum 2 years of experiencing working with adults in a hospital within one of the following areas in the United States: Virginia, Maryland, North Carolina, and Washington, D.C. The interview responses were coded, and emerging themes were analyzed. I conducted semistructured individual interviews with 11 experienced healthcare social workers; each interview lasted approximately 1 hour. The research sample size provided enough data to reach saturation for this research (Guest et al., 2020). The interviews were conducted virtually through

Zoom. The Zoom interviews were recorded, and the recordings were kept on a laptop where all data are being kept protected by a password. Informed consent was initiated prior to each interview session. The qualified participants were recruited using a simple purposive sampling method; the recruiting took place via social media and/or flyers in hospitals. I conducted the data analysis to determine in combination with a secure software data analyzation program.

The final report within the qualitative design provides voices of healthcare social work participants, my introspection, and the illustration and explanation of the research problem and how it aligns with the literature reviewed. This research design promotes for an understanding where change may be warranted.

Methodology

I used a qualitative research design in which I conducted data collection through virtual individual interviews. Open-ended questions were asked during the virtual individual interviews conducted with 11 healthcare social workers who had worked in a hospital in Virginia, District of Columbia, Maryland, and North Carolina. Interview responses were coded, and emerging themes were analyzed. Structured individual interviews with the 11 experienced healthcare social workers lasted approximately 1 hour. The interviews were conducted virtually through Zoom. The Zoom interviews were recorded and kept in a laptop, where all data were kept protected by a password. Informed consent was initiated prior to each interview session. The qualified participants were recruited through simple purposive sampling; recruiting took place via social media and/or flyers in the hospitals. I conducted analysis of themes in combination with a secure software data analyzation program. Each qualified healthcare social worker participant had at least 2 years of experience in the acute medical environment working with adults in Virginia, District of Columbia, Maryland, or North Carolina. In addition, each participant had a master's degree in social work.

Data Analysis

The collection of data through a web-based platform known as Zoom allowed the participants the flexibility that was needed for the participants to process the interview question and provide for a narrative response to their experience. I asked open-ended questions related to the social workers experience in managing the psychological traumas of medical trauma. I had the social work participant identify what psychological encounters were encountered, and how they responded to those. I had the social work participant identify how they perceive their experience in managing the psychological responses to medical trauma to obtain an overarching understanding of their phenomena.

I prepared the data that was obtained and organized the transcripts. I identified themes, for each of the interviews, through coding and condensing the codes. I configured a data chart that represented an illustration of the data that was obtained with use of a chart, and discussions. I utilized a data analyzing software known as the Free QDA which is Free Qualitative Data Analysis. This tool kit is a software for professional qualitative research data analysis, such as interviews, manuscripts, journal articles, memos, and field notes. This has features that promotes for the software to be simple with a touch screen experience. The coding experience promotes for a simple layout that is reliable. The data software has a user-friendly interface that includes a web browser orientation for its coding components. This software is ideal for a small sample size qualitative research design analysis.

Methods utilized within this research approach is to document everything to include the experience of the researcher, and the participants. Documentation of the researchers and participants level of comfort in the environment while enduring the research process and identifying with the different feelings felt to include what prompted them were documented.

Ethical Procedures

I requested for a review from the Walden University Institutional Review Board (IRB) once the research proposal has entered the phase of the university research review (URR). I completed Form A (Description of Data Sources and Partner Sites) to obtain guidance on which forms and documentation that were needed for that study's data sources and related partner organization. I prepared required documents that the IRB requested in Step 1 and work out ethical issues, with support and guidance from the Research Ethics Support Specialist. The IRB provided its preliminary ethics feedback (PEF) service, sending written feedback until the materials met the university's ethical standards.

I planned and conducted an ethical procedural study that promoted for trustworthiness, where the researcher provided full disclosure on the overall research, peer debriefings, case analysis, and authentications. I anticipated and addressed all issues that emerged during the study. I implemented ethical standards when gathering data, along with the analyzation of data. The ethical standards included demonstrating respect for the participants with respect through privacy, and the obtaining signed consents. I had ethical consideration for the overall welfare of the participants with regards to safety, and justice with use of demonstrating equality.

I informed the participants of any changes. I provided for a step-by-step overview of the expectations. I provided for an explanation on what would be the outcome of the data that each participant provides, that participation is voluntary, and that they may withdraw at any time without recourse. I obtained all informed consents. I kept the participants informed of data record recording, and other mechanisms utilized to process the data they provided. I put in place methods to alleviate personal impact to research study, or participants, as the participants were anonymous, and because they were recruited through a simple purposive sampling, where the recruiting took place via social media and/or flyers in the hospitals. I utilized audio recording

with the permission of the participants to ensure all data was gathered appropriately and accurately. I did apply an alternative data software to ensure validity and creditability of the analyzation of data. I spoke towards the extent to which confidentiality was applied in the research. I utilized pseudo names to keep the actual name confidential. I kept written, signed, or audio retrieved data locked and secure. The data will be destroyed after 5years, as set by the university.

Summary

I applied a qualitative research design in attempt to provide an understanding of the social problem that readers can ascribe too. I have located an area of study and implemented an investigation that is convenient, flexible, and purposeful. I used a simple purposive sampling technique, where the recruiting took place via social media and/or flyers in the hospital. The recruitment was for qualified participants to engage in individual interviews, and the collection of data was obtained through a web based virtual platform known as Zoom. The individual interviews were 11 healthcare social workers. The qualified healthcare social worker participant had at least two years of experience in the acute medical environment working with adults, within one of the following states: Virginia, District of Columbia, Maryland, and North Carolina. In addition, had a master's degree in social work. I transcribed the data from the recordings, along with any notes that were taken during the interview. I used a coding software to identify themes and create for an illustrated and detailed explanation of the findings. The analyzed tool was a Free QDA, which is best for interviews, field studies and related manuscripts.

Section 3: Presentation of the Findings

Introduction

In this study, I used a basic qualitative research design with a simple purposive recruitment process to gather participants. Participants were 11healthcare social workers who were a representation of the acute care hospitals in Virginia, District of Columbia, Maryland, and North Carolina. Each participant's level of education included a minimum of a master of social work degree, with least 2 years of acute care hospital experience working with adults. This research was conducted to examine healthcare social workers' experiences responding to and managing the psychosocial impacts of adult medical trauma in an acute inpatient environment. My overall intent was to promote awareness regarding adult medical trauma and to establish best practices among the social work profession within the hospital environment. The practice-focused research question is: What are the experiences of healthcare social workers in managing adult medical trauma in an acute inpatient environment? This section includes details on the data analysis techniques, findings, and an overall summarization.

Data Analysis Techniques

Eleven participants participated in virtual interviews via Zoom; 11 questions were asked in each interview. Recruiting began in July 2021 and ended in November 2021, after completion of the final interview. The initial interview took place in September 2021, three occurred in October 2021, and seven took place in November 2021. I advertised for participants via the flyers posted on Facebook, Linked In, and Instagram. I posted the flyers in groups, organizations, and for individuals. The flyer advertised about the research and directed qualifying participants to a website. The website discussed the research in detail, provided the informed consent form, and gave potential participants the opportunity to submit an email, which served as a signature for the informed consent. Within 24–48 hours postconfirmation of submission, I sent an email thanking

them for their willingness to be a participant, provided a copy of the informed consent, and sent them a Calendly link to schedule their Zoom interview. I amended the informed consent form to reflect the changes in the participant market and provided the participants an updated copy of the informed consent.

The response rate initially was not as well as hoped for, which required me to return to the IRB three times to amend the participant market. Each time I was able to obtain approval. I initially had an inclusion that restricted the participant population to be in a specific region of the state of Virginia and that participants had to be actively working in a hospital. I amended these inclusions on two occasions to take out the actively working in a hospital requirement and the other amendment widened the participant market to all of Virginia. These changes led to a few more inquiries. Some participants changed their minds and never scheduled the interview after submitting a request to be a participant. On two occasions, I had scheduled interviews and the participant was unable to attend or reschedule. I amended the participation criteria one final time and expanded the participant market to all of Virginia, District of Columbia, Maryland, and North Carolina. I obtained more participants once the expansion occurred. When recruiting, some participants were busy, and being a participant was not feasible at that time. Once participants registered and scheduled their interview, the interviews took place within 2 weeks of the date they registered. On four occasions participants had to reschedule their interview.

Each participant engaged in an audio recorded virtual interview over the Zoom platform that lasted up to an hour. Each participant answered 11 questions. After the interviews, I transcribed the audio recorded interview using Microsoft Word. Once Microsoft Word transcribed the audio recording into a textual transcription, I manually reviewed the audio recording along with the textual transcription to ensure accuracy. I coded each participant's transcription under the interview questions and provided a copy to each participant to ensure the

data responses were captured correctly for validity. None of the participants requested any changes to their transcript for accuracy and validity.

After transcription and checking for validity, I began to analyze the data. I started the initial data analysis by manually coding each participant's response to each interview question. The interview questions were the initial codes. I further broke down the research codes to subcodes, making the research questions the parent codes of the subcodes. I used NVivo to conduct these manual data analyses. In addition to the manual data analysis, I auto coded the manually coded data for the purpose of validity, and auto coded the initial manual coded items for comparison of themes that resulted in the subcodes under the parent coded research question. In comparison of the coded data, I was able to identify a cross comparison of themes and related coded items. This cross check allowed for reliability and validity. I used NVivo for data analyzation and coding, which is a known software program used for data analysis in both mixed-method research and qualitative research. NVivo software has the capability to analyze video, audio, unstructured text, and data through image. This data analysis software is commonly used for surveys, focus groups, interviews, journal articles, and social media. For interviews and transcribed text, I chose this software to assist with the data analysis and coding for this research study.

Limitations did occur with this study. The interviews were conducted virtually during the COVID-19 pandemic. Many participants were actively working, and their work often impacted their availability as a research participant. This made recruiting difficult and made it difficult for participants to be able to follow through with their interviews. By expanding the inclusion to other states and not requiring that participants actively be in the inpatient setting, with a 2-year adult experience, allowed for more participant opportunity. I found within this pandemic crisis,

turnover was higher for social workers in the inpatient setting, where participants with 2 years or more adult hospital experience were minimal.

Findings

The sample included 11 healthcare social work participants with at least a master's degree in social work, and a history of 2 years in acute inpatient hospital experience with adults in Virginia, the District of Columbia, Maryland, and North Carolina. Some of the participants were actively practicing in the acute setting, and many were other healthcare roles, including the outpatient environment. Each participant represented the medical environment both from a mental and physical health standpoint, allowing for responses to be both diverse and holistic in nature. The participants' social work specializations represented areas including trauma, oncology, cardiology, gerontology, renal, orthopedic, medical surgical, critical care, and mental health. Interviews consisted of 11 questions, totaling 11 codes, and each code was broken down into themes. Participant responses were analyzed and coded into these themes.

Medical Social Work Meaning

The themes of the codes described what it meant to be a medical social worker by settings, roles, and experiences. The participants' responses to the meaning of being a medical social worker meant working in a health setting in either outpatient or inpatient and working in medical specialties, such as cardiovascular, gastroenterology, oncology, trauma, mental health, orthopedics, intensive care units, emergency department, and/or behavioral health units. The role theme created a meaning for medical social workers as being a support provider, discharge planning, problem solver, broker where the social worker linked individuals to resources, and one that helps individuals with their health or psychosocial issues. The experience theme was best described by a participant's response as an overall analogy describing the experience of the

medical social worker as being one that must be able to make a masterpiece for the patient. Participant 1 stated,

> That this is a loaded question. When I think of a medical social worker—you're the glue to the puzzle. You are running around to find every puzzle piece. Some people present with the puzzle pieces that are there. Other team members are the puzzle piece, but you really must glue it all together. When the puzzle doesn't seem to line up, you must be able to make your own masterpiece and make a new puzzle that works for the patient. You're with people at some of their most vulnerable times with their medical issues and with their social issues. You are working to help develop a plan for them, so that they can be on a road to recovery and to have health and wellness. As a medical social worker, I just feel like you are a Jack of all trades, a problem solver, and incredibly solution focused.

Participant 2 stated,

> Well, to me, it's basically being a social worker in the medical setting where you're in a medical facility or whether it be in like the hospital or maybe outpatient center. Basically, just providing services for individuals who has like social determinant, health needs and things like that.

Participant 3 stated,

> I think a medical social worker is a professionally trained social worker who works in a medical setting. Our special role on an interdisciplinary team is to help the team treat the whole patient while considering the psychosocial factors. Linking those with social determinants of health and the patient's health assessment and needs to ensure that patients and families have the best outcomes. This very often also involves helping providers understand psychosocial factors, and how those impact those social

determinants of health and the patient's participation in their care. Additionally, social workers work with patients' families to empower them to understand their experience and speak up for themselves and understand how to effectively interact with their providers in the healthcare system.

Participant 4 stated,

To me, a medical social worker is primarily one who's going to work in the hospital setting, but that could be any floors like ICU, CCU, and ED. Primarily the medical portions of the hospital. Some people think the social worker here are just the discharge planners, but sometimes they are on the forefront and assessing people or they may be called in for consulting.

Participant 5 stated,

It means that you are diving in at the acute phase of any type of crisis. It's usually a new situation for me, and you are there to support the patient, their family, and the other medical team member in the hospital.

Participant 6 stated,

I work in the acute care setting. I assist patients with safe discharge plans from their hospital to home transition. My day today looks very different because in an acute care setting you are discharging inpatients very frequently. Sometimes you don't have that much time to really get to know the patient. You're assessing them on admission to see what needs that they potentially may have based on their admitting diagnosis and other things that's going on. So, I work on a gastroenterology floor, so I have a lot of tube feeds, a lot of patients that are on dialysis, new start dialysis, patients that are going from peritoneal dialysis to hemodialysis dialysis. I also have a lot of patients who have social barriers, so not only are you focusing on the healthcare, but you're also having to focus

> on the social determinants that affect healthcare. One of those things is for my patients is transportation to implement their dialysis appointments.

Participant 7 stated,

> I think that it depends on the role that you're in, as it varies very much. I think that's one of the things that makes it very challenging within the medical field. No one knows exactly what a social worker does, so they end up filling in the gaps or being kind of hit with the grunt work that other people don't want to do or don't feel comfortable doing. I work mostly on the outpatient side with oncology patients and am responding to psychosocial distress related to the cancer. On the inpatient side, I know the medical social workers I work with feel like they're practicing very far out of their scope. There's very high turnover, they're doing a lot of insurance coordination, equipment ordering, and not really getting the chance to really talk with patients or go to that depth of how you are doing emotionally and with this trauma or handing a resource guide and not being able to take the time ok what's holding you back from accessing these resources. So, in a true social work answer, it depends.

Participant 8 stated, "To me it means a social worker working in a medical setting. That could be in a hospital, primary care, or whatever medical facility that you're located in, and that is a setting where, you are working with people." Participant 9 stated,

> For me, being a medical social worker, it's about understanding people and having positive collaboration with your multidisciplinary team first and foremost, because if there isn't clear communication, and if you're not gaining perspective and ideas from everyone on your team then you are failing your patience because everyone has a different skill set. Everyone has different knowledge they could bring that can contribute to the patient care and that patient recovery. So, for me, being a medical social worker is

having a true passion to help people and having strong communication and open mindedness and working with your multidisciplinary team to ensure that your patient is getting the best care they can and receive to thrive and be successful upon discharge.

Participant 10 stated,

You're dealing with the health issues, you're dealing with the mental issues, and then the psychological issues that's impacting or potentially delaying the healing. So basically, being a medical social worker encompasses the entire person the patients, as well as the family and then all those outside factors that's impacting that person's healing.

Participant 11 stated,

To be a medical social worker, it means that you're working in a health setting, outpatient, or inpatient. You are providing care coordination for patients for immediate care, for services such as transportation, medication, medical equipment, appointments, while addressing their psychosocial needs. A medical social worker within an inpatient setting it can entail coordination of services like home care placement, short term facilities, long-term facilities, rehabilitation centers, and behavioral health unit. You would coordinate any barriers that you would address, like medication access, food insecurities and any kind of deficits in the home barriers. So, if they had their leg amputated, and they need a ramp to get into the home or certain equipment, that's also, partakes in coordination. In addition, both inpatient and outpatient settings, you do have a role that you play with addressing their psychosocial, their emotional aspect of things. So, if they're in oncology or addressing the psychosocial issues that's related to their cancer partnering and collaborating with other professions like dietician and physical therapist. So, it's collaborating with many service providers, including home care you may have to set up. It's holistically looking at someone who is medically fragile or has a chronic

illness that a social worker is needed to address. The social worker may address some type of social determinants of health, psychosocial issues that pose as barriers to their medication, medical access, or housing access. So, it's a lot of care coordination.

Medical Social Work Experience

This code was described by two themes. The two themes included experience and employment history. The participant shared their experience of the medical social worker as working with people of all socioeconomic backgrounds, religious backgrounds, and various encounters within their population type. The employer theme displayed the participants as having a very diverse background that contributed to their expertise as being a medical social worker

Participant 1 stated,

Working as a medical social worker has been very diverse. I've worked on a multitude of units at the hospital. I have worked on intensive care, intermediate care, med surg, mother baby, labor and delivery, and the emergency department. I feel as a medical social worker, my biggest piece is to be an advocate for my patients and their families, while dealing with the bureaucratic red tape of the hospital, their desire to save money, to reduce length of stay, to meet CMS guidelines, working within the constraints of the poorly structured insurance system that you know the downfalls and the deficits of Medicare Medicaid. You are working with people of all socioeconomic backgrounds, religious backgrounds, and so it is not a job for the faint of heart. By any means. I think that it can be incredibly rewarding. To see someone, have a positive outcome from their hospital stay and to regain their health and to be to be doing well, particularly during COVID-19. It has been incredibly difficult to be a medical social worker, and really be working with not just one of your patients, but their loved one in the room, is also patient,

or their loved one is also a patient on another unit and seeing entire families impacted by this pandemic. It's taken a toll. Healthcare workers, especially me as a social worker.

