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The Lived Experience of Transformation in CAM Providers Trained in Trauma-Informed Care

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Abstract

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Submitted in Partial Fulfillment

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Abstract

Public and professional awareness of the nature and consequences of psychological trauma has resulted in a greater interest in becoming trauma informed. Complementary and alternative medicine (CAM) providers have begun to incorporate trauma-informed care in their practices. However, there is a lack of research exploring how training in trauma-informed care (TIC) personally and professionally transforms CAM providers. This descriptive phenomenological study explored the lived experience of transformation in CAM providers who participated in TIC training. Transformative learning theory (TLT) was used as the conceptual framework. Nine participants were interviewed, and their experiences of personal and professional transformation were analyzed using Giorgi's analytic strategy. While the reasons for participating in TIC training varied, the shared experience included the recognition of behaviors of self and others as expressions of trauma, the importance of uncovering personal experiences of trauma, and acknowledgement of the need for change in how they worked with clients and patients. They described seeing new ways to address physical symptoms and the connections of symptoms to unresolved trauma. They also shared greater understanding of the boundary between retraumatizing and healing, for themselves and those they treat. Opportunities for positive social change include increasing awareness of the value of TIC training and the resulting personal and professional transformative consequences. The more understanding about the impact of trauma on health and well-being in all professions, the greater the chance of enhanced clinical health outcomes, lessening of provider burnout, and positive change in society.

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Dedication

To my students who have listened, questioned, and above all been transformed.

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I wish to acknowledge my husband for his consistent and ever-present love and support for all that I do. Dr. Michele Rene for supporting me in the creation of a trauma-informed healthcare course. The countless students who have taken that course and especially the ones who have expressed the need for it to be required learning. To the hundreds of authors in the field of psychological trauma and its healing.

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Chapter 1: Study Introduction

The topic of this study was the transformation experienced by complementary and alternative medicine (CAM) providers who have participated in trauma-informed care (TIC) training. Integrative and complementary healthcare approaches (ICHA) are in use in over 30 countries around the world (Phutrakool & Pongpirul, 2022). These are referred to as CAM, complementary and integrative medicine (CIM), and practices that are thought of as outside mainstream or Western medical approaches. Use of CAM has increased in the adult population by as much as 10% from 2012 to 2017 in the United States alone (Clarke et al., 2018). Use of both traditional and complementary medicine (T&CM) concurrent with conventional or Western medicine is estimated worldwide to be between 1.8 and 76%; and a survey of healthcare consumers showed the expressed need and desire for an integrative approach, person-centered care, and safety and quality in the care received (Ee et al., 2020).

The term *trauma-informed* has become ubiquitous, and its presence in social and news media, scholarly journals, and professional training programs indicate the increasing awareness of the emotional, psychological, and physical symptoms associated with psychological trauma. In 2015, the American Psychological Association (APA) published recommendations for the education and training competencies TIC of mental health providers. These same recommendations can be used by other healthcare providers as guiding principles to follow. The preamble to those guidelines lists minimal expectations in five broad competencies that include subsets of knowledge, attitude, and skills to be considered in trauma-informed training and educational material (APA,

2015). TIC has also been defined by the Substance Abuse and Mental Health Services Association (SAMHSA, 2018) as encompassing 4-R's: realize, recognize, respond, and resist re-traumatization. For health care providers and consumers, this means *realize* how trauma can affect people and groups, *recognize* the signs of trauma, *respond* to trauma with resources and systems in support of an effort to *resist re-traumatization*; this is further explained in Chapter 2. These national organizations encourage healthcare providers to learn about and recognize the physical presentation of both acute and chronic psychological trauma. As CAM providers have come to play a substantive role in the delivery of integrative care, it has become important to understand how participation in TIC training transforms their practice.

Major sections in this chapter include a brief background summary of the literature and related gap found for CAM providers and TIC training. Next, the problem statement is addressed in addition to the purpose of the study and research question, followed by the conceptual framework and nature of the study. The last sections include definitions, assumptions, scope, delimitations, significance, and a summary.

Background

The outcome of training in TIC has been researched in a variety of healthcare providers. For example, studies have reported that pediatric nurses have been effectively trained to identify potential trauma and relational difficulties between parent and newborn (Clancy et al., 2020; Goddard et al., 2022). Medical residents in training and family medicine providers have been trained to identify and refer those who have suffered psychological trauma (Dichter et al., 2018; Kokokyi et al., 2021). Other studies

have examined how pediatric primary care residents and midwives can be trained to become trauma-informed in the delivery of their services (Dueweke et al., 2019; Long et al., 2022; McNamara et al., 2021). However, research literature in TIC training as it relates specifically to CAM providers is limited. A recent online search of CAM plus TIC provided just under 800 articles published in 2022 with the majority referencing nursing, pediatrics, mental health providers, and yoga. There are guidelines for allopathic medicine providers in relation to CAM therapy use in conjunction with life threatening illnesses such as cancer (Akeeb et al., 2022; Kristoffersen et al., 2022), mental health issues including anxiety (Ng & Jain, 2022), and musculoskeltal issues like neck pain (Ng et al., 2022). None of the articles mentioned both TIC together with CAM as either a stand-alone group or as individual providers. What this points to is a gap in the research, education, and implementation of TIC for CAM providers.

Problem Statement

There is an abundance of articles related to TIC training for nurses and others in the allopathic medical community, for schoolteachers, and mental health providers (see Carello & Butler, 2015; Clancy et al., 2020; Dichter et al., 2018; Dueweke et al., 2019; Goddard et al., 2022; Long et al., 2022; Wathen et al., 2021). Additional research revealed that allopathic medicine providers and their patients believe TIC made a difference in care given and received (Kokokyi et al., 2021). Another study showed that medical students reported an overall improved sense of understanding the connection between adverse childhood experiences (ACEs) and negative health outcomes (Chokshi et al., 2020). Schoolteachers expressed feelings of greater emotional connection with

students after completing training in TIC (Herman & Whitaker, 2020). More than one study showed TIC training increased the understanding and awareness of occupational burnout, vicarious trauma, and compassion fatigue in mental health providers exposed to clients current and past psychological trauma (Butler et al., 2017; Henning et al., 2021). The literature on TIC training is lacking however, for helping professions that include complementary and alternative (aka integrative) medicine. Several articles point to the need for formal studies to be done in a wide range of primary care settings with a wide range of healthcare providers (Hansen et al., 2021). Therefore, more research is needed to explore CAM providers and training in trauma-informed care.

Purpose of the Study

The purpose of this qualitative study was to explore the lived experience of CAM providers' personal and professional transformation after training in TIC. For the purpose of this study, CAM providers include acupuncturists and/or providers of Chinese medicine, doctor of chiropractic, and massage therapists. The primary phenomenon of the study, the experience and meaning of transformation, is ideally suited for investigation within the constructivist paradigm. The primary assertion of this paradigm is that people come to understand and learn through personal experience (Adom et al., 2016). Two ways that people process knowledge is through accommodation and assimilation. Accommodation being how people fit new knowledge into existing cognitive frameworks and assimilation is about incorporation of new with old information (Adom et al., 2016). In my study I have created semistructured interview questions to elicit descriptors of

possible transformation from research participants based on what they learned in the course of their TIC training.

Research Question

RQ: What is the lived experience of CAM providers' personal and professional transformation after participating in trauma-informed care training?

Conceptual Framework

The conceptual framework that grounds this study is transformative learning theory (TLT), as described by Mezirow (1990). TLT has its roots in consciousness raising, shifts in perspectives (what Mezirow called "paradigm shifts"), and adult education. TLT emphasizes that adult learners can and do make changes in themselves in the process of learning, through integration of various core elements. These core elements include experience, reflection, dialogue, orientation, context, and relationship (Mezirow et al., 2009). Two of the most applicable elements are individual experience and self-reflection. Individual experience is what students bring to the classroom as well as what they experience within the learning environment. Self-reflection, a skill in the transformative learning process, allows adults to reformulate the meaning ascribed to an idea, concept, or issue ideally resulting in personal growth. The process of personal growth is the interaction of self with others. Individuals ultimately learn new ways to cope with the world, engage in problem solving, and change behavior.

A foundational aspect of TLT is based on the critical reflection of assumptions which is central to how adults learn (Mezirow, 1994) When adult learners begin to reassess roles and relationships, identity may be questioned and the ability to critically

self-reflect becomes necessary. Critical thinking and self-reflection call for challenges to be made about assumptions that support long-held perspectives, judgments related to beliefs, values, and feelings (Schnepfleitner & Ferreira, 2021). Ultimately transformative learning is about growth through recognition of problematic ways of thinking. The transformation or establishment of a new point of view can lead to increased awareness of existing bias (Bentz et al., 2022). Through this awareness meaningful and lasting change can take place.

There is a logical connection between CAM providers intentionally learning what it means to be trauma informed and their methods of practice. This goes beyond identifying or diagnosing symptom patterns thereby questioning what might be underlying contributing factors. By understanding that psychological trauma may be the root cause of (or contributing to) their symptoms instead of only a clinical presentation. This requires a shift in perspective as well as a conscious effort on the part of the adult learner to challenge their own beliefs that have their basis in academic understanding. Further exploration of the central tenets of TLT are discussed in Chapter 2 and clarify how CAM providers construct their reality and reshape how they interact with others. The development of the interview guide and proposed data analysis plan is based on TLT's foundational elements.

Nature of the Study

In this qualitative study, I explored CAM providers' lived experience of personal and professional transformation after having taken trauma-informed care training. The study was designed to gather richly detailed descriptors from participants in order to

understand their first-hand experience of transformation. Through the lens of descriptive phenomenology, as outlined by Giorgi (2009), participants were questioned while responses are recorded, coded, and analyzed. A constructivist-based paradigm was used to reveal how these providers use their education in TIC to shape themselves and their clinical practice.

Participant recruitment and selection took place through social media and snowball sampling. Eligibility was established through initial questions regarding type of practitioner, past training, and education in the field of psychological trauma. Semistructured interview questions were asked to gather participant descriptions of perceived transformation. Following Patton's (2015) 12 tips for establishing solid groundwork in data analysis, interview sessions were recorded at the same time notes were taken. Immediate impressions were noted, while later review of responses was analyzed and coded for patterns and themes. Additionally, I kept a journal containing my reflections throughout the process to remain reflexive (see Shenton, 2004). An Excel document was used in the data analysis process. Issues of trustworthiness were addressed through consistent and coherent reporting of participant responses to interview questions.

Definitions

Complementary and alternative medicine (CAM) provider, complementary and integrative medicine (CIM) provider are practitioners who use nutritional, psychological, physical, or a combination of modalities in the care and treatment of patients or clients.

Acupuncturist or Traditional Chinese Medicine (TCM) provider is a highly trained practitioner who inserts fine needles into the skin (NCCIH, 2022) or uses herbal

remedies to treat health conditions. They are trained to diagnose and treat using principles and practices based in traditional Chinese medicine (TCM), sometimes referred to as Asian and Oriental medicine (AOM).

Chiropractor is defined as a licensed health care professional who diagnoses and manually treats disorders of the musculoskeletal system with an emphasis on the body's innate healing ability (Clarke et al., 2018; NCCIH, 2019a).

Massage therapist helps to manage health conditions or enhance wellness through manipulation of the body's soft tissues (NCCIH, 2019b), often using a wide variety of techniques most of which are hands-on, such as cranio-sacral therapy (CST), trigger point therapy (TPT), or Swedish massage. Some therapeutic techniques are hands-off, like Reiki or healing touch (HT).

Trauma-informed care (TIC), according to SAMHSA (2018) should include training about the physical, behavioral, and social impacts of psychological trauma.

Scope and Delimitations

The target group boundaries of this study include providers that practice complementary and alternative medicine, specifically acupuncture, chiropractic, and massage therapy. Descriptors from each participant about their type of CAM practice, years in clinical practice, and primary population demographics are included. Additionally, information about type of TIC training, length of time interested in psychological trauma, and any other role in the trauma field (i.e., mental health training, teaching of TIC, etc.) provide context and transferability (see Shenton, 2004). Allopathic

medical doctors or nurses, physical therapists, yoga or meditation instructors, and CAM providers who have not had some type of training in TIC were excluded.