Participant 2 stated,

I was a medical social worker, and a travel social worker. Being a travel social worker for medical social work, I really didn't have like a set unit. I worked all units. 2 hospitals were trauma hospitals, trauma level 1, trauma level 2. You never knew what your day would be like, especially if you would be at one hospital. One day you may be at another hospital the next day. You never knew what you're going to walk into, or you what you're going to have to deal with. At times I felt very unappreciated. As a social worker, I felt more like a discharge planner. I didn't feel as if physicians or like, PA's or nurse practitioners really appreciated me as a medical social worker or my education for my internship learnings that prepared me to be a medical social worker in the hospital. At times I felt as if I was the help, and as if I was not smart or as educated as the physicians and nurse practitioners and PA's. It was rewarding at sometimes, but that's just the one thing I didn't really like about it. I just really felt that I didn't really matter a lot. As a social worker, you try your best to help people, and provide services. It's very fast paced but at times it just felt like nothing was good enough at times within the hospital.

Participant 3 stated,

I've been doing hospital social work in a dual role as a clinical social worker and case manager, which in most systems involves primarily discharge planning for 15 years. 1st working with bone marrow transplant with cross coverage in really, honestly any population in the hospital, both inpatient and outpatient there. I did outpatient memory transplant. I'm now working a dual role for inpatients. Technically, we're not supposed to do outpatients, but we cover the left ventricular assist device population, and sometimes

they have needs that arise in clinic that are case management needs and the clinical social workers they're not available, so to help with that, cause that's not within their role, so I also help with those. We're going to help our providers understand what's effective, what can and can't be done.

Participant 4 stated,

As a social worker in the inpatient setting, it's been primarily behavioral health. I've had to collaborate with medical departments within the hospital setting. If somebody were to transition from the medical inpatient side to the behavioral health inpatient side and vice versa. Especially as it relates to discharge planning and any placement coordination, such as like a nursing home or a rehab facility.

Participant 5 stated,

Well, it started out in skilled nursing facilities back in 2008 and then I went and got my master's degree. I started working in a hospital as my master's level internship, and then they hired me afterwards and that was like in 2011. I worked medical for about 2 years, and then I went into acute care psychiatry for about 2 years to get my LCSW. Afterwards, I came back to medical social work, where I have been working for the past six years mostly doing discharge planning. At times, working on the trauma service as part of the float pool.

Participant 6: stated,

The hardest thing for me as the social worker is of course we have the code of ethics as a social work profession, but then we also have hospital code of ethics, and I have Medicare guidelines to follow. One of the things that sometimes gets hard is which way to go as far as the patient care. So, a lot of times you're at a conflict, because this patient needs to be amputated, but sometimes the hospital is like well, what are we going to do as

far as they're homeless, and they don't have any support. The hospital is like, is it logical for us to amputate this leg, or should we just try to put a band aid on it. So that's just been my experience. I can discuss how patients are a lot more complex medically. Not only are they dealing with medical issues, but there are a lot of behavioral health issues. They're not managing well in the outpatient setting, and then of course it's the recent the pandemic. There were a lot of changes and it seems like patients are more complex now and the need is even higher. So, at my organization, they really take heed and try not to discharge patients. So, what we call our length of stay is very high for a lot of patients. So, on my unit I mentioned that I have a lot of social needs. Families drop them off, saying yeah, I'm not taking care of you. I can't get patients to rehab because they over the rehab weight limit. There has been a lot of barriers that the system has put in place. Participant goes on to say, so, a lot of what I do is really thinking outside the box. I'm also a cheerleader, so sometimes I am stopping everything that I'm doing because I have a patient who is not working with therapy like they should and they need to, so that we can get them to the next level of care. A lot of times they are dealing with mental health issues, so I see everything like anxiety, depression, schizoaffective disorder, bipolar one and two. I pretty much do it all and I see it all. I do work on the adult side, and sometimes with pediatrics, however very rare. I have people 18 and up, all ages. I think the oldest patient I probably have seen is about 130 maybe. I see all types of patients, patients who have support systems, patients who have nobody, and patients who I'm investigating trying to figure out, while finding emergency contact. I notify family too. All the while doing this, I'm also expected to meet hospital metrics. We must assess patients in a 24 hour on admit. That's the organization's goal. I do manage about 24 to 32 patients, roughly.

Participant 7 stated,

I started kind of as a fluke in this field of oncology. I moved up to Virginia from North Carolina. Started looking for a job and thought oh it's a good idea to work at a hospital, as they're kind of a central stable area. I didn't have any training in the medical field, never did any practicums or internships. I did one kind of shadow internship in a primary care office, and he was doing just standard outpatient therapy, and was just based in that primary care office though. It was for oncology and they were trying to grow this role like not really understanding what they wanted. They saw this need for counseling but also had this big push for social determinants of health and case management and just make sure that patients show up to treatment and save us money or don't let us lose money.

I will say the last four years have really been a mixture of psychosocial assessment, defining, or what are we defining as psychosocial, and what are we leaving to our nurse case managers as more coordination. A lot of help for financial distress, and a lot of help for transportation. Trying to define how do we bring in counseling, because we have a bulk of patients saying my emotional needs are not being met, but they also don't have the means or the energy to go to a support group outside of their regular treatment or make yet another appointment outside of their regular treatment. So, figuring out some short-term interventions to really meet them where they are to focus in on the oncology trauma itself and then referring out to more comprehensive mental health resources is needed. I don't do a lot of care coordination and making appointments. Depending on the person, if I have a good rapport, they call me for appointment reminders. Of course, I'm going to give that to them, but as a general rule I'm not the one saying, OK, you need to follow up with your PCP, or I'm going to make that for you, and make sure you follow

up with that. They sometimes try to get me to do it. I've gone head-to-head with a couple people before. I have a really good team. I think specifically being in oncology that the nurse case managers I work with are very, very uncomfortable with the emotional impact that a cancer diagnosis has, and they are very quick to say no I can handle that coordination, but please take the time to talk to this person because I don't want to do it, or I don't feel comfortable doing it.

Participant 8 stated,

I started working as a medical social worker while I was in grad school, during my foundation in my 2 internships. I was in a hospital in oncology for my first year of graduate school. My second year I was in Gerontology primary care. Then my jobs after grad school, I worked in primary care settings in urban cities for a couple years, and then I moved into the hospital setting working in transplant, which involves outpatient care and assessment as well as inpatient care and assessment, including the (ICU) Intensive Care Unit and SICU (Surgical Intensive Care Unit).

Participant 9 stated,

It's very much of an eye opening. You learn so much more about various diagnoses like mental health diagnosis, and how to adapt and to deescalate. So, my experience has taught me lots of empathy, lots of patience and the crucial need for active listening because there are key things that patients say that is important to catch on to. So, you can either assist them in that issue, or utilize whatever they say in their discharge planning.

Participant 10 stated,

My university, they had a joint bachelor's and master's program, so I have my masters and bachelor's in social work. The track I took was health mental health. So, we did, a lot of mental health, but they incorporated the geriatric population in within our core set

because at that time we were thinking that was going to be like a really needed area. It was thought that if we were going to get a job, it was going to be dealing with the elderly. So, they incorporated that into our training study at that time. Most of my experience has been working. I started fresh out of grad school in hospice and stayed in hospice for about 6 years. From Hospice, I went to PACE, which is once again working with the elderly. I did that for about four years. I did direct case management as a medical social worker because we are all in one building. You had the doctors, the nurses, the aids, and more. Everything was in that adult healthcare setting. So, I left pace and went to my current employer. So, the early part of my career was mental health, but for the most part, it's been in a medical setting.

Participant 11 stated,

My experience working as a medical social worker includes me working in pediatrics, behavioral health, cardiac oncology, and now I'm primarily with adults for complex patients. My experience as being a social worker has really opened my eyes to what I would say a lot of things that we take for granted in life with our own health and through the emotional burnout that as medical social workers you would either see by death of your patients or seeing their health unravel.

Medical Social Work Training

This code was broken up into three themes. The themes were certificate, community-based training, and training on the job. Each theme contributed to describing the training the participants endured in contributing to their medical social work expertise. Under the certification theme, some participants shared that they have their case manager certification to include the ACM (Advanced Case Manager), or the CCM (Certified Case Manager), to include other certificates. Within the community-based training, some participants shared training experience

obtained in the community through seminars both in person and virtually through organizations or other institutional trainings. Many participants shared their on-the-job training experiences. The theme on the job training, identified many participants experiences mainly coming from their employment history.

Participant 1 stated,

> I don't have really any trainings outside of the hospital, I try to attend events that have CEU's (Continuing Education Units) just to be abreast of what's out there. There was an initiative within the hospital system to really push towards motivational interviewing. Though they've provided us with what they felt to be extensive training on motivational interviewing, I would say that my coursework in motivational interviewing was more beneficial. We had trainings regarding the Virginia DMAS regulations for completing the uniform assessment instruments. I do have my ACM. I think maybe some universities should investigate maybe hospital social work certifications and stuff because it is a very niche field. it's a lot to learn in your first two years on the job.

Participant 2 stated,

> my on-the-job training, I had a preceptor that I basically shadowed received hands on training. It lasted about six weeks. About the first week was at the corporate office where we learned the systems, how integrated care coordination worked, because as a medical social worker you were in the integrated Care Coordination Department, working side by side with our [registered nurse] who was a case manager. All my training just came from on-the-job training. Some things I had learned with my internships while I was in graduate school. I was able to apply some things, but I can honestly say that working was probably the most training I had. Some things I didn't know, and I had to learn as I went, was the LTSS (Long Term Services & Support) screening, which is formally known as

the UAI (Universal Assessment Instrument). I didn't know how to do it at first, and I briefly did it in grad school. We had a class, that focused on that assessment when it was time for me to do one in the hospital setting. I really didn't know what I was doing. There was an incident with an older social worker who was a LCSW. Instead of her coming to me and try to assist me with having a better understanding on how to do the screening properly, she basically just went to the team coordinator about the multiple errors that I had, and that she was worried about me not being able to do it. I honestly feel like my training just came from trial and error, when doing certain things.

Participant 3 stated,

I've been to lots of trainings. I will say that it's has helped me since my role is a combined clinical and case management role. It was very helpful to start out with a solid grounding in clinical social work. My first social work job was in a psychiatric crisis walk in clinic and I got to learn a lot about the different mental health diagnosis treatment pathways, and levels of care. I will say that I took the substance abuse curriculum when I was in social work school. That has been tremendously helpful. Since then, I've attended many trainings particularly in medical social work. I was a member of Association of Oncology Social Workers for many years while I was in bone marrow transplant since that's the kind of the professional organization that houses that specialty. Learned a tremendous amount through them about ways to support folks and resources to do that. I've also attended a member of NASW, and I have attended other trainings, as well. I think specific to medical social work, it's been particularly helpful to have trainings around working with veterans, working with PTSD, and working with substance use, and continuing to grow in those areas as the fields develop. I've been in practice a long time now and you must keep current. In addition, I have attended some good conferences

through the NASW. I have attended dementia trainings, and informational things such as hoarding within the aging population. We do have trainings within our own department and within my own team that we do for each other and those have grown my expertise. Also participating in anything that's related to the specialty that I'm in right now. There's a LVAD (Left Ventricular Assist Device) Social Worker Forum put together by the company that makes LVADS. I attend those and it's a quarterly. It's a forum I, but it's an opportunity to hear from other colleagues in the same field and what they're doing.

Participant 4 stated,

I think that since I've been in the hospital setting where I've have been in contact with medical social workers on the medical side of the hospital, has been longest I've gone in not participating in a lot of trainings after like the jobs that I worked in before. It wasn't out of the questioning to have my employer have some sort of Inservice or training every few months. I feel like once I started to work in the hospital that started to seize, and I can probably count on one hand how many trainings I've participated in since I've been in the hospital setting. I did get my CCM (Certified Case Management) certification, however I did that on my own to expand my knowledge since I was trying to transition into more of the medical social work as I switched career fields a little bit just so I can have a better understanding of the insurance fee. Honestly, I think in the hospital setting it's sometimes lacking from my point of view training, unless you are kind of seeking it yourself. I got licensed in November of last year while working in a hospital setting.

Participant 5 stated,

Having gotten my master's level internship at acute care hospital allowed me pretty much six months to learn the job. Also, having worked at a skilled nursing facility prepared me to step into acute care. With having a third of the patients at skilled nursing facilities that

are leaving and going home, and you must do all the discharge planning as well as prepare them to go home from having experienced whatever traumatic event that they have experienced or landed them in rehab. So, between having worked in a skilled facility, and then having six months to learn the job, that was great. My current employer, every year we're required to do compass modules, which is like case management education every single year. There's a great deal of modules, but most of it, I would say is on the job training and learning as you go.

Participant 6 stated,

I have a background in social work education. I have done mental health first aid to know how to respond, to know what things not to say. I've also done embracing difficult conversations, which that is usually the bulk of my day, every day. I've done leadership certificate programs. I've done expiring leaders, and I've done more diversity and inclusion. At my last organization they really had a lot to offer as far as education. Most of everything that I did was at a different organization before I got to this one. I did a two day like 16-hour training for motivational interviewing.

Participant 7 stated,

I joined ASW, the association of oncology social workers, and went through their certification. It's not like the case manager certification. There's no test, but they have a board requiring a certain number of continuing education hours specifically in oncology, and a certain number of working hours. To get this oncology social work certification, it's essentially three years of experience in oncology and then 20 hours of training specific to oncology every two years. I've done specifically some trainings on therapeutic interventions. I try to find like the therapeutic interventions that can be translated well to oncology patients. There is an interesting one on DBT (Dialectical Behavioral Therapy)

informed interventions for oncology. It's not your full DBT practice. You're not available 24/7, but really focuses on those dialectics and living in the and, along with frustration tolerance, and mindfulness. Also looking at barriers within the medical field that make it difficult for people to thrive through their cancer treatment.

Participant 8 stated,

Right off the bat in graduate school, during my first year, I knew I wanted to pursue medical social work. I really enjoyed the setting, the research, and just all of it. I took two healthcare certificate programs while I was in school. I did a health social work in healthcare certificate, where it focused on medical social work, and then I did an aging healthcare certificate because a lot of the folks are older in a lot of these settings. That's why I did kind of a gerontology aging certificate. I had asked social workers that I was getting to know while I was interning, what coursework should I do as like electives, which they had advised me to take a trauma course and a substance use course as my electives. I pursued those coursework's which has been absolutely what I needed to do as a beginning really. I also joined the social work transplant society. It's an organization of social workers who are in transplant. I started doing that when I started working in transplants. I went to a virtual conference that year, and did the conference two years in a row, for three days and all the topics were relevant to working with transplant patients in the hospital.

Participant 9 stated,

We must do handle with care, which is a way that we ethically can restrain or physically deescalate patients if they are psychotic or if they are trying to elope. It's a combination of physical restraints and verbal de-escalation training. We make sure the patient feels safe when you're trying to either get them in a state of mind, or you're trying to prevent

them from harming themselves or anyone else. That experience has kind of taught us about safety, because the whole point of that is to keep staff and the patient safe because clearly, they're not in the right state of mind if they're manic or if they're trying to elope, or if they're trying to harm someone else. Restraints are a last resort, once you've exhausted all your options, but used if it is needed. I have a bunch of online trainings including CPR (Cardiopulmonary Resuscitation), de-escalation tactics, even compassion fatigue trainings. There's a lot of different avenues of trainings that my employer provides for continue education, while in the psych unit, because it's kind of a different battle than the medical floors. Overall, it is things that we are required to do just to maintain competency as a social worker.

Participant 10 stated,

The track that I took in school we did health mental health. I did my internship at the master's level at the VAMC (Veterans Affairs Medical Center). Anytime you get in the VAMC there's every area of social work within that hospital setting. So, I got to experience a lot of different areas when I was an intern there. I've done suicide assist training, and QPR (Question, Persuade, and Refer) gatekeeper. There's just so many different trainings, and different things that I've had the opportunity to do like guardianship training. It's just been a lot over the years because I've been doing this for 16 years. I even did my motivational interviewing at the VAMC. I started the first part of it at the VAMC. It's just an accumulation of different things. One thing I can say about the medical field is, when I was in hospice, the social work department at one hospital institution would offer different trainings that were related to dealing with grief and caregiver. We used to have social work like conferences. Just like the VAMC, get trainings from the medical stuff experts at other community hospitals

Participant 11 stated,

> I am a certified case manager through the ACM. We go through an extensive training, which requires a test. They touch on everything such as sex trafficking and human trafficking, and transportation not just within the medical setting. Touch on the way that Medicare the government works, and how Medicare and Medicaid work when a patient becomes disabled. Really lot of training, so that we're informed on how to help individuals within that medical setting.

Case Management Model Experiences

Participants within this code had a theme where it defined the roles of the medical social worker, and a theme that spoke to the experience of the medical social worker in how they were impacted by the case management model, and overall experience with it.

Participant 1 stated,

> I think overall the golden silver lining is the idea of that if we utilize insurance money appropriately, then more people have access to care, or they will have their care covered because people are utilizing the mutual funds of insurance correctly. I think there are so many constraints. The flawed system of Medicare and Medicaid makes it almost impossible to meet the needs of my patients really, and truly. You can put a band aid on it, but I don't think we ever properly address the issue. I think when you're in an acute setting, you have a limited amount of time with a patient, so obviously like their years of trauma or their long-standing social issues can't be resolved that quickly. The case management model does not offer a lot of evaluation of your services. You don't typically get to follow up with patients after they're discharged. There's a terrible gap between insurance case management and community and hospital case management. I think the stress of wanting to reduce length of stay, the stress of multiple calls a day about

can you beg the doctor to discharge? Can you do this, along with micromanaging. When do I have time to sit with a patient, and really, truly develop that rapport with them, get to know them, develop a plan where they have things that they can do to help themselves, and what can I do to meet them there. During these times, especially with Covid with limited resources, it's like, hey, these are your options. What are we going to do with it? We got to just keep it rolling. Just to speak frankly, and it's not my proudest moment as a social worker, and it's tough. Especially today, I was getting off work late because I was trying to advocate for my patient, and what we were doing was not what was in the best interest of the patient. It was not meeting their needs. Everyone just kept telling me why they couldn't do something, and I said but we can, and we need to, we should, and we have to. I think there's definitely a big gap. I don't think social workers are used to the capacity that they should in the hospital setting. I think that the misconception that social workers are a be all, that they can solve all, and they know how to solve things without access to any type of resources without money, without being valued, or without being recognized. They just think if you have a problem like, we have some magic Rubik's Cube, and that we can take care of anything. I think that the case management model needs revamping, 100%. I feel very passionately, yes!