TLT is the conceptual framework for this study primarily because of the emphasis on personal growth and social change in adult learners (Mezirow, 1994). Theories that were not investigated are those related to or concerned primarily with trauma or health care professional teaching. It should also be noted that TLT is a learning theory that describes adult education; learning theories that posit children's learning processes were not included in the development of this research.

The assumption of this research was that participant providers will have undergone some type of transformation as a result of TIC training. However, it is not without reason that participants will not have experienced any change either personally or professionally. Contributing reasons or explanations are explored and reported, showing confirmability of the study. Participants were encouraged to accurately describe, in detail, their experience and reflections on the outcome and result of their training.

Limitations

Limitations of this study were primarily related to attaining a sufficient sample size. Since there is no formalized TIC training for CAM providers, there was a risk of a lack of eligible participants. With smaller numbers of CAM providers who have participated in TIC training, the issue of transferability is raised. The use of snowball sampling and repeated posts on social media with requests for participants addressed this limitation. The potential bias of only those experiencing positive results from their training being willing to share was noted initially. However, participants honest reflection

of positive and negative training experiences is included. Another limitation was the risk of bias –the lack of researcher reflexivity and familiarity of trainings. I employed many strategies, detailed in Chapter 3, to identify and sufficiently mitigate biases that may have influenced the process of data collection, analysis, and interpretation. These strategies of mitigation address transferability and dependability, along with transparency of the data collection and reporting process.

Significance

The significance of this study is towards a better understanding of the role TIC training plays in improving the quality of care provided by CAM practitioners. With the increasing prevalence of research related to and addressing the issue of psychological trauma, it is important to include all helping professionals (Butler et al., 2017; Carello & Butler, 2015; Chokshi et al., 2020; Hansen et al., 2021; Henning et al., 2021; Lotzin et al., 2018). As detailed previously there have been articles stating the need for studies in the field of TIC and a wide range of healthcare providers (Clancy et al., 2020; Dichter et al., 2018; Dueweke et al., 2019; Goddard et al., 2022). A potential contribution of this study is to the awareness of how healthcare providers are positively influenced by trainings that specifically address trauma (Herman & Whitaker, 2020; McNamara et al., 2021; Wathen et al., 2021). With increasing awareness about how unaddressed trauma affects multiple aspects of a person's life, it is important for providers to understand, assess, and either treat or refer those that are affected (Machtinger et al., 2015; Lewis et al., 2019). Another contribution of this study is that of the field of healthcare provider

education. With this study there will be greater awareness of how healthcare providers can become better equipped from the beginning of their educational pursuits and beyond.

Summary

Over the last 2 decades worldwide usage of CAM therapies has increased as has the awareness of psychological trauma. CAM providers are trained to assess, identify, and treat all types of health concerns but are limited in their education of psychological trauma. There is a wide range of research of TIC with allopathic medicine providers but is lacking for CAM practitioners. This study lessened that gap by exploring CAM providers personal and professional transformation experiences after TIC training.

TLT grounds this study along with a constructivist paradigm. The use of descriptive phenomenology helps to illuminate participants' reported experience. Potential bias and issues of trustworthiness were addressed through researcher reflexivity. A detailed data analysis plan is presented in Chapter 3. Brief definitions are included along with scope and delimitations that show the boundaries and demographics of study participants. Inclusion of limits and significance are presented for possible future studies. Chapter 2 presents literature showing the importance of TIC of various helping professionals as well as support for the need of further research into TIC education for CAM providers.

Chapter 2: Literature Review

There is considerable research on the value of TIC training for physicians, nurses, schoolteachers, and mental health professionals but limited research with CAM healthcare providers. Healthcare professionals and researchers have acknowledged the pervasive nature of psychological trauma and the value of becoming trauma informed, many are even incorporating TIC into their practice. The purpose of this qualitative study is to explore the lived experience of personal and professional transformation of CAM providers who have participated in either formal or informal TIC training.

Through an extensive literature search pertinent articles highlight the usefulness of training in trauma-informed care for professionals in a variety of fields. Several articles pointed to positive change experienced during personal interactions in disciplines that involve direct client or patient contact (Kokokyi et al., 2021; McNamara et al., 2021; Wathen et al., 2021). Teachers and a variety of healthcare providers reported significant changes in the recognition and understanding of psychological trauma, and that this translated into how they interact with students and patients, respectively (Clancy et al., 2020; Henning et al., 2021; Herman & Whitaker, 2020). Similarly, participants in several studies reported an increase in overall confidence when interacting with clients and patients who reported psychological trauma (Chokshi et al., 2020; Dueweke et al., 2019; Goddard et al., 2022). Additionally, there was a decrease in perceived barriers to working with people presenting with signs and symptoms related to psychological trauma. Participants also reported functional changes in clinical practice, changes in clinic spaces,

and lower rates of burnout, creating an increased sense of safety for both clients, patients, and providers (Butler et al., 2017).

There is sufficient literature showing the value of using TLT as a conceptual framework for my study. TLT is an integration of theoretical models that emphasize personal growth and social change in learning environments. Research showed that participants experienced both personal and professional shifts when TLT principles are used (Cheesman & Ahonen, 2019; Oh et al., 2021). Improvements in self-reflection, self-confidence, and frames of reference have been reported (Namaste, 2017).

Major sections in this chapter include an introduction followed by literature search strategies. The conceptual framework, TLT, is the foundation for understanding how transformation can affect what transpires in a learning environment. The literature review of key variables and concepts reviews and summarizes what is understood about TIC and its value as a subject matter for professionals in medical and healthcare fields. Areas where more research is needed are identified, and the chapter concludes with a summary and transition to Chapter 3.

Literature Search Strategies

Through literature searches on various databases, using both broad and narrow parameters, there appeared to be an abundance of articles related to TIC for nurses and others in the allopathic medical community, for schoolteachers, and mental health providers (e.g., Carello & Butler, 2015; Clancy et al., 2020; Dichter et al., 2018; Dueweke et al., 2019; Goddard et al., 2022; Long et al., 2022; Wathen et al., 2021). The

literature on TIC training is lacking for the specific group of helping professions that include complementary and alternative medicine practitioners and providers.

Databases and Key Terms

In an attempt to cast as wide a net as possible, the database search began with Education Source, ERIC, CINAHL and Medline, Psychological Databases Combined, and EBSCO with no specific dates or article sources defined. Keywords used included *trauma informed care or trauma informed practice or trauma or trauma informed approach*. In Education Source the keywords yielded nearly 18,000 articles and was narrowed down to four with the addition of the words *complementary and alternative medicine* which was promptly replaced with *training programs* yielding 186 articles but nothing applicable to CAM/CIM or mental health providers. Using the same keywords in ERIC brought up over 5,000 articles but was decreased to zero with the addition of *complementary and alternative medicine.* Again, remove CAM, add *training programs* which yielded 86, none of which were specific to the training of CAM/CIM or mental health providers. Switching to CINAHL and Medline with the same keywords gave nearly 300,000 potential articles. The addition of *complementary and alternative medicine or integrative medicine or complementary alternative and integrative medicine* narrowed that number to 388, narrowing further to 314 with the parameters of only peer-reviewed articles and narrowed even further to 191 with the inclusion dates between 2017-2022. Attempting the addition of the key phrase of *training programs* limited this search to one article. The vast majority of the 191 articles were related to physical trauma although some did include CAM/CIM but nothing about psychological trauma or mental

health providers. Lastly, using the same keywords in Psychological Databases Combined brought up over 119,000 articles. The addition of *complementary and alternative medicine or integrative medicine or complementary alternative and integrative medicine* narrowed that to 82 with 59 being Peer-Reviewed, further narrowed to 27 with the addition of the defining dates of 2017-2020, interestingly enough it would not change to 2022. Most of the articles were related to the use of yoga for psychological trauma and the use of CAM/CIM in the treatment of psychological trauma, but nothing about trauma-informed care training.

The use of EBSCO, Psychological Databases Combined, and CINAHL and Medline with the keywords of *trauma informed care training* had marginally better results. In EBSCO there were 21 peer-reviewed articles, with the majority being conducted with and for elementary schoolteachers and mental health providers. In the Psychological Databases Combined there were 71 potential articles, 50 of which were peer-reviewed, 44 included in the dates between 2017-2022. These articles were specific to mental health providers, teachers, those involved with foster care, and pediatric healthcare providers.

Several useable articles point to the need for formal studies to be done on various aspects of TIC in a wide range of primary care settings with a wide range of healthcare providers (Hansen et al., 2021). It is important to note that clients and patients report a more positive experience with their providers post TIC training, thus there is the need for more training. The vast majority of articles also indicate that after training in TIC, providers report positive changes, including increased levels of confidence, a more

positive attitude about, and understanding of what constitutes psychological trauma, and how it may present clinically (Chokshi et al., 2020). Therefore, more research is needed to explore how complementary and alternative medicine providers describe their personal and professional experiences after completing a course in trauma-informed care.

Conceptual Framework

TLT has been applied in a variety of settings and disciplines since its inception in the 1970s. Two key elements which are recognizable features of TLT include critical thinking and meaning making. According to Mezirow (2008), the founder and developer of TLT, critical thinking leads to transformed meaning making and perception. This is integral to adult education, allowing the adult learner to deliberate for themselves instead of taking on another's point of view. TLT is used by educators to facilitate and determine progression of learning. In TLT, the learning process is dynamic, with the learner being the active ingredient in the transformation process.

Foundation

TLT was shaped by a number of authors and disciplines including philosophers, scientists, psychiatrists, educators, and the women's movement. It is rooted in 10 phases of learning and six core elements, each of which will be described in a separate section. These two critical aspects of TLT were influenced by and adapted from the work of contemporary thinkers, Kuhn, Freire, and Habermas.

Kuhn

Although Kuhn was initially educated as a physicist his work was influential in multiple fields and disciplines. Early in his career Kuhn began teaching a course in the

physical sciences to nonscience students (Sturm & Miller, 2022). In addition to teaching, he also began to explore and study multiple academic fields that were directly and indirectly related, causing him to question the roots of scientific understanding. Kuhn saw that when difficulties or conflicting ideas arose in scientific attempts to solve problems, a crisis of thinking often led to a search for a new approach (Sturm & Miller, 2022). The search for and application of a new way of thinking in the sciences is commonly referred to as a paradigm shift, a concept that influenced Mezirow's developing theory. TLT is about perspective transformation, changing frames of reference, the development of new meaning perspectives, and altered habits of mind as it applies to an individual not an entire field or discipline (Kitchenham, 2008). TLT, at its core encourages adult learners to critically assess assumptions and ways of being, thereby shifting problematic beliefs, values, thoughts, and actions.

Freire

Freire was born into poverty in 1921 in the northeastern part of Brazil (Diaz, n.d.) having experiences that were influential in his later life's work. In high school he taught grammar to younger students shaping his eventual career path as a leader in the field of education (Bentley, 1999). Freire internalized the notion that in education a learner brings with them a lifetime of knowledge and experiences. A vital concept in his work is "conscientization" or critical consciousness, in which people learn to recognize and even question their personal history and social situation (Bentley, 1999). Freire put forth that education can be a source of empowerment for learners and posed three stages of growth of consciousness:

- Transitive, i.e., that life is under the control of God or fate.
- Semitransitive, problems can only be addressed one at a time and others are the effective agent of change.
- Critical transitive, the ability to think and act globally and critically to affect change (Kitchenham, 2008).

Critical reflection requires a person to question deeply held beliefs that have their root in personal experience. The ability to critically self-reflect then act is a basis for transformation.

Habermas

Habermas, a philosopher in the social sciences, proposed domains of learning that include technical, practical, and emancipatory with two key types of learning (Finlayson & Huw Rees 2023). The first is technical or functional and second is communicative which includes understanding the significance of a function. Comprehension of both is key in the re-conceptualization and alteration of the meaning making process. It implies a deep level of understanding which sets up new ways of thinking, feeling, and acting. To determine if new learning is valid, worthy, and appropriate there is personal assessment of whether current thoughts, behaviors, and actions are problematic. Assessment of the validity of what is being proposed based on both the technicality of how or why change is needed and what it ultimately means to change. Analysis of self is the essence of critical self-reflection and may pose a personal dilemma or crisis, which is the first phase of learning in TLT.