Participant 2 stated,

Just assisting them with SNF (Skilled Nursing Facility) placements. Making sure that they understood their rights as a patient and ensuring that they don't have to feel like they're being forced to go to a facility that we presented to the patients. Being realistic with them about their benefits, so that they understood what their insurance payers were going to be covering. Providing alternative options for patients because some people may not want to go to a rehab center once discharged. Some people may just want to go home,

with home health services. Making sure that they understand what the insurance is going to cover and what they can expect while receiving home health services. Being that support for the patient because you do have some patients who may need to go to a higher level like IPR (Inpatient Rehab or the LTCH unit (Long Term Acute Care Hospital). Just making sure that you advocate for them so that they can get placed because those are special units that require specific medical needs. That was difficult at times in respecting patient's wishes, and families because my hospital system I work for have their own facilities where they will always want you to automatically send a patient to a facility without asking their permission.

You would feel as if you would get in trouble if you did not discuss that with them. I didn't like that. That was very hard for me because I felt as though it was a HIPAA violation, and I wasn't respecting the wishes of a patient or their family which is in direct relations to client self-determination, which is a part of our code of ethics as social work. So that was always difficult at times. I felt like I wanted to file an anonymous complaint to Medicare regarding it, but I was afraid that if I did, I would get in trouble or lose my job. It was very uneasy doing those type of things. In a way, I felt that it did give me the tools when needed to do my day today when helping my patient population. When it came to arranging their services, making sure that you do things in a timely manner, because the hospital center is very fast paced. You're dealing with the doctors trying to push people out and have the patients wanting to file an appeal with Medicare, so that they don't go home. With the case management model that I have experienced with is the dyad partnership with having the nurse. Sometimes having that nurse with me, better helped me to understand the needs of the patients, because although I'm a medical social worker, I don't know everything in healthcare and medical terms. When it comes to

certain diseases, and certain diagnosis, it was difficult in trying to understand. The case management model has that interdisciplinary care team where you are collaborating with other people inside the hospital. That was very helpful, but at times I felt as though people are always calling you for help, but when you need help, nobody has time to help you meet the needs of the patient and their family.

Participant 3 stated,

I think case management does a good job of thinking about helping folks focus on medical needs and things around that. I find it extremely helpful with, particularly with populations whose needs are with advanced therapies or complex medical conditions. To be able to bring in some clinical social work to understand how that may be impacting folks. Case management was born out of in my personal view, social work. The early pioneers like Jane Addams Hall House in Chicago. I think those models are, helpful in that way. I will say that I find them limited because typically they tend to be mostly formed out of nursing discipline and tend not to have a strong psychosocial component and within many systems hours included. You know the traditional case management role doesn't do a whole lot of things. They don't assess mood. They don't assess coping, and they don't have resources for that. I think that's it gives a good grounding, and it helps focus us as social workers, as we might get a little too carried away with those psychosocial. Case management can be helpful in focusing where we need to put our attention and efforts. It's good, and it has limitations as well.

Participant 4 stated,

I think working for a for profit hospital setting not that that's a negative thing, but it definitely exposes me to case management in terms of the importance of working in an interdisciplinary team, the importance of documenting, what's typically paid for and

what's not, learning about length of stay, as well as figuring out what's going to meet someone's needs post discharge within the means of payment. I think for me when I hear case management, I'm working in the hospital, I think insurance, and I think payment. I've collaborated with case management in terms of ensuring I have appropriate documentation to justify whatever service at the hospital is offering. I also speak with insurance care coordinators quite regularly about what the hospital is doing treatment wise, and what the discharge plans are. I think that the case management model is a good model. I think there are multiple good models. I think that's one of them that's decent from what I know about it, so I think it can be positive. Now does one size fit all, not necessarily, but I think the case management model is something that's quite important in the hospital setting.

Participant 5 stated,

I am a CCM certified, a certified case manager. We assess the patients on day one and ask what their idea of an ideal discharge plan is even before really knowing what their new baseline may be, or before therapies have worked with them. Functioning as a case manager, we do the case management model from the beginning, and somewhat to the end. I've got to be completely honest with you. It's somewhat of a broken system. Once they discharge from the hospital, I'm gone. We give like a very lukewarm handoff to any ancillary service like home health, skilled facility, hospice, or rehab. Once we fax them the paperwork, we've signed off and it kind of drops from there. With case management, you kind of want to provide better handoff and follow your patients. The system is not set up that way. You have 24 to 25 patients a day that you're fully responsible for, and there's nobody to look back on the ones that have discharged to see if they are falling through the cracks or if they need any additional services, or if they went home and need

SNF because they have a 30 day look back where they can go to a SNF. They declined it on discharge, and so it's somewhat broken.

Participant 6 stated,

We do an assessment, then follow up, and then of course I don't really get to evaluate, but I'm doing all of that at the same time pretty much, and then the patient is discharged. So, in the assessment phase, I'm gathering information about the patient prior to their admission, like were they independent, who's their primary care doctor, who are they seeing, how do they get to their appointments, and just assessing the whole person. If I have someone with mental health issues and I'm checking in to see, are you following up with your case manager, your psychiatrist, and do you know when you're feeling manic or when you are about to have an attack, and what do you do. Then from there implementing things in between making sure that everything is set up for them to go, and then from there my evaluation will be making sure they have appointments that they need. Making sure they know who to call, and what resources to follow up on that what we discussed. That's how I use the case management model. I think with the way that the climate has changed, I think it would be beneficial to be altered. I guess we do need the steps because if you're a new case manager, you do need that information, but when you've been doing case management for a while, I think it would be better if it was more of like a resource hub, to kind of direct.

Participant 7 stated,

I don't personally use, and I don't have a lot of familiarity with this model. I think we do less medical case management. Obviously if somebody has had some significant history of non-compliance and we have access to their schedule, then Of course we're going to be following up at certain touchpoints, and saying, OK, what's holding you back from

today, or trying to really get people to adhere to their treatment. If it is a treatment that they want, but nothing formal, then I think the extent to I'm communicating with the insurance companies is for transportation coordination. If somebody really is not understanding their benefits, I might help them make that call to gain a better understanding, or if our insurance authorization representative is like this is not making sense, or they're struggling with this, help I might jump in and see what I can do, or connect them with the insurance case manager. Especially once someone has finished their treatment and I'm out of their case and don't really have a comparable hand off. I'll at least connect them with that insurance case manager. It's certainly an opportunity for me. I don't have that case management training.

Participant 8 stated,

I don't have discharge planning experience beyond like some consult work because that's the unique thing with working in transplant is that your primary role is to do assessment and support a patient through the transplant process, and then they have the hospital unit floor social workers that help, that work in case management, where the nurses did the discharge planning. I haven't really had to do that model, I have helped with helping with home health aides or other resource connection of resources, but I didn't have to get into those kinds of priorities. I really utilized the case management folks on the for that. Although, I relied much on the case management folks, and not having to specifically use the case management model, I have been impacted where the patient may have been discharged to early, or general concerns with the discharge plan. The social workers on the floor will sometimes communicate like you are following this patient or am I. There are some patients where there have been other social workers notes in them and then they'll get passed over to me and so then sometimes I've had to call that

social worker to be like, well I'm getting a different story, or I just want to have a conversation about some of the notes in the in the chart to kind of clarify with that person who was helping that patient. I may ask what some barriers were, and what were the challenges.

Participant 9 stated,

I collaborate with the social workers on the floor and it's important and is one of the biggest things which I'm sure every social worker battle is insurance and availability to resources. I know our department has a resource list, we have, rehabs and halfway houses and therapies that are specific to certain insurances. So, let's say a patient has out of state insurance, we'll do our best to accommodate their needs and figure out what we can do to get them the resources they need, even if that means if you want XY and Z resources, you might have to return to your state where your insurance is, you'll have to transfer insurances to this state depending on the situation. With case management, we normally work a lot with connecting them to rehabs, housing and different outpatient programs so they can continue to have a successful recovery upon discharge. So that's more of a collaboration effort between myself, the social worker, but I've also done that work as well when I was an intern for medical social work in the psych unit.

Participant 10 stated,

The hospital I currently work at has a specific set of triggers that identify cases and to them that will potentially be social work cases. Do I agree, No. I feel like social workers and nurses should do the same job when it's case management. We basically do the same job, but sometimes I feel like the case management model that we're utilizing is more of a medical model. So, it's like if you're homeless, if you have a have drug issue, or any substance abuse, or mental health, with my employer that is automatically social workers.

Most of the nurses will pass that off to the social worker. I don't agree, I feel like we should all do the same thing. The issues that they have before they come into hospital, they will likely have them when they leave, no matter what interventions I put in place. I hate to say this, but what I found in my experience to be in the case management model that we use, is if it's an African American, and somebody gets smart, then the case manager will refer that to the social work, but nothing was really done. When I get in there as a social worker, and I talk to the family, and find out like nothing's been done, like they didn't even come in and talk to them. On the model that we use, it kind of picks where it puts the nurses and the social workers against each other. I just want to make sure the patient is taken care of because that's the most important person in the equation. I just want to make sure that patient is taken care of and that they have what they need so they can discharge home and begin to continue the healing process that they've started.

Participant 11 stated,

In the hospital as a case manager, length of stay is really driven by the reason they are admitted, however it is heavily relied on the case managers to get that discharge plan in place. The experience is making sure that you know how to navigate yourself through that discharge plan to get that patient to that next level of care, so they are not staying in a setting for too long, to reduce that length of stay. I do think it helped me meet the needs of my current patient population. When inpatient, I think it had its pros and its cons. A lot of times, I think that some patients that do come in, or their families bring them in knowing that a lot of their issues have been going on for a long time and we cannot solve it. We then cannot discharge them because we can't send them back home or they don't meet the criteria to go to a placement because it's considered custodial. So, the case

management model helps to reduce the length of stay or to meet certain targets and in care coordination that can sometimes work in your favor or not.

Experience With Adult Medical Trauma

Many participants took time to identify the term medical trauma through themes of experience, perception, and situations. Some required further clarity and recognized that this isn't a term that is widely identified within the healthcare setting.

Participant 1 stated,

> I don't particularly work at a hospital that is considered a trauma hospital. I think a lot of my patients have trauma. I currently work in intensive care and intermediate care. They come in and were able to manage at home prior and then they decompensate or didn't do well after surgery. I do think I have a lot of exposure to patients with adult medical trauma. Do I think anyone recognizes their experience as trauma? Absolutely Not! I don't think that people take that into consideration. They go in and they're supposed to have a below the knee amputation, or they get an up to the ankle amputation, and then they come out of surgery and they had to have an above the knee, amputation, or they had to, get additional testing later, then they have the other leg amputated. That's very common. I have a lot of patients who have had amputations. I feel like nobody takes into consideration how trying that can be for a patient. A man who was walking when they came into the hospital and is now unsure if they'll walk again because there's a long road of recovery with prosthesis and things of that nature. I have had patients with sexual trauma, sex trafficking involvement, especially related to their medical diagnosis that were preyed upon in the community. I think COVID is very traumatic. These people are completely isolated to a room where we try to layer up care to minimize how often we must go in there. Their phones die, they can't reach their room phone. They have nobody

to talk to. They're having trouble breathing, and I think one thing I've done to try to just during COVID is just try to call them and just check in on them and let them know I was thinking about them cause some of them have no family or some of them their family members are intubated in another unit. It's enormous, I've lost a whole family as patients. You have a mother, a child, a brother, and a sister. You have kids you know, trying to make decisions for Mom and Dad, and they're both declining and they're preparing for both of their arrangements. I think as social workers we recognize a lot of traumas, and I don't know that all the other professions have trauma-informed care.

Participant 2 stated,

Yes, I may have had a few. That's one thing about the hospital, you never knew who you were going to get. I don't do well with domestic violence, but sometimes you will get domestic violence patients. I had a patient one time; she was a victim of domestic violence. I was at a trauma level Hospital. Her boyfriend basically physically assaulted her. He slammed her head into the concrete multiple times and having to hear her tell me her story and how traumatizing that was for her and how traumatizing it was for me. You know things like that you don't forget. Especially if that's not the population you'd really prefer to not work with. You can't pick and choose who you get in the hospital. Another was my first hate crime was at a trauma level hospital. I had an individual who was basically a sex worker. A man who you know allow people to pay them for sex to cover their transition from male to female. They were assaulted. They were stabbed over 30 times and having to tell me about that and how traumatizing it was for them having to explain. You know the guilt that they had and the embarrassment, knowing that they were a sex worker, so that they could pay for the surgeries that they needed, and the hormone treatments. I did have one patient who it was my first fetal demise. Patient that I had it

was very traumatizing for her and the child father. It was their first child. It was around Christmas time. The baby was full term; however, he was still born. With her explaining that process to me because I'm not a mom and I have not been through that yet, and her having to deliver a deceased baby, and having to push when trying to do your best when you are already exhausted from pushing out a deceased baby was very traumatizing for her. When I was doing their bereavement because they were Pagan for their religion, I had to do the bereavement process because they were not able to receive services from the chaplain. So, as the social worker that was my role to assist them with that. They had a feeling though people were looking at them different because they really didn't understand, being Pagan and them wanting the deceased baby in the room with them. That was my first time being around a stillborn baby. The mom constantly wanted to change the baby because she only got those few days with the baby before they you knew they had to take the baby to the Funeral Home, and it was hard dealing with the nurses on the unit. The mother baby unit. They were making very negative comments about the mom and the father. I think the mom, I'm not sure if she was hallucinating or if she was just so traumatized that she thought she was smelling things up. She was saying that the baby had a bowel movement. She needed to change the baby and she was calling the nurses. Having to explain to the nurses to have some sort of empathy for parents because they just experienced a traumatic loss that they would never get over, and especially with-it being Christmas time. I have issues with that. I think about that family every year. Since it has happened come the next day, I did wake up, and I was very emotional. I was crying. I wasn't sure if I was going to be able to work that day, because it just hit me the next day as to what I had experienced. I just never experienced something, so traumatizing like that.

Participant 3 stated,

My entire hospital career, and my primary assignment has been with populations that have very scary diagnosis in bone marrow transplant. Those are oncology and bone marrow disorders. They're always life threatening and in my current position is solid organ transplant with heart transplant LVAD. Those are life threatening disorders. So, everyone gets a diagnosis. I think it's been helpful to see how the experience of the medical system can come impact a person's experience of their medical care and then folks who've had to go through just awful things as part of their medical treatment and there just wasn't a way around it. Like terrible pain because of an illness. We do our best to control but aren't always able to control it well quickly and adequately. We have a fair, routine, small, but routine encounters with adult medical trauma related to ICD shocks, so those implanted defibrillators for some people they experience actual just real bad pain. Some people just experience a very shocking jolt, but in any case, it's always out of the blue. It's just like it'll knock you down. Almost literally, knock you flat down and it's scary and people then respond. So, the folks who are vulnerable to that can then respond to that with PTSD. Watching how that impacts them. They're interaction with the medical system, helping the patient understand how their response is link t to their experience of trauma. I try to help them come up with coping strategies, and then helping the system around them. Nursing, medical team and others identify what things may be triggering to someone. Helping to provide that environmental support in those internal and external are going to help somebody realize what's going on and deal with it.

Participant 4 states,

I would say my experience with medical trauma has been on the forefront, has been minimal. I've typically met with people who have medical trauma, but they didn't come

to me until it became something that was difficult to cope with in everyday life. So, the medical trauma resulted in job loss, or resulted in a just a change of lifestyle that's in the transition has been difficult resulting in depression and resulting in potential thoughts of suicide. If some that developed a mood disorder, or if somebody already has had a mood disorder, it kind of exacerbates an issue that they were already having. That would be my experience with medical trauma. Also, just on the sidelines of working with patients who are taking psychotropic medications but also taking medications for a severe medical issue or some type of medical trauma and ensuring that It's going to just work well together to meet their needs.

Participant 5 stated,

At my hospital, we have a large trauma team and being part of the float pool, I frequently end up on trauma because they have high turnovers because nobody wants to do it. We have everything from gunshot wounds, stabbings, to having falling trees from construction workers, to falls off roofs, motor vehicle collision, and any kind of trauma you could possibly imagine. It's at this hospital because we're a level 1 trauma center. I guess the good thing about our hospital is not only do we have myself as a case manager, but I can also consult another LCSW (Licensed Clinical Social Worker) to come in and do more in-depth social work. The thing about trauma that stresses me out, is that I don't like dealing with the fact that you're not just working with their insurance, but you must deal with workers comp, deal with victim's assistance fund., and you must deal with the automobile liability insurance. Also, part of my experience working with trauma is that no one wants to do it. Well, they don't lessen the case load. At least at my hospital it's not a lower-case load if you got 24 with much more complex situations and then all the psychosocial stuff goes with some of that.

Participant 6 stated,

I will say that this is the perfect timing because I had a situation this week with again hospital regulations. So, I had a patient who apparently on the weekend she had some confusion trying to get up and was a fall risk. So of course, the nurse tried to redirect her and tell her like hang on, but she was just saying I must go to the bathroom, I must go to the bathroom, I can't wait. In a nutshell, she ended up having to have a tele monitor in the room. That's camera that alerts someone that's watching or has the screens up in their office that if someone gets up out of the bed, then it's going to call the nurses station, so that someone can get down there. Although it was a safety measure it was trauma for her because she had issues. I guess in her childhood she had an issue with being raped, and it was related to a camera. For us it was like safety, we can't have you falling, and for her It would just set her off. I mean she did not like it at all, and she shared about the camera so that's been my most recent experience. A lot of times in the African American community, patients do not want to have treatment from the hospital just because of past experiences. Whether it was they getting diagnosed with something or something happened that they had a procedure and then it caused issues somewhere else, so they just hadn't trusted. So, they were usually reluctant to care, or very resistant. At the same time, one of their strengths is they are coming to the hospital to try to get here, but it's very hard for them. A population that is usually the hardest thing is the VA population. So, our veterans live in a totally different world than we do, and usually have to respond to them. It is a totally different way than an average civilian. So that's just in a nutshell, my experience.

Participant 7 stated,

It's all my patients. I work with adult cancer patients and most of them describe even getting a cancer diagnosis as traumatic. I know, looking at the most recent updated DSM 5 definition of PTSD. It doesn't really include the routine medical treatment or illness, but I would argue the minute someone hears the word cancer, it's perceived, as a threat to our life uhm and thoughts of mortality come into play. There are feelings of loss of control, and it's very traumatic. The treatments that people go through. I think any surgical procedure where somebody is cutting open your body and altering, is in some way, planned or not planned incredibly traumatic. Specifically, my thoracotomy patients. The thoracic surgery is one of the most painful surgeries. I think on record the neuropathic pain afterwards is excruciating, and most people as much as the surgeons and the practitioners try to prepare them for that and try to stay on top of that, are caught completely off guard when they wake up in the hospital and is in excruciating pain. Particularly for my patients that have a history of PTSD from other traumas, whether it be military, whether it be childhood traumas, violence, sexual traumas, it all comes roaring back up after a procedure like that. Chemotherapy, if you really break it down, you're poisoning your body and it's like kill the cancer first, or do I kill myself first. That can be a very traumatic thought for people to cope with, and radiation as well. When people go into radiation therapy, the door there behind is thick. It must stay locked and closed. You're lying on this very hard table, and there's this thought in you, like what is being put on my body. It is so harmful that people can't be on this side of the door with me. I had a patient very recently who had a military history. He had been trapped underground in some way, kind of pinned underground for some time in some way, and the position he had to lay on the radiation table was in the exact same position where he had been pinned

underground. So that was an incredibly traumatic experience. Having to go through that every single day to get this lifesaving treatment.

Participant 8 stated,

I think from the beginning from the start of working in medical social work right away, you become sensitive to and need to assess for trauma or PTSD to get a baseline. I currently use my psychosocial questions when I meet patients, to include have you experienced a significant loss or trauma? From the very beginning I asked them about any kind of traumatic experiences they've had, and this is before the actual transplant surgery. So many times, they come with already like some PTSD from some situations from their medical, from their medical situation, and from their disease. There are some frightening things that happen to people when their liver starts not functioning, so a lot of them have what I wouldn't necessarily say it is PTSD, but some people do, and some people say I feel a little bit traumatized. So, I just assess for it because we do tell folks that being in a hospital or going through such a major surgery can re trigger old trauma and can create new trauma. So, we want to have a baseline understanding of what they're bringing, and what they've experienced before surgery. If we can, and they are able to speak and talk, where their loved ones understand it, we would discuss that. Where it becomes tricky is folks who are in the ICU in the hospital setting for a long time or have had complications of surgery. Given the fact that a lot of the symptoms can mirror hospital delirium or just a lack of functioning or liver, it's hard to discern if it is medical trauma, or If it's delirium, or if it's their behavior under stress. Participant 8 continued to share, I think while they're inpatient, we notice and the team notices behaviors that could go into any of those buckets. We get a psyche consult involved mostly after they've discharged. We invite them to come after when they're getting ready to discharge, and we

talk to them again about the emotional journey of this medical procedure. Sometimes it's a delayed response, so we specifically point out if they're having intense feelings, or whether it's anxiousness, or depression and they can't articulate it, or if it's intense or they're numbing out and feeling nothing. We asked them to inform our team, we are asked to follow them closely once they're home in an hour post-surgery clinic and we look out for signs of behavior that is concerning. We have an organ support group which can support people in understanding kind of long term in what it would be like. Also, people do share some of their experiences while trying not to like have people traumatized, or other people traumatizing others, or re traumatize themselves by talking too much in detail. There is a place that they can talk about their journey and continue to get referrals for psychotherapy or medication if that would be helpful too.

Participant 9 stated,

It's very extensive because even though it's normal mental health crisis that brings our patients in, there is a lot of times where there are medical components involved. We've had patients that have walked in front of traffic and got hit by a car, or we've had patients that have had lacerations on their arms and wrists because they were attempting to die by suicide. We've had patients that had an overdose, so there's medical components, too, obviously when these patients are suicidal or manic or psychotic. My experience is to just be fragile with these people. Once they graduate from being on the medical floor and getting stable, they then come to the psych unit probably having feelings of shame, embarrassment, guilt, sadness, and hopelessness because they obviously tried to do something to themselves. My experience with trauma is to handle it in a very fragile way, to understand that every person response to trauma is going to be different, it's not like a one size fits all, it's a very time sensitive thing, and our setting is very acute. They're not

usually there for more than seven days, so you're not going to resolve or have this significant impact on healing of trauma in seven days, but it's just kind of laying that groundwork and foundation. Once they are discharged and continue with outpatient therapy, they are at least aware of the tools that they need from the trauma they've experienced, to hopefully learn from it, understand why it happened, and set the interventions in place to not do it again.

Participant 10 stated,

I am the trauma and orthopedic social worker. It's been an eye-opening experience. I have seen a lot. My main goal with what I've seen has been basically making sure that the family is well supported. I have a gift, and I don't call it a talent in being able to meet people where they're at. It's so much sometimes, especially in being in the pandemic over the past two years. It has been so much worse than when I first started. When I came in, all I had was case management experience from hospice, PACE, and little mental health background. Most of my experience has been dealing with hospice and dealing with care management from PACE. Coming into the hospital fresh, with no trauma experience at all was overwhelming. After a while it can affect you mentally. I think in the pandemic, I started to burn out because of the amount of domestic violence cases, the increase in stabbings were out of this world, and the shootings because we are a certified level 1 trauma center. I don't think there's nothing at this point that I haven't experienced as far as medical trauma. I've seen the worst of the worst accidents. It puts you in a place. Seriously, you try not to take it home with you, but to sum up some of the cases is that they really pull at your heartstrings. Overall, I wouldn't trade trauma for no other area because even though it is overwhelming and even though it does burn me out and I get

frustrated, I feel more should be done. There are a lot of positives that I do to help the patient, and the family.

Participant 11 stated,

> That happens frequently based on misdiagnosis or missed opportunities that a patient could be going to the doctor and they may be giving an antibiotic or giving some medicine to treat something, but there was not more of a diagnostic evaluation and then they come into the hospital and they have something very serious or even terminal going on with them. The patient is guarded, and they are deflecting all their emotions, and they can be kind of irate to the staff and just non receptive to anything that you are trying to do, or when and engaging them. I think that the experience has been learning how to just listen, step back, and wait for them to come to want to engage, like meeting them where they're at with the whole situation. That happens frequently and it's sad because a lot of times they're very young and they have families or children and they're devastated. They go through the stages of grief, learning and most of the time we meet them when they're at that stage of anger. So just learning to use the clinical skills as a clinical social worker and incorporating the role of you of the care coordinator because most of the time, we are setting up things that are heavy. When I say heavy, that is meaning I'm going to have to talk to you about end of life, or I'm going to have to talk to you about hospice. So, it's going to be a deep conversation. That's heavy, and sometimes that can be like traumatic.

Frequently Encountered Diagnoses

The themes that best represented this code was diagnosis, and scenarios. Participants responses to diagnosis included, peripheral vascular diseases as it often led to loss of limbs, HIV (Human Immunodeficiency Virus), TBI (Traumatic Brain Injury) cancer, dementia, burns, covid, diabetes, renal diseases, cardiovascular diseases, and transplants. The theme scenarios best

described the medical trauma encounters that were not specific to a diagnosis, however experienced from situations.

Participant 1 stated,

> Peripheral vascular disease or the one where people had to have amputations. Then you have some traumatic brain injuries. Anoxic brain injuries, so my patients are trach, vented, vent dependent, vegetative states, and cancer. What is another like super common thing that I see with my patients? HIV! I think those are a lot of like really to like heavier diagnosis. Oh, and diabetes. I know that doesn't seem like much, but when you're diabetic and you're impoverished, with a with a low literacy level, you're at higher risk of amputation. I see that a lot. Oh, and of course obviously COVID, and Hemodialysis

Participant 2 stated,

> I would say a cognitive disorder due to dementia. You will see that a lot in the hospital, especially with patients who already have it and they may get a UTI (Urinary Tract Infection). They become more combative, with behavioral issues. The hospital is seen as a drop off place. I like to say for people, for caregivers who are very overwhelmed, you will see that they will bring their loved ones to the ER a lot, especially those who have dementia that they just no longer can't take care of them at home. It's just very overwhelming, or just too much. That was a frequent thing. I would see them being dropped off at the hospital. I had a family member who crossed state lines from North Carolina and dropped the father off in the ED (Emergency Department), with a suitcase and never came back up. So, you have those things where you know people have dementia and they're trying to be independent and stay at home, and they're not taking care of themselves.

Participant 3 stated,

I think it's really a broad range because it totally would depend on the experience of the individual. So, while it was certainly very common or more common, probably in cancer patients. You would see this in trauma settings you would see it in burn patients. You could see it in just about any diagnosis that's going to have a risk for severe pain or a sudden onset of a severe symptom. I'll especially say lasting trauma effects of trauma tend to happen to folks who have risk factors. You know internal risk factors from prior and so they're coming into the experience. Without those resilience factors that are going to help them just deal with that moment and be able to say well, that was horrible, but it's over now. Instead, it's going to carry on in their body and their life as no it's happening again. So, I think not just the medical diagnosis, but also understanding perhaps the other risk factors that patients may have. That have these that have any medical diagnosis. What other risk factors might they have for that? Their providers are probably going to know in their medical history. What they might be, you know whether they might be at risk for any of those severe onset, severe sudden onset symptoms, but oh I forgot to mention pulmonary, you know there's so many of those folks. Covid and you know asthma. With a severe asthma attack where you feel like you can't breathe. Any of those lung symptoms.

Participant 4 stated,

Not sure what you would call it diagnosis wise, but trauma related to being intubated, after a suicide attempt. What that does to the throat along with not only recovering from a suicide attempt, but they're recovering from being in the ICU after being intubated and stuff like that. Participant 5 states, There are other traumas that you and I as social workers would consider as trauma. They don't necessarily land on the trauma service. Of course, having worked in a float pool, well actually I used to be the team leader of

general medicine for the case managers here, and I worked with the limb loss team. That's very traumatic. It's sometimes traumatic for me because the surgeons are not very gentle, and they would come in and say yeah that we would be rounding and say that legs will have to come off and I just want to pass out on the floor that they would say it like that to somebody. You wouldn't walk in my room and say that. I am going to need a new surgeon today. Then of course when I work oncology, new diagnosis or finding out there's no more treatment options is extremely traumatic. Those patients don't land on the trauma service per say, but I mean working in acute care, everything including fractured hip is a trauma.

Participant 6 stated,

The anxiety, depression, Bipolar, schizoaffective personality, and flat affect. I have patients that are manic who do require one to one sitter, and restraints. The only thing that, and again hospital regulations, which I usually don't agree with is they're isolated. I get it because it's safe. It goes back to safety. However, being in a room, being in a certain color and outfit, so that you can be identified if something goes wrong makes the patient not feel like they're normal, and I'm sure that's something that you've already struggled with it just like years ago or when they were first diagnosed with it, so that I don't agree with it. I think sometimes staff members make comments, and I know sometimes I think we all do it. Some medical diagnosis I would say, I do see a lot of dementia patients, so sometimes if they're having issues with a UTI that can set it off even in the older adult population and that can trigger other past experiences, and past diagnosis. Sometimes when labs are all out whack, like the sodium levels are low or the white blood count cell or different things like that can cause other issues. So high blood pressure can lead to confusions and blacking out and all kind of different things. So, it

works together as a whole. I have a lot of patients who have had amputations or need an amputation. So, then you're talking about their mental state. I came in here with both of my legs now, I'm going to leave with only one. It's a lot of that, that I encounter.

Participant 7 stated,

I have worked with people with comorbidities, along with cancer. I work with all the cancer types except for head and neck cancer, which is a trauma. Most or many people with head and neck cancer end up with a tracheostomy So, suddenly, they wake up, they can't talk, and they can't eat. It's a very disfiguring cancer, and unlike breast cancer, where health insurance is required to pay for reconstruction, they aren't required to do that for head and neck cancer. I don't work with that population, but that would be a very interesting one to study as far as trauma. I think that's the population they found that ends up with the most significant psychosocial distress or rates of mental illness. I would double check that, but I read that somewhere. Many of my patients are older. They are like 60 plus for getting this diagnosis, so they might have issues with ambulation already, have issues with self-care, many people have diabetes overall, or in poor health to begin with, then that can impact, their ability to care for themselves and access their care.

Participant 8 stated,

I have experiences with liver issues or cardiovascular diseases, and heart transplants. So, a lot of my liver patients also have cancer, so there's like oncology cancer. There's also trauma just in terms of folks who get organ transplants. Sometimes they've had an accident which has been traumatic body trauma to the body which has also led to adult medical trauma. So, there are folks who've been in like construction accidents, or all kind of things which that would damage their organs. Those that have had traumatic experiences related to gunshot wounds to the abdominal area that will require a

transplant. There is diagnosis like autoimmune issues that cause folks to need a transplant Some of them have been kind of sudden and some of them has been like long time coming. Also, I've had worked with patients who've fallen, they're, weak and have shattered a hip or something and that's been traumatic. They get scared of falling again.

Participant 9 stated,

We frequently encounter bipolar, borderline and schizophrenia. Then obviously lots of anxiety and depression disorders, which kind of coincide with bipolar and borderline. Obviously, schizophrenia, but those are probably our main ones. With bipolar it usually one of the main ones because when you're set in a state of mania for a certain amount of time, which is normally what brings them in. In the state of manaia, state of mania, they're acting in a way that's abnormal or gets them in some type of legal trouble or their family brings them in because they're interacting in a manic state and their families concerned. That's normally a big one, because that's what brings them into admission. With schizophrenia, you have people that are hallucinating and have the voices telling them to do horrible things. So obviously like that will bring them in. Those are probably the main ones we see and typically we can do our best to help them, but those three are probably the primary ones that is in our unit anyway that we serve. So those diagnosis are the first and foremost. I do find it triggered by some medical diagnosis. We've had patients that have been diagnosed with cancer. We have patients that have been diagnosed with dementia and it sends them over the edge and they just become super depressed or who are very just overwhelmed and then they stopped taking care of themselves appropriately, which leads them into our unit. So, there is cancer, we've also had. we've had a lot of eating disorders too, which can result with lots of, nutrition issues. We've had patients come in having received diagnosis of various kinds that have been or

even have a family member related to them that have a diagnosis that sent them over the edge as well. So, there's medical components that causes the mental breakdowns and responses for sure and like with dementia, we're not really supposed to get dementia patients, but we will get memory care patients and that makes it even worse because they can't rationalize logically what's going on. So, it's difficult, it's a tricky web when it comes, and it's not psych anymore, it's more of a memory care, a medical geriatric thing. We do our best to nurture the mental health component that is tide into that diagnosis.

Participant 10 stated,

Traumatic brain injuries #1. Traumatic brain or anoxic brain injuries. Those are like the top ones that that I've encountered. Others are car wrecks, and spinal cord injuries. Those are going to be the most frequently diagnosed at the hospital, because a lot of people come in that have that trauma. I had a 29-year-old guy that I sent home on the vent a couple months back. I think I sent him home in April. He was a firefighter from Aberdeen. He dove into a lake after he had been drinking with his buddies. He smacked his spinal cord. It was a tough situation. After he had been here for a few months and switched to social work, we were able to accomplish and do more, by the grace of God. Once rapport was built with the family because the trust has been broken, I was able to gain the trust. His spine was bad. He became a total quad. I would have to say it just depends on what they come in there with, even if they have gunshot wounds. For the most part it will likely be brain injuries. Brain injuries is what we see mostly at the hospital because most of them are car accidents. People fall 30 feet from scaffold and get spinal cord injuries. I don't really touch people that have heart attacks and stuff like that. If it's a surgery, or substance abuse, then I would probably play a role in their care.

> Participant 11states, I would say cancer, definitely cancer. It would be the oncology patients and then heart disease, would come next.

Impacts of Adult Medical Trauma.

The participants when coding their responses to how they were impacted by adult medical trauma created 2 themes: impact, and scenarios. Participant 1, stated,

> What provisions are in place to protect him to help him get better? I think that's how I think when I think about when I'm treating the trauma. I think the biggest thing I always had the hardest time with is people having to go to facilities they didn't want to go to. The only facilities accepting them because of the injustice of the system, and the prejudice that exists is like one-star facilities that you know have no air conditioning, or that you know have been on the news for elder abuse, but still are up and running, and I think, that makes you feel that as a provider, and as a practitioner that you're stuck in a rock and a hard place. You're trying to motivate your patient to not feel like they're stuck in a rock and a hard place, and try to instill some hope in them, and sometimes it still just doesn't pan out. Yeah 100% these affects me as a provider. I was sobbing at work today because I was like why I'm here and I'm trying to do a great job, and like maybe I'm just not cut out like I often am like, maybe I'm just not cut out to be a social worker, maybe this isn't the field for me. Maybe it's time for a change. Experiencing compassion fatigue. It's past the point of burnout. Burnout is like the first year and then you just want to do such a good job, but like there's things beyond your control about not doing a good job, and then sometimes you're like, well, am I giving it all? Am I giving it my all because I'm so tired today? You know that the patient to case manager ratio is terrible and it does impact. It's troubling because you know when people who are in social work should be in social work, because they feel it to be their calling. It is hard to feel that way,

and it's also hard to compromise your integrity, because you have no other choice, and that I feel to be like that is how it's impacted. The compassion fatigue it's terrible. I think I will speak candidly, because I think this is very crucial on how I've tried to explain it to people who aren't in the field, like you and me. I would never want my patient to have a death. I don't want my patients to pass unless it's you know their time and that's what's comfortable for them and that's what's been decided, but sometimes there's the feeling of relief when one of your patients passes away because it's one less thing on your plate to do. It's not the relief that you know that they're no longer suffering. Sometimes it's like, OK, all right now I'm down to X number of patients and then I must, then I must pull myself out of that, and I was like I don't ever want to be in a place where I hope that happens to somebody. But you know what kind of environment you're in when that gives you relief? If you're caring. If it's complex and you're carrying the weight of your patience, and we're so empathetic for our patients. We're carrying their worries while also not knowing how to reassure them.