Phases of Learning

The 10 phases of learning came out of the 1970s phenomenon of "consciousness raising", which was originally part of the women's liberation movement with the intent of creating change both on an individual and societal level (Braun Rosenthal, 1984). According to TLT, how a person faces the issue of change is based on past conditioning, held beliefs, and life experiences. The 10 phases of transformative learning are disorienting dilemma, self-examination, assessment of assumptions, recognition of the connection between discontent and transformation, exploration of new roles, planning a course of action, knowledge, and skill acquisition, trying new roles, confidence building, and the integration of new perspectives (Mezirow, 2008).

Disorienting Dilemma

When faced with a challenge that involves cognition, there is often an uncomfortable internal sensation. What is done with this discomfort largely depends upon who or what is involved. In the education process, being curious about the psychological source of or meaning related to the discomfort is the first step (Kitchenham, 2008).

Self-Examination

Curiosity about the psychological aspect of the discomfort may lead to a cognitive understanding of assumptions and bias (Mezirow, 2008). Recognition of previously held assumptions or bias does not in and of itself mean change is inevitable. Through the process of self-examination there is an increase in awareness, which lays the foundation for potential transformation. Along with self-examination there must be an openness to change or run the risk of reinforcement of previously held beliefs.

Critical Assessment of Assumptions

Assumptions and bias, based on previous experience, are part of what the learner brings to the classroom. Through communicative learning and healthy discourse, problematic ways of thinking can be brought to light (Mezirow, 1997). By challenging ideas, beliefs, values, and feelings through verbal exchange and learning about alternative points of view, a person may begin to critically assess assumptions and bias. Being open to receiving insight is what moves the transformation process forward.

Process Recognition

The process of transformation begins with the recognition of one's biases and assumptions and how they conflict with new incoming ideas and data (Kitchenham, 2008). Recognition of assumptions (accompanied by openness to insight) can happen when learning anything new "butts up" against previously held notions or ideas. Through discussion and activities there is, ideally, an understanding of the necessity for change which is accepted and acted on.

Exploration of New Roles, Relationships, and Actions

When the process of change becomes apparent, there can be more discomfort which may be at the prospect of shifting roles and responsibilities. An important aspect in TLT is the learner making informed and reflective decisions about relationships and actions (Mezirow, 1997). Acting on the increased awareness and changing assumptions gives rise to altered points of view. Transforming viewpoints leads to changed meaning schemas and perspectives which necessitate new ways of being.

Planning a Course of Action

Another part of the critical reflection process that is so fundamental to TLT is utilization of the newfound awareness. Through the elevation of each person's conscious understanding of problematic thoughts, actions, beliefs, and expressions lasting transformation becomes possible (Mezirow, 1997). Learners will now be able to plan for and decide what more is needed for them to move forward with their learning, career, or personal goals.

Acquiring New Knowledge and Skills

The acquisition of new knowledge and skills allows learners to carry out their plans. Through the transformational process a continual assessment of beliefs, thoughts, ideas, and assumptions can take place (Mezirow, 1997). This process opens the proverbial door for expansive ways of being. These new perspectives allow for the continuation and enhancement of current and future learning.

Provisional Trying of New Roles

Throughout the learning process, beginning with self-examination, there are opportunities to not only reflect on but act on new skills, knowledge, and roles (Kitchenham, 2008). This is about choice from the place of consciousness requiring an increased level of cognitive maturity. With this comes increased responsibility to not only know better but do better from a place of deep understanding.

Building Competence, Self-Confidence, and Integrating New Roles

Building competence and self-confidence in new roles and relationships is about putting what has been learned into practice (Mezirow, 1997). This is a continual process

of self-reflection and assessment. The cycle of these 10 phases of learning can and should be used throughout a person's life. Transformation may not always be easy and straightforward, however, the more practice and experience with assessment and examination the more confidence there is to be gained in the process.

Core Elements

As previously described, Mezirow (1994) suggests that adult learners can and do make changes in themselves in the process of education. In TLT there are six core elements that work in collaboration with the ten phases of learning, which include personal experience, critical self-reflection, dialogue, holistic orientation, appreciation for context, and authentic relationships (Taylor, 2000). Through analysis, critical reflection, and challenging of held assumptions transformation is experienced in relation to oneself and others.

Individual Experience

Experiences shape the lens through which a person sees the world and what meaning is ascribed to whatever is encountered (Mezirow, 2008). Meaning structures and perspectives are shaped through the process of socialization beginning with the people who are most important and present during developmental phases, namely parents and teachers. Not only are past experiences part of the learning process but what a person encounters within the classroom in pursuit of higher education shapes their transformational progression. Engagement with course content or material that challenges currently held beliefs and ways of being can be the disorienting dilemma. This is the

connecting piece between the learning phases and core elements necessary for transformation.

Critical Self-Reflection

Critical self-reflection is the second of the core elements. An individual's transformation and personal growth is emphasized in TLT and rooted in analysis of the self (Mezirow, 1997). Critical self-reflection requires a person to question assumptions and beliefs, asking not only why they do what they do, but also the meaning given to thoughts and behaviors. There is a level of cognition required in self-reflection that is not available to those in the first or even second decade of life, giving rise to this theory in adult education. There are three types of critical reflection in TLT which are processes of transforming meaning perspectives (Kitchenham, 2008). First is content, which is the ability to reflect on what is perceived, thought, felt, and acted upon. Second there is reflection of process or the capacity to reflect on how the function of perceiving is performed. Lastly, is premise, the awareness of how something is perceived or known. Through the process of self-reflection and analysis a person makes the unknown known thereby transforming the self and worldview (Taylor, 2000). Part of testing personal transformation of ourselves and our worldview is through relational communication.

Relational Communication

The act of relational communication is a third core element in TLT, involving healthy discourse or dialogue that focuses on content (Mezirow, 1997). TLT encourages equal participation, freedom from coercion, openness to expressing alternative points of view, empathy and concern about the thoughts and feelings of others. TLT advocates for

the ability to objectively weigh evidence and assess arguments with a willingness to arrive at an understanding between all involved. An essential connection of healthy discourse to personal growth and transformation is to focus on exploring personal assumptions and beliefs (Mezirow, 1997). The ability to recognize and assess personal bias, prejudice, or inconsistencies is tantamount to higher learning. Talking about what is being psychologically uncovered can be difficult, requiring courage and support. Healthy discourse requires empathy for self and others along with a willingness to weigh evidence and assess alternate views objectively. Therefore, being able to take a proverbial step back to gain a broader more holistic perspective, supports growth.