Participant 2 stated,

Yes, I it was a young lady. She was 19 years old, and she was HIV positive. She had just delivered a baby via a C-section. The child father did not know that she was HIV positive. She was basically on her way to having aids because her T cell levels were so low, and she was not taking care of herself. She had good health insurance too. She was connected to the Ryan White Foundation, which is at EVMS that's a nonprofit organization that helps individuals with HIV, AIDS and make sure that they had their medications. It impacted me so much because even though she was 19, I wasn't much older than her when that happened. It's just having to have that conversation with her and encouraging her that she needs to tell the father because the way she saw it was he's not

going to leave me because we have a baby now. I had to be realistic with her and let her know that there was a possibility that he may leave you because you may have possibly exposed him to HIV. Being that they have been having unprotected sex, had a child together, lived together, and not how hygiene practice was inside the home. The nurses were nagging that she should tell the father, and that the father needed to know. I had to make them aware that you can't disclose anybody's HIV or AIDS status. It is against the law to do so. Even with that situation it was very tough, but I couldn't say anything. Just having that conversation with that mother and worrying about her the next couple of days, even until this day I worry about her cause you wonder if they are still alive. You wonder how the baby is doing because you know the baby must be put on antiviral meds when they're born to try to prevent them from catching it. You hope that the father doesn't retaliate and do physical violence against the mom. It impacted me because you just never know what the outcome is. You know when they leave the hospital, you give them resources and try to tell them how to do the right thing, but you at the same time is wondering when or if you are you going to see them in the ED because you know something has happened because they just didn't disclose that. So, it impacted me. You want to make sure that I do the right thing in trying to get them to stay the get tested and are utilizing resources. I can say medical trauma will keep you on your toes of taking care of yourself and try to be as preventative as you can with your own health needs. Not just with you know sexual health, but overall health in general.

Participant 3 stated,

I'm very fortunate that I have a clearly defined role and, I'm in a hospital setting where I don't have to often meet with people right when they're in the middle of feeling awful, which is a time when they often can't process when feeling physically awful. They can't

process a lot, so I haven't seen probably the most you know, difficult aspects of it that nursing I think sees all the time in medicine. Sometimes I have been impacted by people whose experiences are provoked by anxiety and irritability. They could be a little bit cold and then occasionally there will be someone that will have their course where I will need to be involved in a very difficult multidisciplinary team meeting. Difficult in the sense that we must tell them hard news and I may need to process with them, and that's kind of beyond medical trauma in the sense that you could have that with several settings. That's just sad. I have only been very peripherally involved in that. I had to have one patient exsanguinate, which means basically he bled out in the ICU because of his outflow cannula. The tube that was linking his heart support into his heart just came out, and he bled to death in the ICU. It was a hole in his heart. So, he immediately bled to death and I didn't even see it. I just read about it and I still remember reading that and going oh my God. He had some medical trauma impact. He had heart disease but not so serious, and then suddenly his heart disease got much worse. He got hospitalized, and then he had to have advanced heart therapy. He went through a series of surgeries to put in different levels of support until we put in this more durable support and it was when we were trying to get him through the recovery for that. I wasn't eve at the hospital, but I would say that it was impactful. It stays in my mind. It does not, I think, has impacted other aspects of my practice, and has not impacted me personally. I don't think about it at home, it's not intrusive, any of those things.

Participant 4 stated,

I think all or any impact that I've gotten from working with patients with adult medical trauma has been positive because it just expands my knowledge. I have been able to come more versed in medical terminology and more versed in medical diagnosis. Having to

think outside the box in terms of typical community-based resources that I may refer to because they may need to take into consideration the medical trauma issue that someone is dealing with. So, I feel like that has been the biggest impact and then one of the biggest impacts is just having an interest in working directly in medical social work.

Participant 5 stated,

I must be honest with you if nothing else. Social work career will make you grateful for what you have, as well as what you don't have. I can come into work feeling sorry for myself and leave thanking GOD that I'm not in the situation of these patients here in the hospital. Sometimes it makes you feel sad, I guess. Three or four months ago, I sent a guy home whose birthday was four days before mine. I sent him home with hospice and oh man, that weighed heavily on me for a few days. I mean there are some secondary traumas but like all good social workers, I'm in therapy too.

Participant 6 stated,

I normally do very well, which I thank God for. At the end of the day, I'm also human. So, at first when I first became a case manager, I would have patience pass away. I would just kind of suck it in, but now and that's one of the things that I told my intern that is, you must embrace your feelings. A lot of my patients stay for a while or because they're dialysis. They come back and forth, so I get to know some of my patients, more than others. If they pass away, I just kind of acknowledge it or be OK with being upset or being hurt because I'm a social worker, but I'm also human as well. I try to treat my patients like I would if I was treating my family, but I avoid the transference and countertransference. Now there was a time where I did have a difficult time, because I had lost my dad earlier this year. I was all in the thick of it, so he was in the hospital and was septic and all that good stuff. So, I was the one that was trying to explain to my

family like this is like it. It's nothing that they can do at this point, so that was a hard time for me, and I do remember coming back to work which was too soon, way too soon for the setting that I'm in. I had a daughter, a male patient was her dad, and he was just saying like look, I'm tired, like I don't want to do this anymore and I've been doing this, so I keep coming back. He was like I'm ready to chill now, I'm ready to receive comfort. So, she opted in for Hospice, but of course she was hurting, and I cried in the room with her, and I was like listen, I really do apologize, I lost my dad and just went through this. I think it was literally like a two weeks later or like a week later. So, it Definitely certain things can trigger, but I think it's important that you respond to it, how you need to. I don't agree with crying in the room with family. I was very disappointed, but I mean it is what it is, and she understood. It sucks, because I think sometimes people see us in our white coat and they think that we're high and mighty. I meant to mention, we wear white jackets, and some patients do not like that. They don't feel like you can connect. I guess they just feel like you above them.

Participant 7 stated,

I get very frustrated with our medical system. I appreciate this new push in medicine to focus on social determinants of health. I think that's a step forward, but I think that it forgets that just because distress is normal with these medical diagnoses that it isn't something that should be dismissed. I think the system is very task oriented and it is how many patients can you see in these 15-minute increments. Certainly, does not fit the social work model and certainly do not fit what patients need to feel like human beings, and feel that they have dignity. I find a lot of contentment in my job because I feel like I can set myself apart from the medical system in some ways simply by returning a phone call. When you talk about being therapeutic without you doing therapy, it always amazes

me how much it means to people to return a phone call because they're waiting weeks to hear back from their doctors' offices and being able to have someone feel heard within a system that's very dismissive. I think it can really make a great impact in their care. It is frustrating though. I think that the patient experience is often dismissed. Those patients that are really struggling are seen as the problem patients. Those that are trying to advocate for themselves, and the only way they know how are seen as annoying. On the other hand, I understand how burnt out these practitioners are. Certainly, I'm amazed by the resilience of many of my patients, and I find a lot of joy in what I do and think I can make an impact. On the other hand, I do have a lot of frustrations with this system. I have a lot of frustrations with how this system treats social workers, because I think there's a lot more we could be doing.

Participant 8 stated,

I think there are cases that will never leave you. You will remember the folks who've gone through that you've met, and you'll remember their journey. You remember some of them that have had a long drawn out ending and some of them that have had a quick ending. You will also remember the conversations you've had either with family members, or sometimes you remember some of their wounds unfortunately, and you just think about them from time to time, because you're human. You just feel sad for them.

Participant 9 stated,

Working 12 hours make time fly by and it's impacted me in a way where I learn to compartmentalize with my stress and just my ability to kind of decompress at the end of the day because there's some hard stuff that happens and you must leave it at work. You can't take it home with you, and obviously we're human. That's going to happen, but for me just compartmentalizing all the negative because you'll get patients that really test

your patience and really upset you, but you must remember that at that point, you're now letting someone else's symptoms affect you, which makes you not able to implement interventions as needed. So, it's just kind of recognizing, like this patient is sick, good customer service and remembering that you are there for them, and to figure out proper ways to take care of yourself and decompress at the end of the day, because otherwise you are just going to become exhausted. After doing 12 hour shifts in a mental health unit, it gets overwhelming, so just taking care of yourself and practicing good patient care is probably which I know everyone is like self-care. Seriously, taking care of yourself is crucial to thrive, especially in any type of medical, especially acute adult setting.

Participant 10 stated,

I think I look at everything a lot differently and it makes you really value life and wanting to take care of yourself. Wanting to better than what you were doing because it's the little things. Sometimes things happen that you don't think could happen, happens. Just making sure you have a good self-care plan in place because mentally it will wear you out. I think sometimes people take your meekness for weakness and they are trying to take advantage. They be knowing what they are doing. It's a lot of dumping going on. However, you've got to learn the power of no, and you want to make sure you're doing self-care. Take your days off. That's what they give you PTO time for. Take your PTO because you don't need to work like we've worked every day. I think at first before the pandemic started, it really wasn't an issue 2019, like it was in 2020. Social workers are leaving in droves from my hospital. So, they're burned out mentally.

Participant 11 stated,

Well, that led me to come here last year. I was seeking to step outside of the inpatient role. I think it got to a point where the death was really just breaking my spirit in every

way and I noticed that it got to a point where I could not hold back my tears as the professional when talking to patients. On top of that we were dealing with the influx of COVID in the hospital and those patients. One was surviving, and the other family member wasn't, and then you had to wait to tell the other family it was just emotionally draining. I think the fact of seeing so many people like closer to my age in their 40s, or late 30s that are primarily the ones that are coming in as the oncology patients. We had our elderly; however, the percentage was so high in that age group between 35 and 45. They were having not just like OK; we're going to give you chemotherapy and radiation. We were like planning for their death. Especially the men with colon cancers and stuff. It was heartbreaking, and I needed to step away from it. This was a way that I could still be in the medical setting and use my expertise but help in a different way where I'm addressing a lot of the more psychosocial issues, and the barriers too medication access, and medical access. I still have patients who sadly passed away. I think that that's just the medical component itself, it took a toll. For the first time in my career, I lost a patient back in May to suicide. It completely, and emotionally devastated me. The worst part about it was I was trying to put boundaries in with her. She had this way of calling me whenever she was missing her appointments. I had made a pact with her that moving forward, if she misses her appointment, we're going to reschedule, but I'm not going to take her calls unscheduled. She wanted to speak to me, and I decided to wait till the next morning. Well sadly, the next morning came, and the next day, and then I found out that that same day that she reached out to me that she died by suicide. It completely mentally drained me. I blamed myself there was really nothing other than talking to personal assistant services which is like the EAP (Employee Assistance Program) and or speaking to colleagues about it to help process it. So, I definitely think because I know I'm not the

only social worker who's experienced something of a traumatic loss of a patient or just grieving with your patient who's dying of cancer.

Treatment Approaches Against Medical Trauma

The theme for this code was approaches. The participant described using approaches such as motivational interviewing, solution focus, empowerment, client centered, psychoeducation, cognitive behavioral therapy, supportive therapy, and DBT (Dialectical Behavioral Therapy). Participant 1 stated,

> Motivational interviewing, and solution focused. Yeah, I don't know that we use a lot of modalities because our interventions are supposed to really be brief and not too social work based, but I think motivational interviewing. My goal is to empower my patients not to enable them. I want them to be able to have an idea of how to take direction when they leave the hospital to take care of themselves? I want to give them the tools to do it. I must be able to teach them. I think part of what I've developed working in the hospital so long is becoming more familiar with diagnosis and the needs. I feel like sometimes I'm a teacher, I can't teach too much about the diagnosis, but I can give you a road map for what it looks like moving forward, and I think that is very beneficial for patients when everything seems so unknown. Especially, if you're waiting for your biopsies to come back or your staging was cancelled. I try to navigate my patients through some of those things or their family members especially when patients now lose their capacity and you have a family member who's like, how do I do this and that and you then grab your resource book. I think we do need more indication of like how like how this should be done. I think there should be more of a focus to help social workers utilize research for treatment approaches, because you must be, and the patient must want to be on board too. The patient must want to change but also must be able to access what they need to better

understand their health and what happens moving forward to the path of recovering. So, I like to use this when I have the opportunity sometimes to do this with longevity.

Participant 2 stated,

I like to use open end questions. I like to have a basic conversation with the patient. I don't want to sit there and just take notes the whole time while they're talking to me. I try to remember everything as much as possible and repeat back what I heard for clarification, because that's what you're taught in social work school to repeat back what you hear. If you don't understand something, ask for clarification on what you know is going on so that you can meet the needs of the patients and the caregivers. One of our treatment processes that I like to use is just to have that open dialogue, like conversation, because when you do that, sometimes it will answer future questions, or they may answer the next question. It kind of helps you get a better picture on everything that's going on because sometimes with people they can be a little guarded. They may not feel comfortable talking to you about certain things. Once you have that conversation, you know that you have built rapport, because in the hospital setting you are very limited on building a rapport with a patient because it's fast paced, and you must make the best of the referral while they're with you. So, when you're talking to them and things are flowing, you can kind of get to know a lot of information from them to help you know them better and help their situation and what's going on. I have used the client centered approach.

Participant 3 stated,

So, in the hospital, often folks are in crisis mode and I most often am doing assessments just to get a handle on what exactly is going on because the presentation of course is you get called or you go in the room and someone is clearly anxious or irritable or staff is

reporting that they're, refusing to work with therapy or any of that. It starts with a good assessment, and then engaging the patient in them under assessing, and their understanding, doing some psychoeducation. It's often brief. I don't usually have to say a lot, but some psychoeducation about medical trauma and helping them formulate immediate strategies. My own and linking supports whenever possible. My most recent experience, I think would be a guy this is kind of a lower level, but he had a heart transplant. He wasn't working with the physical therapist, and would refuse, or he wouldn't do much and the therapist told me he can do more. He will do it and so the therapist came to me after a session and said, yeah, he sat down and said I'm done and I said no, you're not. I made him walk, and he did a whole lap. So, I went in to see him and I processed that with him and what he was able to tell me was that, or what we were able to discover together was that he had anticipatory anxiety because he had a traumatic experience with his first attempts at moving around after his transplant surgery. He'd never had a big surgery like that, and he wasn't expecting the pain. You know our physical therapists were not inappropriate or mean, but because he was totally unexpected, not expecting it, and then he had some complications after that with some delirium, so that whole thing kind of got jumbled up all together and was producing this anticipatory anxiety for him. So, we talked about how he was going to confront that, and I think half of it for him was just realizing that this was anticipatory anxiety. It wasn't going to happen, and empowering him saying what do you think will help you? Know that it's not going to be like that this time, and one of those things was just that time and practice. With his wife, he was very fortunate in having a solid spouse relationship and his spouse was there and I also knew from his psychosocial that he had served in the Army National Guard. So, I said, OK do you remember boot camp? He said, yea! and I

said boot camp wasn't easy and he said no, and I said, OK, this is boot camp for transplant and here's your drill instructor and I pointed to his wife. He then engaged. People may not without a plan for how they're going to cope with those symptoms, and then explaining to the medical team so that they can provide reassurance to him about his current condition and education so that he has cognitive ways to coach himself through the anxieties he may be experiencing. So, those are the primary things I do. I reframed that for him that his struggle as boot camp so that it's just like in boot camp. Well, you're going to boot camp so you can get trained and be a good soldier. You're going to transplant boot camp, so you get trained and be a good transplant survivor, and when you go to boot camp there, you're going to come out stronger.

Participant 4 stated,

Solution focused, that's the biggest thing for me. Just working in the hospital setting sometimes you feel like you're working on a bit of a clock or a sensitive time frame to try to get as much as you can get done in a short amount of time. So also, just working on some reframing and talking about you know what things can look like in the future, if they're utilizing other services consistently to continue to heal both mentally and physically, to move past whatever trauma they've experienced.

Participant 5 stated,

That's one tough one for me. We provide reassurance, we've listened to everything, but as far as anything in-depth that's outside of the realm of the case manager. I would consult a clinical social worker, here to meet with the patient and or their family to go in depth about those issues. We provide referrals for mental health victim assistance. We provide referrals to Alzheimer's support, cancer support, transplant support, and lots of outside resources to follow people we have in house Chaplains, stress management,

which I never seen in hospitals. My role is pretty much providing assurance and support in the moment, and then provide resources for follow up.

Participant 6 stated,

Other than doing client center approaches, I try to sit down, especially if it's a difficult patient. I try to take the time to be more like one on one with them, meaning I take the time to try to get to know them. I engage them like how many kids do you have; What did you use to do; Where did you live; what's your football team? Just letting them talk and listening. I try to make them feel like they're the best person in the world and on top of everything that they're dealing with, in having to make decisions about their health and dealing with family issues. I just tried to make it as easy as possible. If my patient doesn't like talking at 8:00 o'clock in the morning, I totally understand it, because I'm the same way. So, if they want me to come back in the evening, then I'll come back in the evening. Like I said, if patients don't like you standing up now, make sure to sit down just whatever they need that I can do safely for myself and in guidelines. That's what I try to do. It is client centered, based on the patient.

Participant 7 stated,

Other than DBT, I do a lot of CBT work, a lot of mindfulness work, sometimes, just basic breathing exercises. Gosh honestly, I normalize and /or validate. I feel like all my notes say normalize and validate. Really normalization and active listening makes a huge impact. I do a lot of CBT informed. I try to help people begin to form that narrative of their story. I don't do any kind of long-term treatment. I very often tell people, when I do some of these interventions, they will be bit more structured and they may be band-aids to start but doing a breathing exercise will not get to the root of the trauma of what you experience, that it is going to be continued processing, and putting it into your words and

your voice and taking back control over it. We'll begin to do some meaning making and processing of that. In such a short period when I do those CBT interventions, I'm really surprised how much it sparks people to say I'd never considered therapy before, I'm realizing I had all this other trauma in my childhood, and I'm going to continue outside of our work. So that's a big one. I do a lot of that, and I don't know how much, however I guess it goes hand in hand with the psychological impacts of medical trauma. Also, motivational interviewing. I'll give the example, I worked with a patient a while ago. She was a very nice woman, a lot of morbidities, end stage renal failure, with trying to balance dialysis with her cancer treatment, was labeled as the non-compliant patient. She wasn't showing up to her treatment, said it was a transportation issue, and said the Medicaid cab wasn't showing up for her. Our case manager or nurse case manager had sent multiple taxis to her house and she just hadn't gotten in them. I talked to her a little bit on the phone about how her life would be improved if she came to this radiation and inquired about what was holding her back from it. I asked is it fear of the unknown or was it very scary for her. We were able to talk a little bit about how scary it was for her when she started dialysis and how she was resistant to it and didn't want to do that. Then we generalized that out to the cancer. That was what helped her start the dialysis treatment. Now she's doing it, and it has become this routine that's she's very comfortable with. She gets in the car and makes her treatment.

Participant 8 stated,

Usually because I know from taking my course in trauma, I don't necessarily want to open them up to talking about their trauma, if I'm not going to be the person who's supporting them afterwards. So usually, I try to kind of put some bumper rails on when I'm assessing them, and when they're starting to tell me, I try to help them kind of not go

into it right there but help them understand the big picture in why I'm asking them and then if I have recommendations of them getting connected to a therapist or consulting with psych now based on what they're sharing with me now, or just letting them know that that is an option. Since I am working in a hospital setting, I'm not going to be a community social worker who can follow them, so I want to make sure that they understand that I'm a referral source and an assessor for that. I get them to understand that I will be assessing them and then referring them out and making sure they have connected when I follow up with them or had any challenges once they're out of the hospital. If they're in the hospital, I will ask them how it was with talking with psyche, do they want to talk to a chaplain, or what else would be helpful.

Participant 9 stated,

So, for me it really, we utilize a lot of different modalities because we do support groups throughout the whole day. So just depending on the group of patients, we have 24 beds, so depending on the group I kind of waiver the modality I want to use. Sometimes it'll be solution focused, other times it'll be CBT, other times it'll be DBT, or person centered, or patient centered. It really just depends on the needs that you kind of feel out with every patient. Obviously, everyone is different they, they're not going to benefit from all those things. Someone might need something else more than another type of treatment. It's just getting them to understand and utilizing it appropriately, where you can kind of do a one fits all with solution focused or cognitive behavioral therapy. I would say probably CBT is one of the biggest modalities that that we use so we really range with all kinds of stuff. It just depends on the need of the patients at that time.

Participant 10 stated,

So, I do a lot of positive self-talk. I do empowerment with the patients. I'm a minister, so it's kind of hard like I don't open the door unless they open it. But I do like when you in Rome you do what the Romans do, so if they are saved or believe in Jesus or whatever, I use what they tell me, and use that to get them to do what they need. I do what needs to be done in meeting the patients where they are. I do some cognitive behavioral which leads to motivational interviewing to get them to look at their situation or their hobby habits or what they're doing to try to promote change. Positive self-talk works brilliantly when it comes to those patients. I just apply everyday common decency, and just being genuine. I believe that the patients respect you more when they know you're being genuine, and they can tell when you're not. I'm not the social worker that goes in and does just your admission assessment and then don't come back and see you until you discharge, I'm that social worker that goes in does your assessment and every other day I'm coming in to see you. I do this to stay ahead of the curve. I want to know that you're doing OK, if there's any issues I can address or not. So just being present. It's not hard.

Participant 11 stated,

We use quite a bit of motivational interviewing. We also use brief interventions and also psychosocial support. As a case manager or as a medical social worker we don't do any diagnosis, so coaching and providing that emotional support to them and just trying to help them make decisions about them, their stuff, and what they needed to do. So that's where the motivational interviewing really kicks in. So, there's one thing that they like to use here called mapping. It's like an agenda way of planning with the patients so that they can kind of navigate through their health. So, stuff like that we used to help to, kind of help them work through their emotions with something significant.

Trauma-Informed Care Experience

This code formulated themes such as education, employment history, and experience. Participants described the experience of trauma-informed care through education, described what the trauma-informed care experience looked like through their employer, and its rewarding experiences. Participant 1 stated,

> I don't have much trauma-informed care training from like a hospital setting. We don't really talk much about that at the hospital, like in a formality way. I have trauma-informed care prior to working in the hospital setting I was in foster care and in the adoption field. We were looking at what trauma-informed care is and how to make sure that all individuals were informed about what trauma is like. I think that my experience with trauma-informed care is I'm trying to educate people on trauma-informed care. If I have patients who are survivors of domestic violence, or sexual assault I'm trying to make sure that all the staff members that are involved in the patients' care are informed about what would be a best practice. How do we meet the patient where they're at and get them what they need? That sometimes looks like we need to stop judging their drug use, because their drug use is a coping mechanism because they've experienced something traumatic and unfathomable. So, if we operate to the place that they are hurting and they need help, instead of saying that they have brought things upon themselves. I've had to have that conversation with many of providers. I feel like my role as of social worker, is to make sure that people are informed. I do think that there needs to be a formality of understanding. I think also advocating. I think the biggest thing you can do when you're trying to be trauma-informed is to advocate. I try to give patients a voice if they can't have one themselves. I don't think it's seen like that right away with individuals with traumatic signs because of medical. I think trying to remind to people, and providers that

they've just undergone something like being amputated even though you may have amputated 15 people this week. Being like this is this person's first amputation. We can't be numb to the normal normalcy that it is to us. Especially with like larger diagnosis. Even diabetics, when they are diagnosed in the beginning, is very dramatic. It's a lot to grasp to take care of yourself. I think it's not seen as much because practicing medicine to everyone is supposed to be like second nature to them.

Participant 2 stated,

Its's been rewarding. It's taught me a lot. You just never know, what will happen in your life, and to be prepared for the unknown. Trauma-informed care is inevitable. I like it. It's fast paced, and it's not for everybody and you can survive it. It makes you feel good inside that you made a difference in somebody's life and help them go through a traumatic experience because trauma can be in so many ways it can be psychological trauma. That's one thing that I learned in the hospital trauma could be car accident, domestic violence, the burn unit, things like a medical diagnosis or terminal illness. So many things could be traumatic, and I have learned so much in the trauma-informed care setting. I probably had maybe two gunshot victims in my whole career, but majority of my trauma has been car accidents, burn victims, and that's not always from a fire. Learning that you can get skin burns from motor vehicle accidents. Like that's very traumatic or like a loss can be very traumatic. So, I just learned a lot. It's taught me a lot and built on my experience as a medical social worker.

Participant 3 stated,

I did not come to that early in my career. I have found it most helpful. To kind of keep in mind when I deal with a lot of folks that has had some kind of trauma in the past and then come into a medical system. I wouldn't so much say that they have had a traumatic

experience per say in the medical system, but the risk for them of developing a traumatic response within that system is very high being able to let the team know, that this person is subject to this and coming into them with a different approach and respect. The history that they come into this with and considers the ways that it is going to impact, how they may interact with me and other parts of the healthcare system. I think, particularly, you know folks who had trauma may without even realizing it, find themselves reverting into survivor behavior so they're doing anything when they feel a sense of threat. They'll do anything, to try to get what they think they need, and that may not be functional. It may not be something they need. It may just be a response and then they're doing some pretty. You know things that are destructive things to their relationships, with their teams, and their nurses. Just helping the teams and the nurses understand that behavior and helping them understand what the patients think about their experience by not expecting that.

Participant 4 stated,

I think trauma-informed care is such like a hot button word. I think it's gotten to the point where we started using it a little too loosely where we say we're trying to inform trauma-informed are we really. I think a lot of it comes from just being individually cognizance of trauma and incorporating that into everyday social work practice. So, I think from a hospital standpoint all my experiences with trauma-informed care have been in community based mental health in the hospital setting. I feel like in the hospital having to potentially educate other disciplines on trauma-informed care. I often feel like social workers are the most trauma-informed in the hospital. A lot of times, I often think those who are medically driven need a reminder that this behavior or something is based on trauma and I think recognizing that is a part of being trauma-informed. Now I haven't received any recent trauma-informed training or anything like that, but I think a lot of it

has just come along as I've worked in the field and learning how trauma impacts people and what it looks like even down to the level of walking into an agency or hospital and getting some sort of treatment or requesting some sort of care and how we can be trauma-informed as soon as somebody steps foot inside of a building.

Participant 5 stated,

We have in-services at my hospital about different types of trauma-informed care and we have other resources as far as if you are not familiar with that you can investigate about people's historical trauma. Not really a good answer I believe, and that may be an area to explore for more education. Honestly, I don't. I don't know if you ever worked in a hospital or not, but it is a chaotic environment, and we are urgently trying to find a safe discharge plan and services. I won't say it's all cookie cutter, but it's close to cookie cutter. What do they need? Where are they going, and what do they need to be safe when they get there?

Participant 6 stated,

Other than meeting them where they are and letting them be an expert on their own experience, it's not much else, just because the way that my organization is designed in how things are different, how we're different entities, which is not a good practice. I think we should be able to flow a little bit better, but that again goes back to those hospital regulations hospital barriers. I'm just trying to think through some prior situations where I mean it just kind of goes back to what I said earlier with meeting clients where they are and trying to really get to know them to make an impact and trying to give them what they need. They don't have to search for it, but that's really kind of it in a nutshell with my experience as far as that.

Participant 7 stated,

It's interesting. I've done some trauma. Trainings within the field of oncology and looking at cancer as traumatic and link them between prior traumas and cancer diagnosis. I have not done trauma-informed care. Before this, I really didn't do much with trauma at all. So, I don't have much experience with it beyond looking at cancer as a trauma.

Participant 8 stated,

It's really kind of starts from the course I did. It was a summer long course, and it was eye opening to me. I think it should be a curriculum for every social worker because of all our populations. I mean, it's just so common, especially our populations that are underserved. Like populations who live in under resourced areas and areas of high crime. I just feel like it needs to be part of the regular curriculum. It shouldn't have been an elective for me. I'm so grateful I took it. It opens your eyes to the best practice. I think the biggest thing prior to taking this course, was when had a different career before I went into social work. I was working with low-income high school students and I know a lot of them were reliving traumatic events with me by talking to me. I think now going through trauma-informed care, I think it can be a much better structured place to let them know, what's helpful based on research and what are some options for you and getting them connected to the right kind of care, I think was helpful rather than just being somebody who is just listening, and them what, and then having to repeat it to the next therapist.

Participant 9 stated,

Yes, in my schooling and within my experience in the psych unit is obviously trauma is what brings all our patients in. It's some form of intense trauma that has happened and the result is they are now in our unit too. I guess to reach a state of homeostasis. To get back to some type of normalcy. So, trauma-informed care is something that we receive

continue education on and our realm, is understanding. It's being very sensitive down to the verbiage that is used, and it's being mindful of like trigger warnings like when you are doing a group about domestic violence or being mindful of your crowd and understanding even certain songs or music could be triggering it. It's down to being mindful of the interventions you use or being mindful of the words you use in how you bring up trauma when a patient is not ready for it. It can send them into a spiral, or they can blackout. That's extreme, but it can happen because their mind is not ready to process that yet. It's very crucial to understand where each patient is at with their healing in their trauma and what triggers them and what doesn't. Having and implementing trauma-informed care helps you. I guess I would describe it as being very effectively sensitive, but progressive, because you don't want to stay stagnant. Obviously, we all know like exposure is the way to heal from trauma but doing it in a tactful way to where it is productive and doesn't re traumatize the patient, so that's what we've learned with trauma-informed care. It's way more of slow and steady, which wins the race than forcing someone to just get over it or talk about it as that not If that's not meet the patient where they're at. That's my experience with having lots of patients that have experienced significant trauma.

Participant 10 stated,

A lot of times I thank God because we have trauma conferences every year and they educate us on different subjects and then we also have a lot of meetings. Being on trauma team like it's kind of hard to get my work done, but you don't understand sometimes how you get your work done. I'm kept abreast of whatever trauma related issues that the patient has and obtain much of the education is from what I received during those rounds. I receive it on the patients I am dealing with because I'm present in those meetings and

I'm taking notes. I would take that information and relay it back to the patients and their families in a way that they can understand it. I try to make it as simple as I can, because the doctors use a lot of big words. I sometimes must ask questions myself on some of the conditions that the patients have. I must ask like what this is, come tell me what this is, and what this looks like. Then when you are dealing with the families, you want to make sure that you understand what's going on with them. When they have questions and they can't reach the doctors, then I must be able to do what I can in answering those questions. A lot of their expectations could be unrealistic. Since I have this knowledge that I'm bringing, I'm able to review their goals and provide some encouragement if needed. Sometimes I must be the person to bring them down a notch. Having to review what they were doing before the accident. Having to remind them that it will be a process and just getting them to accept that process so they can move forward. I must be informed so I can inform them. When I see them, I identify triggers, and let them be their own expert. I tell them I'm here for you.

Participant 11 stated,

Just trying to have the informed thought that this person may have had experienced some trauma. Let me approach them this way and not maybe set them off or trigger that. So, I think that as social workers whether you're license or you're not, and you're working with patients we carry a huge torch that we can either keep the light going or we can blow it out ourselves. It's the way that we listen. The way our tone is, and the way that we respond to our patients. So, my experience would be working daily.

Incorporating Trauma-Informed Care

Participant's responses when coded brought forth themes such as approaches, and opportunities. Participants shared how they incorporate what they knew about trauma-informed

care in learning about the event through the patient, to obtain understanding of some psychological impacts. Participants expressed their opportunities to incorporate trauma-informed care into their hospital environment.

Participant 1 stated,

> I've tried my hardest to do it, but I do think it's very much so lacking. I don't know that we weed in western medicine, hospital medicines, have a holistic enough approach. To understand how important psychological needs of a patient are to meeting their medical, physical, physiological needs, and just again trying to take time to let the patient know that I hear them, and I see them. I will try my hardest to get them what they need.

Participant 2 stated,

> I am basically trying to learn how things were prior to the traumatic event. That was the easiest way for me to understand the psychological impacts. When you have a kind of a window or picture perception of how their lives was prior to the traumatic event, whether they're telling you or the caregiver or family members are telling you, really helps. Understanding how it impacts them psychologically because some people you know their baseline may be one thing compared to what it is now that they have experienced that and just seeing how they're processing the whole healing process and recovery process of the traumatic event. The reason why I learned about social workers in the trauma hospitals, is because every trauma patient gets a referral to the social worker, as it is expected for them to have one. They like to call it a hospital situational depression. They have experienced a traumatic event, so it's going to be expected of them to develop some sort of depression. Then whether it be this acute depression, or they may have already had it, but that's why you know making sure they're connected to us as soon as possible so that we can start the treatment process to prevent any further impact. With them, and with

their behavioral health and psychological needs, allowing them to be the expert and be able to share their story without like hearing it or trying to say what it is, but allowing them to be the one and let them tell you how it goes or how it's been going.

Participant 3 stated,

We actually have had some sort of sadly informative experiences on our transplant service with some folks who had trauma in their past, and I think it was not taken enough into account and they were not linked early enough to get good psychosocial supports and unfortunately both of them as a result despite many efforts on our parts were difficult to engage and did not end up surviving the full year after their transplants, mainly because they had not been non adherence related to their responses to their history of trauma. Both were older traumas, not medical traumas, but the medical experiences they had triggered those traumas. I will say I don't think as a system we are good enough at identifying when people have trauma histories, and we are not good enough at identifying the strategies that need to be incorporated throughout the healthcare team to help deal with that. I think social workers can be extraordinarily helpful in creating that supported environment. It's very difficult to because nursing changes every shift. I can tell nursing on this shift but night shift I'm not there and maybe they passed it on and maybe they didn't. Maybe the nurse I told understood it or set it in a wacky way to the night nurse. Just creating things. We do try some stuff. They'll put things in they seem to be keyed into like military veterans who have a history of PTSD. So, you know lights, and sudden movements, the more subtle kinds of medical trauma triggers. They may not get, and the system may lose track of. We had one guy who had medical trauma history and had a troubled response and I just kept trying to tell the nurse practitioner of the day, but they wouldn't tell me before they scheduled procedures and you know he and I had talked. He

was very fortunate in that he'd had treatment. He had some coping strategies, had very supportive of social networks, spouse, well partner and family but I watched us repeatedly like oh, he's going to have a procedure and they think nothing of it, and I think I don't know but you think you may want to give him a little dose of medication or offer it to them? Yeah, like a PRN because he didn't have a substance use history and this stuff makes him crazy. That's not even talking about the people who have claustrophobia, and we're supposed to get an MRI now. How about an MRI of your brain? Even better, let's shove your head up in the tube. Just the kind of inability to put consistent strategies in place in the medical across the care.

Participant 4 stated,

I think the biggest thing when it comes to the psychological impact is making sure before I meet with somebody is understanding what that medical trauma is or what they are dealing with medically overall. Sometimes, that will require me to educate myself ahead of time about the diagnosis, the symptoms, and what they may have experienced day-to-day before I just sit them down and talk to them about how you have been feeling mentally since you've been dealing with this, and stuff like that just so that I have a better understanding of what's going on.

Participant 5 stated,

The only thing that I really haven't mention is dealing with patients with sickle cell crisis. We have a lot more resources for that here. A lot more social resources, a lot more supportive resources, and a lot more support groups. We have a sickle cell day hospital and when someone new in our hospital, it's like sickle cell crisis. You think about external traumas that they're experienced in their lives and offer those support. We have employees here that are considered sickle cell champions.

Participant 6 stated,

I do have a patient and he said, you know these people and these white coats. I had a white coat on so when I go in his room, I don't put my coat on. Just things like that, like that are barriers to a patient receiving you the healthcare that they need, as they are being concerned about somebody in the white coat. So, if I'm on your level then maybe some things could change, you feel more comfortable over there, but that's been my experience. He's not the first patient. It's a lot of patients they don't like being stood over, so I always try to sit down as well and be relaxed, so that they don't feel so stern.

Participant 7 stated,

I wish we could do more of it. I think there's a big opportunity, at least in our hospital on the inpatient side of things. With the social workers there, to bring some of those thing's in. That's a high distressed place to be in the hospital. If you are someone that values control in a hospital, you must ring a bell for someone to help take you to the bathroom. Your independence and control are taken away, so there's a lot of opportunity.