Holistic Orientation

Holistic orientation involves engagement in ways of knowing. According to Mezirow (2009) there is affective knowing which involves development of awareness about feelings and emotions, and relational or socialized ways of knowing. The naming of this aspect of TLT suggests an ability to see the big picture of held beliefs, assumptions, and actions, which begs the question of personal awareness. Holistic orientation is an exploration of emotional issues that begin to address resistance to learning while supporting individuation as a way to understand, realize, and appreciate the self. The exploration of new ways of being along with the acquisition of new knowledge and skills is part and parcel to moving through the phases of learning.

Appreciation of Context

The fifth core element is awareness of context, appreciation and understanding of both personal and socio-cultural factors in the process of transformation and personal

growth (Mezirow, Taylor, & Associates, 2009). A prime understanding in TLT is that transformational learning can be situational and on-going or through an immediate event. Regardless of how or where transformation takes place, flexibility and receptivity are necessary. Transformation through exposure to the ideas, beliefs, thoughts, and actions of others create alterations in meaning schemes. These alterations allow for assessment and reassessment of personal meaning perspectives. The event or experience does not have to be personal but can be learned about through discussion with those directly impacted. For example, by becoming more critically aware of how an idea, belief, or understanding of the world came about, there is greater intellectual access to change. The broadening of personal worldviews can happen through learning how others are impacted, making room for more socially responsible thinking and behavior.

Authentic Relationship

Authentic relationship is fostered through an educator. In order for authentic relationships to develop, educators must hold a strong sense of themselves, be interested and aware of the needs of their students, be genuine and open, recognize how learning is shaped by context, and above all be able to critically self-reflect (Mezirow, Taylor, & Associates, 2009). The act of personal assessment and self-reflection ideally deepens each person's sense of self, allowing for genuine presence. The practice of transformative learning encourages reflective disclosure, discussion, and personal evaluation of previously held assumptions lending itself to acquiring new knowledge and skills. This new way of relating to self and others may at first seem awkward, requiring an adjustment to both personal and professional boundaries. However, as confidence builds

and the process of critical self-reflection continues, an ease may develop. This allows for others to sense a level of safety to explore their own life events perhaps shifting personal frames of reference.

Frames of Reference

Mezirow (2008) used the term frames of reference that include mindset, habits of mind, and meaning perspective. Each of these are part of the structure related to culture and language which adds coherence and significance to experiences. Recognizing, understanding, and being willing to assess and even challenge individual frames of reference or previously held beliefs is a key to personal transformation.

Mezirow (2003) conceptualized mindset as part of frames of reference that help learners orient through cognition, affect, and influencing behavioral dimensions. Mindset tends to be difficult to alter because they include values, preferences, and a sense of self. An example would be the internally held belief about an ability such as being good at math or to act as a leader. Many people believe they are either born good at math or not and there is no way to change this. TLT offers insight into the possibility for change.

Habits of mind are defined as habitual ways of thinking (Bouchard, 2021) that can distort thoughts and alter meaning of an event (Mezirow, 2003). The process of transformation includes making known delimiting thoughts or ways of being. TLT is about transforming problematic frames of reference making them inclusive, discerning, reflective, and open to change. It is critical reflection of assumptions that involves challenging meanings that has been ascribed to beliefs, values, thoughts, emotions, and actions.

Mezirow (1990) stated that traditional forms of education are about learning to perform, where TLT encourages learning to understand self and others. TLT encourages discussions about what is being challenged and reflected on in the learning environment as a path toward change. Communication sets the stage for critical self-reflection of held beliefs, ideas, and assumptions. Assumptions and expectations that frame thinking, feeling, and acting giving rise to meaning perspectives or the process of meaning making. By exploring personal meaning perspectives there is opportunity to challenge ways of being that may feel ingrained or automatic. Transformation is a result of being willing to engage in dialogue, explore, and alter problematic ways of thinking.

Application of Transformative Learning Theory

TLT has been applied in fields as diverse as healthcare (Briese et al., 2020), education (Ali & Tan, 2022), mindfulness practices (Morris, 2020) and the tourist industry (Kumar et al., 2022). Most studies showed a positive correlation between experience, self-assessment, and transformation of perspectives. All showed the emergence of a deep level of understanding beyond just what is being taught when TLT is applied. The studies include qualitative, quantitative, and mixed methods in design as well as those that call into question what is being transformed and how transformation is known.

Insight into participant transformation has been gained in health care during debriefing, post simulation-based learning. One study by Briese, et al. (2020) mentioned shifts in frames of reference and habits of mind. This is believed to affect how students will go on to approach future learning and their clinical experiences. In a second

simulation-based study Oh et al. (2021) compared a debrief using TLT as a framework for questioning compared to conventional debriefing. In this randomized control study four measurement scales assessed participants knowledge, problem solving, critical thinking, and clinical judgment. Findings included statistically significant differences between participants in the conventional debrief and the TLT debrief groups. Both studies cited critical self-reflection as a factor along with feedback enhanced discussions between students. Participants also noted improvement in self-confidence in new roles and relationships.

TLT has been used in both the teaching and assessment of transformation of adult learners as it was originally created to be used by educators. TLT has since gone beyond adults going back to school. Carberry (2017) combined teaching attachment theory and the concept of masculinity to incarcerated adult men through the lens of transformative learning. Glassburn and Hasa Reza (2022) sought to discover the long-term impact of a short-term study abroad program with students in the field of social work. Ali and Tan (2022) used summary research to correlate TLT, life-long learning, and the role emotions play when navigating and coping with negative life experiences. In addition to using TLT for personal change in the learning environment, there is a need to measure transformation accurately and consistently as a result of learning. The development of learning scales (Yildirim & Yelken, 2020), rubrics (Beer, 2019), and curriculum design with evaluation (Namaste, 2017) has been helpful to measure change both qualitatively and quantitatively. Another question is what type of change is happening?

Over the course of the last several decades, since the inception of TLT, the question remains, what is being transformed and how might that affect individuals and the greater society? A broader perspective of change beyond just an individual's experience differentiates adaptive learning and generative learning, with the latter being the intentional application of new skills. Various learning theories have sought to explain motivation and change in the learning process. Cheesman and Ahonen (2019), and Friedman (2022) showed that through discussion and critical assessment of assumptions, frames of reference are altered on a level deeper than just intellectual understanding. Transformation of life purpose can happen through the meaning-making process as well as through more traditional norming and goal setting activities.

The application of TLT concepts to study the mechanisms of change is not limited to the standard learning environments. Two seemingly dissimilar ways of understanding transformation are mindfulness and tourism. Mindfulness as a mechanism of change (Morris, 2020) supports introspection where destination-based travel (Kumar, et al. 2022) supports connection to the outside world. Both are ways to increase conscious awareness of perception, thoughts, and judgements of self and other showing TLT is applicable beyond the classroom.

There is a direct connection to TLT and this study by way of exploring both personal and professional transformation in participants. The phases of learning and the core elements of TLT give a framework for semi-structured interview questions related to key concepts. By inquiring about assumptions or previously held biases the reason for participating in TIC training is revealed. Descriptions of self-reflection and changes to

clinical practice along with any noted change to client or patient interaction point to potential altered meaning making and perspective. Additionally, improvement in both personal and professional relationships as well as better identification and assessment of psychological trauma show increased understanding and knowledge integration.

Literature Review of Key Concepts and Variables

The intent of the proposed research is to explore the lived experience of personal and professional transformation of CAM providers who have participated in trauma-informed care training. This literature review begins with an overview of the current understanding of psychological trauma, followed by a brief description of CAM practitioners and therapies. Examples of the effectiveness of CAM in treating conditions associated with PTSD (post-traumatic stress disorder) are summarized. In the last section I describe the emergence of trauma-informed care as a learning, training, and therapeutic model for working with clients and patients who are managing symptoms related to psychological trauma.

Defining Psychological Trauma

In the late 19th century physicians were beginning to understand that many of their client's symptoms were not physiological in nature, but instead were psychological (SAGE, 2011). This was the initiation of the study of the effects of traumatic experiences, most notably those in the context of military combat. PTSD is not limited to military or combat veterans, people around the globe have encountered stressors since the beginning of human history. It was not until 1980 that the term PTSD and associated criteria were formally listed in the third edition of the Diagnostic and Statistical Manual (DSM). The

current fifth edition of the DSM lists PTSD in the chapter titled Trauma- and Stressor-Related Disorders (DSM-5, 2013) listing definitive characteristics of various anxiety or fear based related symptoms. Currently the American Psychological Association (APA, 2022) defines trauma as an emotional response to an event like a motor vehicle accident, rape, or natural disaster after which, shock and denial are typical. They go on to state that longer term reactions might include unpredictable emotions, flashbacks, difficulty in relationships, and even physical symptoms like headaches or nausea.

In the last few decades dozens of studies, articles, and books have been published on the topic of psychological trauma. In 1998, what is now known as the ACE study (Adverse Childhood Experiences) was published ushering in a new era of understanding how early negative childhood experiences affect later life physical, emotional, and behavioral health (Felitti et al., 1998). A shift in thinking about how symptoms of psychological trauma present in children, adolescents, and adults was underway. Chokshi et al. (2020) studied medical students who participated in a TIC symposium and found an increase in knowledge of the connection between ACE's and negative health outcomes along with a better understanding of what trauma-informed care means. Participants in this study reported feeling better able to incorporate the information into their patient interactions along with an increased level of confidence in their ability to identify and assess the signs and symptoms of psychological trauma (Chokshi et al., 2020). The ability to identify and assess clients and patient's physical signs and symptoms that may be related to a trauma history is beginning to be part of the curriculum and training for both allopathic medical providers and those in mental healthcare fields.

CAM Providers and Therapeutic Modalities

The prevalence of CAM providers and therapies has increased around the globe. Usage of CAM modalities has grown in the adult population by as much as 10% from 2012 to 2017 in the United States alone (Clarke et al., 2018), although defining CAM continues to be a challenge. Lee et al. (2022) presented a summary of current language and modality inclusion along with statistical analysis to show the increase in popularity of traditional, complementary, and alternative medicine (TCAM). Listing healthcare modalities that generally include anything outside of allopathic or Western medicine. According to Helha and Wang (2022) CAM is defined as traditional knowledge, skills, empirical practices, and beliefs that emphasize holistic, patient-centered care. They go on to include mental, emotional, and spiritual aspects with dimensions related to social and community life. For the purposes of this study the focus is on chiropractic, therapeutic massage, and acupuncture which is often refered to as Traditional Chinese Medicine (TCM) and Asian and Oriental Medicine (AOM).

Over the last several years integrative practices and CAM modalities have been used to treat a range of conditions in a wide variety of people. Popular CAM practices include acupuncture, meditation or relaxation techniques with Yoga and Reiki increasing in usage as are therapeutic massage and chiropractic, even though mainstream providers may show reluctance to discuss or refer (Fletcher et al., 2017). The Veterans Administration and hospital systems have used various non-traditional, non-pharmacalogical approaches to manage chronic pain in the military population successfully for years (Donahue et al., 2021). Taylor et al. (2019) reported an increase

over four years from 89% to 93% of VA's offering modalities that include acupuncture, chiropractic, and massage for chronic musculoskeletal pain. A recent systematic review showed that a variety of CAM modalities are successful in the management of pain associated with musculoskeletal diseases that include inflammatory and non-inflammatory arthritis, fibromyalgia, and neck and back pain (Bhoi, et al., 2021). CAM modalities are also sought out by parents of children with sickle cell disease (Alsabri et al., 2023) and cancer (Mora, et al., 2022) to help alleviate pain resulting from conventional treatments. A 2022 cross-sectional study by Eucker et al., showed that 90% of people seeking pain relief through emergency room visits are willing to try some form of non-pharmacological, non-herbal treatment such as acupuncture and massage.