Participant 8 stated,

I think that's one is knowing that I'm not the person who's going to be treating their trauma, but I'm going to be the one who's assessing and handing off. That's the number one thing I have incorporated. I do think that because of my experience when I meet folks who have experienced previous trauma, maybe it's not medical trauma, but maybe it's another type of trauma or people who've never experienced trauma. I'm giving them the heads up or planting the seeds that these things could happen, and so I think that's part of it. I think when the medical team on the floor is having trouble with folks whether it's behavioral issues, is to just be another voice saying like hey, this might not be behavioral issues in terms of what you're thinking or not like necessarily problematic patients. Just

letting them know that they could also be experiencing a traumatic response from their surgery, and just to keep that in mind. I'm not necessary saying it always is, because it's so hard to discern all those things. Again, sometimes when I work with patients, I put up those bumpers. It's like incorporating a trauma informed to kind of determine what kind of bumpers to put out, to kind of shape and help guide people. I want to be clear with them that the reason why I'm asking them is to refer out, and not to have them feel pressured to tell me the details and having them go there when you can kind of see it in their eyes that there's someplace else.

Participant 9 stated,

It's just meeting the patient where you're at and to get information that you feel is crucial for the psychologist or social worker to know. Making sure you have strong communication skills by saying hey, this patient informed me of they were sexually abused, or they were a victim of domestic violence, so, while you're doing their assessment or while you're interviewing them to figure out what they need just be mindful to approach this lightly because it could re traumatize the patient. I would say just express empathy or use just good communication with your team members as well, on what is also good to incorporate, when working with adults.

Participant 10 stated,

Well, I just remind them, on everything that they've gone through and getting them to focus on the positive. Like I've seen people, with severe traumatic brain injuries like people weren't expecting them to progress. Helping them to cope. Teaching them different techniques and advocating for them for the TBI. So, connecting them with the resources and the services that can help address those deficits to help them meet the psychological needs that they'll have, or the family will have. The caregivers need to

know to get them to the point where they're at understanding. Letting them know the person going out will likely not be the same person that came in and they won't ever get back to that point. So, once you're kind of like put the resources in play and link them to the right people, that helps a whole lot. You can't just treat the patient without treating the caregiver. It must be a whole. It's like a 3 three party stool. The doctors, the caregivers of the patient, and then the resource.

Participant 11 stated,

Remembering to meet the patient where they're at. Acknowledgement by validating what they're going through. Inquiring with them. How can I? What can I do or how can I help you? The most you know what? Where do you want to start? So, trying not to have my own agenda pushed like, OK, well you're going to need home health and so and you're going to need this like not. Not forgetting this is a person laying in this bed, or this is a person in this appointment with me that could care less if they can get up their stairs or not, because all they're caring about is will, they wake up tomorrow. So sometimes it's making sure that validation, providing that empathy, and being very compassionate.

Medical Social Work Support

This code allowed for themes to be generated that described the availability of support as being available in the community or through their employer. Participants within the community theme shared much of their support in being through other social workers, their supervisor that is overseeing their supervision for licensure, Instagram, linked in, or Facebook forums, spiritual guidance through prayer, and support through professional organizations. The theme for employer-based support described by participants shared the support through the employer varied.

Participant 1 stated,

I'm thinking my support are other social workers. I think my support is in supervision for my LCSW. I think that's my supervisor. I think there's a lot of influx of social work presence and blogs and things like that like on social media like Instagram and things like that. I think that can be good to sometimes get a motivational reminder or an idea or something. Just that kind of thing to practice self-care. I think overall there's not a lot of support for medical social workers in the hospital because what we sometimes ask for is a direct contradiction of hospital goals. Sometimes it's seen as we're carrying too much, and they want to try to say that there's counter transference or something like that. Like oh, you're caring too much, you need to take an emotional step back when you're just trying to get them to see the bigger picture as well. Yes, you care deeply and if you feel like the other people who are providing care to your patients do not care, can really be hard. So, we always say within my team, within the team of social workers I work with that we always will be a support to one another, and that we can always do our best to educate others. We have been just going back to the Code of Ethics, the good old code of ethics, and if it's against the code of ethics, then we can justify why we won't do it.

Participant 2 stated,

I could say the support is your dyad partner. You get very close to them, because you're working with them every day, as your teammate. You know when you're working with somebody every day and you may not be going to the room each room together, but at one point you're going to meet up to try to go over the case. Sometimes during that time, you just need to vent and get stuff off your chest. Especially when you have a partner that is trustworthy and feel a level of comfort with those dyed partners. Having my preceptor till this day. I still talk to my preceptor even though she may be at one hospital. Knowing that she's there as a mentor, having a chaplain there for support. That's one thing I love

about the hospital setting. A lot of people don't know; they have praying of the hands day that I thought it was just for nurses. But I learned that it's for social workers as well, basically for any staff member, when the chaplains can basically, you know, pray over you, and just bless your hands. It's a day that they do that for all the workers, it's knowing that you're receiving that clinical support, but also that spiritual support. For me, I pray before I go to work. I always pray for God's protection to be with me because you never know if you're going to get angry, or patient, or even an angry family member who may be waiting for you when you get off work. I sometimes didn't feel supported by certain managers at certain hospitals. I did eventually, once I was doing travel, I went to one hospital and stayed there. As a regular employee, the manager was just unsupportive. She really didn't know our job. You really could never go to her. She always had her door closed, and it's like I had to go to my old supervisor who was over the float. I ended up going back to the float pool because I just couldn't deal with it anymore. Her not defending you and you're swamped with work as a medical social worker. You got referrals on top of referrals. You're trying to do placements trying to meet the needs or short staffed, and you just don't have a manager who would just defend against the doctors and stuff, as you know she's working hard and as fast as she can. If she can't get to it today, then it'll be here tomorrow. That was the type of support that I would get from certain managers. Someone like I said they don't support you; they don't want to hear your side of the story because they're so gung-ho on ratings and not caring about your well-being and your burnout. Burnout is very real in Medical social work. I didn't feel support was available by my employers to help get through those periods of where I felt like I was impacted by those traumas that really impacted me. I never really talked about it. I kept it to myself. If I was to talk about it, it would be in my own private therapy that I

do outside of work. I haven't, because it's like I didn't want them to see me sad or crying because then you will start getting worried that maybe they feel as though I'm not fit enough for my job anymore because I'm still emotionally involved and it's just, you know that I'm a human being. I have emotions just like any other human. I cry, I'm impacted by things you know. So, I at those times I never really talked about it. I did see a social worker who did get terminated. Fresh out of grad school because they felt as though she was getting too overly invested into the case. This and she wasn't moving fast enough, so when things like that happen, you do become hesitant to discuss things. I know we have EAP, but EAP is only about 3 sessions at Max. So, it's like you really can't get a good experience out of it, so it's like you must just do things on your own and just get a therapist yourself and just pay that copayment. Even if it wasn't internal. Yeah, and every hospital is different.

Participant 3 stated,

So, I'm very fortunate to have an awesome team with some amazing colleagues in the system I work in. So, we have other clinical social worker case managers with a wealth of experience. I have access to professional organizations. I'm a member of NASW, a member of the ACM, but that's more helpful than straight case management stuff than it is. The medical social work per southeast, and a member of the Society for Transplants Work if I wanted to pay the money. Which I haven't done. I know all those things are available to me and I work in a large academic medical center. We have marvelous trainings available to us. I'm aware of trainings through like NASW helps us know about things. The VA system has a set of trainings that can be very helpful. I have many to whom I can go for and consult with as needed about a resource. I can say can I just run

this by you? I'm not sure how to respond or simply processing my response to a situation that I'm finding difficult.

Participant 4 stated,

With your organization or anything that you belong to, I think there are trainings out there. There are ways to gather CEU's and stuff like that. I feel like a lot of that's on me and it's moving forward. It's likely going to be on me to just stay informed to stay abreast too different practices, different models that are utilized in the setting that I'm working in. Typically, the biggest support I receive comes from those that are within my department specifically, because I feel like they understand the type of work that we do and how it can sometimes be difficult when we are made to feel like we're not as important or we're feeling hurt, or our opinions sometimes feel like it doesn't matter. So, a lot of the support I feel like is often peer based and you know bouncing ideas off each other and staffing cases with one another when things become difficult.

Participant 5 stated,

There are officemates, and in addition to officemates that you can talk to and vent to, we have a program here called COE caring for each other that you can reach out to for support. We have the employee assistance line. We have different kind of educational tools at our fingertips.

Participant 6 stated,

So, I always take the initiative in my career and anything that I do. I don't wait for my organization to provide things for me. I do have a mentor, and I decided to get a male mentor because sometimes we need a man to be straight to the point. I always seek mentorship if I have a particular leader that's over the department and I feel that this is a genuine person that I can try to approach. I'm also in a sorority. So, I have a lot of my

sorority sisters that are medical professionals, licensed clinical social workers who I can bounce off ideas off or reach out to if I have any need. I still have relationships with people that I went to undergrad with who are doing social work in different sectors, and as well as my MSW program. I can always reach back to some of the instructors if needed. As far as at work, we have the EAP available, if needed. My colleagues usually are the ones that are coming to me, but I do have a few that I go to. I am part of a black girl social work group, and so sometimes we bounce some ideas off 1 another or asking questions in the group. There's also a group me that has different social workers in my area that you can also get on to and ask questions and share jobs. They post invitations for CEU credits and all that kind of different stuff. So, I have a lot that I do outside of work. I think my current organization could do better with providing that educational piece because a lot of the things, the certificates that I've gotten, has been from a prior job.

Participant 7 stated,

I get a lot of support through that association of oncology social workers, so that's a national group. They have a list serve. We all ask our questions and bring up difficult cases and get very quick responses. I work with one other LCSW on my team. To give you a perspective though, we have 2000 analytic cancer cases a year in our hospital, and there's two of us. There's still a need for that within our whole network. There's four of us, and I believe that 11 hospital sites. We've been able to create a monthly group where we do case consultation and talk about resources or interventions, and then also some standardization to try to elevate our role within the network. I appreciate the team I work with, those immediate members of the team that I work with really value social work and are very open to us advocating for some of these needs. If we bring up something as an

issue, it's not dismissed. It's heard and taken seriously, whether it's fixed by those higher up is another question, but still, we need more social workers. We need more social work support. We don't have social work leadership which I think would be very valuable, but we do have some resources and support within our little community.

Participant 8 stated,

Other than being part of the transplant society. We have a team of like 5 or 6 social workers in transplant. I have 2 fellow liver social worker that I connect with. I have a team lead, so if there's any challenging issues, I can talk to them. If there is challenging case for the patient, and the floor does this too when they've experienced something very challenging too, we implement what they call a kind of like care conference for the medical professionals in terms if there's moral distress happening with the floor. I would say I did like a team's slash zoom meeting with several multidisciplinary, and medical professionals. It was prompted by the nursing team who are having some moral distress around a patient because of how sick they were. It was hard, I think for them to you know how to care for them day in and day out with how sick this person was. So, we have that venue to talk about your moral distress, why you're feeling strongly, and having difficulty caring. Then we have everyone talk about how we getting to this point, where we are, what are the prognosis, what are our options, and what does the family want. We kind of talk through that, and we've also had it when a patient passes away. We always have these meetings to review everything, but there's a separate meeting to talk about how you felt about if there's any kind of moral distress happening, or questions, or doubt, a place to kind of talk about how you felt about the situation. I've been a part of them; however, I've never prompted one, but I would say that it was helpful for me to hear some of the nursing talk about why they were feeling strongly, that maybe this patient

should be going to comfort care, and then hearing the medical professionals, the doctors and surgeons talk about why we're at this point and a lot of information that just doesn't get to everybody. Overall, it was helpful for people to have a greater context.

Participant 9 stated,

So, I would say our team is very supportive of one another. Our coworkers, all of us, know our supervisor does her best to make sure if there's anything going on that we can come to her and express our concerns or frustrations. So, if we need to utilize the EAP program or the EAP system, we have that. We have resources such as a newsletter for the behavioral health unit specifically that goes out once a month and there's always self-care tips and forms of encouragement. It just motivates us and lets us know that we're doing a good job, which helps for support, because as being a social work, it's a lot and just to know that you're making a difference or you're doing your job right is important. Granted I've never utilized the EAP program, however I would. I will say that we have a very supportive network within the behavioral health unit when it comes to coworkers and supervision so that's where that's my experience is so far with the field, I work in.

Participant 10 stated,

Well, they say that we have support, but we don't. They don't have enough support in the hospital. I think for my hospital to be as big of an entity as it is, there's no support for the social workers. That's why their social workers are showing how much support they've received. That's why they are leaving. It's like a mass exodus. At this point, however for me I'm safe, as I believe in the power of prayer. I pray just as much when it's a up time as it is when it's a downtown. Sometimes, I try to still away and go into the bathroom. I don't have to use it, but I go into the bathroom and I ask God to give me just a little bit more grace. Give me a little bit more grace than this right here so that I can do what he's

called me there to do. Once I'm done, I can leave, but for the most part there's not enough. For my hospital to have a school of social work, there's no social work support. There's no social work recognition. They have the nurse care managers or nurse week, so they get to participate when they celebrate the nurses. So, for care management, they just celebrated the nurses pretty much. They said it was for both our departments. So, we celebrated care management as a whole and explain to the social workers why we got a happy nurse's week for our care management, so they gave us a nurse's mug. So, the social workers at my job kind of formulated our own little support group where we'll do a zoom meeting or whatever to try to support each other.

Participant 11 stated,

So, the only thing really that has been available is like the personal service assistant. We could speak to the chaplain, and our supervisors to kind of debrief. In regard to actually having like a debriefing for some of the things that we go through, I do feel that that that could be, or even should be something that's implemented because, it's a lot emotionally that you go through, and it's not just because of the deaths, but these patients are very, very complex. Most of them that are coming in is not because they're just coming in to have their knee repaired or remove cataracts. They're coming in because they have, and excuse my French, but a **** load of problems that we have to solve and or we're expected to solve. Then we have the mental health issues going on.

In lieu of the coded interview questions, it allowed for me to identify directly how the participant perceived themselves in the hospital environment, their contribution to the hospital environment, level of training, their clinical approaches, barriers, and knowledge and training on adult medical trauma to include trauma-informed care training. The experience of the healthcare social workers validated the experiences drawn in the literary reviews. The education experience

and training differed among the participants. The case management model experience in meeting the psychological impacts for the patients varied, and the impacts on the patients and social workers existed when working with various patient population.

Initially when I started the research, and when recruiting participants didn't fully acknowledge how mental health diagnosis can be identified as a medical diagnosis response. Other unexpected findings were the similarities in experiences to medical trauma, engagement with the case management model whether it was direct or indirect, and the response to trauma-informed care varying across healthcare social work subspecialties. With many similarities, the thought brought forth awareness in how broad medical trauma was, and what groups specifically acknowledged trauma-informed care, and to what extent.

Summary

The research question is how healthcare social workers respond to medical trauma? The research is intended to identify if a need exists for trauma-informed care training among healthcare social workers. The interview questions and the data obtained did give the researcher an idea of how medical trauma is perceived, how it is identified with in the hospital setting, and the experience with applying trauma-informed care to their patient population. As suspected, the knowledge base of the healthcare social worker varies as its related to their employment history, trainings, certifications, and even school education while obtaining their master's degree. Some participants identified current hospital barriers and regulations that contribute to their patient interactions and their practice approach. The researcher asked about impact to see if there were any potential opportunities of vicarious trauma. The impact varied from patient encounters through witnessing it or hearing about it secondary. A participant shared about an experience where a patient bled to death and the impacts of just hearing it.

I identified how such impacts were being identified with and managed. Some sought support external, a few internal sharing, and many participants sharing that not much support and guidance was available in the hospital setting. It goes back to the research question in how knowledge, training, support, and hospital-based regulations to include the applied case management model on meeting and identifying the needs of adult medical trauma. The responses to these interview questions warrants more of cross training, and awareness to see how effective the trauma-informed care approach can be in this patient population, and even for staff members to prevent burnout and other various vicarious trauma experiences. This opportunity allows for further research to occur with the application to the social work professional practice, and implications of social change.

In the upcoming section, the researcher identified applications to professional practice implications to social change. The researcher reviewed applications for professional ethics in social work practice, provide recommendations for the social work practice, and describe implications for social change, with an overall summarization.

Section 4: Application to Professional Practice and Implications for Social Change

Introduction

The purpose of this study was to identify if a practice problem exists in how social workers respond to psychological responses to medical trauma in a hospital setting. I achieved this purpose by applying a basic qualitative design to inform and establish understanding of healthcare social workers' experiences in providing trauma-informed care. I conducted this study to promote awareness regarding adult medical trauma, to establish best practices in the hospital settings for social workers, and to provide patients the opportunity to obtain holistic care when in the medical environment.

In the data collection, I interviewed 11 participants and found their knowledge and experience varied not just because of their area of specialization but due to educational experiences, employment history, and overall training and development. Some participants had a basic understanding of trauma-informed care, and some needed further clarity. The commonality among those who had basic understanding and those who did not was that this practice approach was uncommon in the hospital setting and was not identified with by other interdisciplinary members. Other practice approaches were quite consistent among the healthcare social work participants, including solution focus, client center approach, and motivational interviewing. These practice approaches allow social workers to address patient problems through psychosocial concerns and barriers contributed by social determinants.

The findings indicate that further educational consistency is needed in preparing social workers in the healthcare environment. The findings identified the availability of support to social workers in managing the psychological impacts of adult medical trauma. The findings show how essential social workers can be and how they are perceived by other interdisciplinary team members. Healthcare social workers would benefit in becoming trauma-informed-care trained

whether they work in mental health, cardiology, oncology, or general medicine. Patients with special situations also come in contact with areas that are not within their specialization, especially if the area of concern in which the patient is seeking care for could be of another specialty, but with the same trauma history. The participants identified with their role and were also challenged to step outside their role to meet the needs of the patient populations. The findings show that a need for reevaluation of roles is necessary for social workers in healthcare settings in efforts of practicing at their educational capabilities and potential expertise. Consistency in training and education can lead to social work best practices in the hospital environment. The recommended solution based on the research findings is the need for trauma-informed care training and education. Once trained and educated social workers can implement this approach in the hospital setting. Over time, this approach can have potential long-term benefits for the hospital's organizational goals and outcomes.

Application for Professional Ethics in Social Work Practice

When responding to the psychological impacts of medical trauma healthcare social workers have principles and values, they need to adhere to for patients in the healthcare environment. Such principals include the values of service and social justice (CSWE, 2015). A healthcare social worker's response to the psychological impacts of medical trauma needs to reflect ethical value service and the principal to help people in need, including addressing social problems that involve a social worker pulling from their values, knowledge, and skills to help those in need. Social workers elevate service to others above their own self-interest (CSWE, 2015). The value social justice and related principle to challenge social injustice involves a social worker implementing social change, particularly with and on behalf of vulnerable and oppressed individuals and groups of people (CSWE, 2015).

The findings impact the social work practice through the type of service delivery being provided and how the patients are responding and benefiting from the type of services being rendered. Historically, social workers practiced case work in the hospital setting and addressed the social and psychological needs of individuals and families and the community (Ruth & Marshall, 2017). Over time, the social work scope in this healthcare environment evolved, causing the profession to limit its focus to the social side of illness and leaving disease to the medicine and public health professions (Ruth & Marshall, 2017). The question remains, however, whether the practice approach currently being implemented by healthcare social workers meeting patients' needs in the healthcare setting. Some participants identified their attempts to meet their patients' needs in the healthcare setting as being dictated by the rules and regulations of their hospital organizations. This includes the standards that have been identified by individuals other than social workers for the practice of social work in specific role settings. This risk of various practice approaches among healthcare social workers and minimal consistency can challenge social justice as it creates the risk of many patients remaining vulnerable and oppressed.

Recommendations of Social Work Practice

Based on the findings, more research is necessary from a social work practice approach to establish and create best practices within the organization, the healthcare setting, and its subspecialties. The profession of social work has been facing marginalization and has been an ongoing feature of the profession of social work in the institutional health setting (Beddoe, 2013). The profession of social work will benefit from generating a consistent identity in the healthcare setting to best meet the needs of patients and allowing social workers to pull from their own strengths and knowledge base. For the social work profession to achieve such an identity will require time and involve the consistency of values, knowledge, skills, and beliefs commonly shared by other healthcare social workers (Beddoe, 2013). The social work organization within a

healthcare setting would benefit in educating other interdisciplinary team members to build cohesiveness and holistic approaches in meeting the growing complex needs of the patient population. Therefore, all stakeholders can acknowledge patients' experiences and history as being traumatic, while resolving patients' fears of disease and treatment (Tsai & Yan, 2021). Having a more integrated approach can allow the social work professional to anticipate the psychological impacts and provide a trauma-informed care approach that promotes safety, dignity and self-worth, empowerment, strength, and resilience.

These findings have already begun impacting my own social work practice as an advanced practitioner. I have taken trauma-informed care educational courses, obtained trauma and resilient certifications, and learned various practice approaches that can complement this approach rather than be a contraindication. I anticipate growing in this specialization and continuing to provide research and education to the social work organization as whole in efforts to continue to inform the organizational practice within the healthcare environment.

The findings identified similarly to the literature review that the education amongst the participants varied (Bent-Goodley, 2019). The findings identified that the healthcare social worker can benefit from further education from their institution to be prepared for the healthcare environment, and its complex patients that they will come in contact with. The healthcare social worker will benefit from trauma-informed care training as a proposed treatment approach in the institutional setting while institutions are educating and preparing social workers in with other modalities (Levenson, 2017). The findings showed that the participants began to become experienced while on the job with minimal preparation. The findings showed that the experience is always from the hospital environment and or from a different subspecialty prior to the hospital environment. The findings showed that the healthcare social worker feels more secure and knowledgeable in their approach when having gained that integrated experience from previous

employment outside of healthcare. The data showed how essential social workers can be, vs how they are currently received and perceived. The findings do identify gaps in practice, and it showed what changes are necessary to continue to inform current practice approaches.

Further research would be beneficial in expanding the participant population pre and post the adoption of trauma-informed care training in all aspects of social work practices in the healthcare environment. Once social workers can adopt such an approach, other interdisciplinary members would benefit in adopting similar approaches within their specializations. In doing so will create for social change in the healthcare settings and improving overall patient outcomes. The history and experience of the profession of social work has a history that identifies threats to health and well-being as being much more than disease (Beddoe, 2013). The social worker's ability to attack the links between health and social inequalities allows them to be immensely diverse withing the institutional ram weather its inpatient or in the primary care setting (Beddoe, 2013).

Some limitations may occur due to current social distancing protocol due to the nation being in a pandemic as some social workers may not find the time to engage in alternative media platforms to be reached regarding the study. Some social workers are feeling overextended through their employer, or other education opportunities were finding the time to contribute was not foreseeable. Limitations occur where the social worker may not feel they can advocate for change, as it could possibly impact continuous employment. Lastly, some social workers have requested and advocated for change in the past, and contributing is pointless, as change will not occur, so they stop trying. Those limitations are contributed by compassion fatigue, burnout, and vicarious trauma (Newell, 2020).

The project can be best disseminated through social work publications, and speaking on panels that discuss healthcare challenges, to include challenges experienced by members of an

interdisciplinary team. Awareness of medical trauma, trauma-informed care training, and social workers contributing to their own practice approach as being subject matter experts can create for an optimal healthcare environment for the workers, and the patients (Bent-Goodley, 2019).

Implications for Social Change

The potential impact for positive social change can occur in how the profession of social work goes about establishing an identity appropriate to the healthcare setting (Beddoe, 2013). An identity that allows social workers to practice at the top of their profession, and inform own practice, while in the hospital (Beddoe, 2013). Social change can persist in how other members of the interdisciplinary teams perceive the department of social worker, and the identification of practice roles. Roles to include competencies, trainings, and the ability to be subject matter expertise within own profession. The potential impact is the organization's ability take ownership of own professional practice within the healthcare environment and not allow other professions to continuously identify it by how they would prefer the social worker to be based off own ideological thought processes (Levenson, 2017). Establishing the social change for social work in healthcare can alleviate the profession of social work from being compartmentalized within other professions, as it promotes for identity crisis, role confusion, and inability to be own professional subject matter expertise. Reidentification, competencies, and adequate training will promote for optimal social environment that will allow the social work profession to adequately meet the service needs of the patient population with regards to identifying and treating medical trauma.

Summary

Medical trauma in the hospital is a growing health disparity. A health disparity that is accompanied by social determinants (Mikhail et al., 2018). Among the standards of care embedded within the social work practice, one is to assist in alleviating such disparities, and social determinants (CSWE,2015). The focus of the practice research problem is the experience

of the healthcare social worker's response in managing the psychosocial impacts of adult medical trauma in an acute inpatient environment. The findings showed that adult medical trauma is not widely identified in the healthcare setting, and treatment approaches is nonexistent or limitless to a problem that hasn't been identified with (Janssen, 2020). Healthcare social workers do identify that some patients have a trauma history, and some patients do verbalize some experiences has been perceived as traumatic. With the various experiences of the healthcare social workers, role restrictions, and institutional barriers can leave patients more vulnerable and oppressed causing them to endure more trauma, become retraumatized, or the social worker to become impacted and experiencing vicarious trauma (Hall & Hall, 2016).

Trauma induced in a medical setting is an experience that is widely encountered, however often misunderstood, misdiagnosed, and underreported (Janssen, 2020). This experience is a source for acute stress disorder, and posttraumatic stress disorders that is accompanied by events and circumstances that promote fear, terror, and helplessness (Janssen, 2020). The experience of the social worker as an integral member of the integrated care management team does contribute to this practice problem due to their responsibilities of having to adhere to the healthcare delivery system that the hospital institution has adopted. This healthcare delivery system has confined the professional practice of social in their ability to recognize and appropriately respond to the psychological effects of medical trauma (Ashcroft, R., & Ambrose-Miller, 2016).

References

Ambrose-Miller, W., & Ashcroft, R. (2016). Challenges faced by social workers as members of interprofessional collaborative health care teams. *Health and Social Work, 41*(2), 101–109. https://doi.org/10.1093/hsw/hlw006

Badger, K., Royse, D., & Craig, C. (2008). Hospital social workers and indirect trauma exposure: an exploratory study of contributing factors. *Health and Social Work, 33*(1), 63–71. https://doi.org/10.1093/hsw/33.1.63

Beckett, K., Earthy, S., Sleney, J., Barnes, J., Kellezi, B., Barker, M., Clarkson, J., Coffey, F., Elder, G., & Kendrick, D. (2014). Providing effective trauma care: the potential for service provider views to enhance the quality of care (qualitative study nested within a multicentre longitudinal quantitative study). *BMJ Open, 4*(7), e005668. https://doi.org/10.1136/bmjopen-2014-005668

Beddoe, L. (2013). Health social work: Professional identity and knowledge. *Qualitative Social Work*, *12*(1), 24–40. https://doi.org/10.1177/1473325011415455

Bent-Goodley, T. B. (2017). Living our core values. *Social Work, 62*(4), 293–295. https://doi.org/10.1093/sw/swx046

Bent-Goodley, T. B. (2019). The necessity of trauma-informed practice in contemporary social work. *Social Work*, *64*(1), 5–8. https://doi.org/10.1093/sw/swy056

Broad, R. D., & Wheeler K. (2006). An adult with childhood medical trauma treated with psychoanalytic psychotherapy and EMDR: A case study. *Perspectives in Psychiatric Care*, *42*(2), 95–105. https://doi.org/10.1111/j.1744-6163.2006.00058.x

Campbell, C., & Khin, P. P. (2020). Building resilience through culturally grounded practices in clinical psychology and higher education. *Vermont Connection*, *41*(1), 47. https://scholarworks.uvm.edu/tvc/vol41/iss1/7/

Council of Social Work Education. (2018). Specialized practice curricular for trauma informed care social work practice: 2015 EPAS curricular guide resource. https://www.cswe.org/getattachment/Education-Resources/2015-Curricular-Guides/2015EPAS_TraumaInformedSW_Final-WEB.pdf

Cowgill, M., & Petrakis, M. (2018). Hospital-based trauma social work. In M. Petrakis (Ed.), *Social work practice in health: An introduction to contexts, theories and skills* (pp. 50–66). Allen & Unwin.

Coyle, L., Hanna, D., Dyer, K. F. W., Read, J., Curran, D., & Shannon, C. (2019). Does trauma-related training has a relationship with, or impact on, mental health professionals' frequency of asking about, or detection of, trauma history? A systematic literature review. *Psychological Trauma: Theory, Research, Practice, and Policy*, *11*(7), 802–809. https://doi.org/10.1037/tra0000434

Daniels, S. (2011). Introducing HCM v3.0: a standard model for hospital case management practice. *Professional Case Management*, *16*(3), 109–127. https://doi.org/10.1097/NCM.0b013e318212b5c1

DiLauro, M. D. (2018). Examination of an integrative health care model for social work practice. *Health & Social Work*, *43*(4), 261–268. https://doi.org/10.1093/hsw/hly028

Edmonds, A. W., & Kennedy, T. D. (2017). *An applied guide to research designs:*

Quantitative, qualitative, and mixed methods. SAGE Publications.

Fraser, K., & Campagna, V. (2018). Under the case management practice "umbrella": CMSA's standards and CCMC's code of conduct. *Professional Case Management*, *23*(6), 342–344. https://doi.org/10.1097/NCM.0000000000000326

Fraser, M., & Curtis, K. (2006). A day in the life of a trauma case manager. *Australasian Emergency Nursing Journal, 9*(2), 73–78. https://doi.org/10.1016/j.aenj.2006.03.003

Guest, G., Namey, E., & Chen, M. (2020). A simple method to assess and report thematic saturation in qualitative research. *PLoS One*, *15*(5), 1–17. https://doi.org/10.1371/journal.pone.0232076

Hall, M. F., & Hall, S. E. (2013). When treatment becomes trauma: Defining, preventing, and transforming medical trauma. *VISTAS*, *73*, 1–15. https://www.counseling.org/docs/default-source/vistas/when-treatment-becomes-trauma-defining-preventing-.pdf

Hall, M. F., & Hall, S. E. (2016). *Managing the psychological impact of medical trauma: A guide for mental health and health care professionals*. Springer Publishing.

Heenan, D., & Birrell, D. (2019). Hospital-based social work: Challenges at the interface between health and social care. *British Journal of Social Work*, *49*(7), 1741–1758. https://doi.org/10.1093/bjsw/bcy114

Janssen S.J. (2020). Medical trauma. *Social Work Today*. https://www.socialworktoday.com/news/enews_0416_1.shtml

Judd, R. G., & Sheffield, S. (2010). Hospital social work: Contemporary roles and

professional activities. *Social Work in Health Care*, *49*(9), 856–871. https://doi.org/10.1080/00981389.2010.499825

Kawam, E., & Martinez, M. J. (2016). What every social worker needs to know…trauma informed care in social work. *New Social Worker.* https://www.socialworker.com/feature-articles/practice/trauma-informed-care-in-social-work/

Levenson, J. (2017). Trauma-Informed Social Work Practice, *Social Work, 62*(2), 105–113. https://doi.org/10.1093/sw/swx001

Mersky, J. P., Topitzes, J., & Britz, L. (2019). Promoting evidence-based, trauma-informed social work practice. *Journal of Social Work Education*, *55*(4), 645–657. https://doi.org/10.1080/10437797.2019.1627261

Mikhail, J. N., Nemeth, L. S., Mueller, M., Pope, C., & NeSmith, E. G. (2018). The social determinants of trauma: A trauma disparities scoping review and framework. *Journal of Trauma Nursing*, *25*(5), 266–281. https://doi.org/10.1097/JTN.0000000000000388

Muskat, B., Anthony, S., Mishna, F., & Greenblatt, A. (2017). Development, delivery and evaluation of a social work elective offered in a hospital setting. *Journal of Practice Teaching & Learning*, *15*(1), 63–80. https://eds.s.ebscohost.com/eds/pdfviewer/pdfviewer?vid=1&sid=429c0bba-69b5-4083-a156-2f6cd71cf6b9%40redis

Nelson, K. R., & Merighi, J. R. (2003). Emotional dissonance in medical social work practice. *Social Work in Health Care*, *36*(3), 63–79.

https://doi.org/10.1300/j010v36n03_04

Newell, J. M. (2020). An ecological Systems Framework for Professional Resilience in Social Work practice. *Social Work*, *65*(1), 65–73. https://doi.org/10.1093/sw/swz044

Praglin, L. J. (2007). Ida Cannon, Ethel Cohen, and early medical social work in Boston: The foundations of a model of culturally competent social service. *Social Service Review*, *81*(1), 27-45. https://doi.org/10.1086/511013

Polmanteer, R. S. R., Keefe, R. H., & Brownstein-Evans, C. (2019). Trauma-informed care with women diagnosed with postpartum depression: a conceptual framework. *Social Work in Health Care*, *58*(2), 220–235. https://doi.org/10.1080/00981389.2018.1535464

Rhodes, B. E. (2019). Trauma-Informed Contemplative Pedagogy: Implications for undergraduate course revision. *The Journal of Baccalaureate Social Work*, *24*(1), 139–152. https://doi.org/10.18084/1084-7219.24.1.139

Rikard, R. V., Hall, J. K., & Bullock, K. (2015). Health literacy and cultural competence: A model for addressing diversity and unequal access to trauma-related health care. *Traumatology*, *21*(3), 227–236. https://doi.org/10.1037/trm0000044

Rogers, M. J. (2018). Ethical Dilemmas Facing Clinical Supervisors in Integrated Health Care Settings. *Journal of Social Work Values & Ethics, 15*(2), 23–36. https://jswve.org/download/15-2/articles15-2/23-Ethical-dilemmas-JSWVE-15-2-2018-Fall.pdf

Ruth, B. J., & Marshall, J. W. (2017). A History of Social Work in Public Health.

American Journal of Public Health, 107, S236–S242. https://doi.org/10.2105/AJPH.2017.304005

Sedgwick, T. W. (2012). Early hospital social work practice: The life and times of Janet Thornton. Affiliate: *Journal of Women & Social Work*, *27*(2), 212–221. https://doi.org/10.1177/0886109912444103

Short, M., Trembath, K. S., Duncombe, R., Whitaker, L., & Wiman, G. (2019). Contemporizing teaching case management: mapping the tensions. *Social Work Education*, *38*(2), 212–226. https://doi.org/10.1080/02615479.2018.1506428

Tsai, L.-M., & Yan, Y.-H. (2021). A preliminary study on applying holistic health care model on medical education behavioral intention: a theoretical perspective of planned behavior. *BMC Medical Education*, *21*(1), 1-7. https://doi.org/10.1186/s12909-021-02746-0

Varghese, R., Quiros, L., & Berger, R. (2018). Reflective practices for engaging in trauma-informed culturally competent supervision. *Smith College Studies in Social Work, 88*(2), 135–151. https://doi.org/10.1080/00377317.2018.1439826

Appendix A: Interview Questionnaire

The following questions are reflective of your experience as a healthcare social worker in the acute care hospital.

1. What does it mean to be a medical social worker?
2. Tell me about your experience working as a medical social worker.
3. Describe any training you have experienced that contributes to your expertise as a medical social worker.
4. What is your experience in using the case management model in meeting the needs of your current patient population?
5. Explain your experience with adult medical trauma.
6. In consideration to your experience with adult medical trauma, what diagnosis are most frequently encountered?
7. When treating adult medical trauma, explain how you have been impacted?
8. Describe what treatment approaches you utilize to meet the psychological impacts of adult medical trauma.
9. Describe your experience with trauma informed care.
10. Explain how you have incorporated trauma informed care in meeting the psychological impacts of adult medical trauma?
11. Describe the type of support that is available to you as the medical social worker.

Appendix B: Flyer

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Do you have what we're looking for?

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Minimum of 2 years of acute care hospital based experience working with adults, within one of the following states: Virginia, District of Columbia, Maryland, and North Carolina?

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SONYA ANTHONY MSW, LCSW, CCM