Acupuncture and Traditional Chinese Medicine

Acupuncture and Traditional Chinese Medicine (TCM) sometimes referred to as Asian and Oriental Medicine (AOM), are similar but have some distinct differences, both are part of CAM practices. Acupuncture is reported to have begun in China over 3000 years ago with medical descriptions dating back to 1680 by a European physician (Hao & Mittelman, 2014). Acupuncture is the therapeutic technique of TCM and involves the insertion of thin needles at specific points on the body, herbal remedies are also used. Over the past 40 years acupuncture have become one of the most popular and most used forms of CAM therapies in the United States (Hao & Mittelman, 2014). Practitioners of TCM are extensively trained to treat a wide range of both physical and mental health conditions.

Acupuncture has been studied and compared with meditation, cognitive behavioral therapy (CBT), and other mind-body modalities. One study showed that 63% of participants receiving acupuncture lowered their score on post-traumatic symptoms scale-self report (PSS-SR) to sub-threshold levels after 12-weeks of treatment, being comparable to CBT (Liu et al., 2018). Other studies showed the beneficial effects of acupuncture for both musculoskeletal, anxiety and mood disorders persist over time (Crouse, 2022; Gerbarg & Brown, 2021).

Chiropractic

Daniel David "DD" Palmer is credited with inventing the practice of chiropractic care as we know it today (ACA, 2022). It is a manual or hands-on therapy that utilizes both extremity and spinal manipulation to influence the action and function of the nervous system. The practice of chiropractic is a holistic form of healthcare that emphasizes a non-pharmacological, non-surgical approach to healing. Chiropractors are licensed in all 50 states and US territories, as well as the District of Columbia, and many countries around the world (ACA, 2022). People visit chiropractors for everything from arthritis and high blood pressure to insomnia and digestive issues.

According to the US Department of Veterans Affairs (VA) website (2022a) several VA facilities around the US offer chiropractic care as an option for treatment of neuromusculoskeletal conditions. Fearing stigma some veterans may initially present to CAM providers for physical complaints, only to disclose a PTSD diagnosis after multiple visits (Rosenow & Munk, 2021). Using a cross-sectional analysis of electronic health records researchers at the VA found that many veterans from recent military operations

including Enduring Freedom, Iraqi Freedom, and New Dawn diagnosed with PTSD also utilize chiropractic care (Coleman et al., 2020).

Massage Therapy

Therapeutic massage is most often practiced to treat muscle pain, joint stiffness, and injury (Star, 2021). However, massage therapists help with a variety of conditions allowing a person to feel more relaxed and perhaps even lessening fear or anxiety by using several different techniques. The VA website (2022b) cites therapeutic massage as an evidence-based practice that is low risk and effective for pain management. Massage therapists are healthcare providers trained to take a general history that can include mental health issues as well as physical health complaints. They often work in conjunction with other health care providers in various settings.

Several studies pointed to the use of therapeutic massage for the relief of pain, anxiety, and other quality of life issues. Massage showed mixed quantitative results for changes in sleep quality in those diagnosed with PTSD, even though participants verbally reported improvement (Sumpton & Baskwill, 2019). The VA studied the use of massage for the 10% of military veterans that identify as female (Mitchinson et. al., 2022). They stated that female veterans are at greater risk than male veterans of developing musculoskeletal disorders, depression, bipolar disorders, anxiety, and PTSD. Massage proved to be a low cost, low risk, and effective intervention for both physical and mental health issues in a variety of populations.

Trauma-Informed Care

The conceptual understanding of trauma-informed care is fairly new. Some notable authors in the field of both psychological trauma and trauma-informed care include Judith Herman (1992), Peter Levine (1997), and Robert Scaer (2001). Organizations that study and house information about psychological trauma and trauma-informed care such as the International Society for Traumatic Stress (ISTS) was created in 1985, the National Center for Post-Traumatic Stress Disorder (NCPTSD) in 1989, and the Substance Abuse and Mental Health Administration (SAMHSA) in 1994 (Curi, 2018). In the last two decades there has been a groundswell of information leading to trauma-informed care being applied to schools, substance-abuse treatment centers, and even the criminal justice system.

Current literature in the field of trauma-informed care and training in trauma-informed care is most often connected to schoolteachers (Herman & Whitaker, 2020), allopathic medical providers (Clancy et al., 2020; Dueweke et al., 2019; Kokokyi et al., 2021; McNamara et al., 2021), and mental healthcare practitioners (Butler et al., 2017; Henning et al., 2021; Wathen et al., 2021). Notable studies are qualitative, quantitative, mixed methods, and summary research giving an overall look at participant perceptions and transformation. Many researchers called for increased levels of training in multiple disciplines. Some key concepts include improvements in relationships, better assessment and identification of psychological trauma, along with increased understanding and knowledge of presentation. What is missing are studies of CAM providers and trauma-informed care.

Improved relationships have been demonstrated in several studies. Herman and Whitaker (2020) reported that schoolteacher participants in a professional development course described enhancements in teacher-student relationships. They went on to report that the relational aspect of a course in TIC was what lead to the most transformation. These changes were also described in both mental and physical healthcare workers. In a study by Kokokyi et al. (2021), patients reported more positive experiences after their primary care physicians completed a course in TIC. Both physicians and patients stated they believed training in TIC made a difference in both the giving and receiving of health-related care (Kokokyi et al., 2021). Not only did study participants relay improved the connection between themselves and those they work with but also reported improvement in identifying and assessing psychological trauma.

In occupations where there is personal interaction, it is not only important to learn what psychological trauma is but also to identify and assess related physical signs or symptoms. McNamara et al. (2021) showed that medical student participants in their study had an improved sense of efficacy in assessing, identifying, and referring patients with symptoms of psychological trauma after a course in TIC training. In a study with primary care pediatric residents, Dueweke et al. (2019) reported a favorable trend in both attitude and perceived competence along with a decrease in the perception of barriers related to the implementation of TIC, post training. They reported there was an increase in both screening and subsequent referrals for psychological and/or psychiatric related services. Thus, giving patients much needed care that may have otherwise gone untreated (Dueweke et al., 2019). Proper screening and referral of psychological trauma extend not

only to adolescents and adults but also to children and newborns. Clancy et al. (2020) reported an increase in the level of confidence of pediatric nurses in the recognition and referral for early relational trauma between parents and their newborns. Each of these studies showed participants had increased levels of confidence and capabilities which was directly related to the content of their training.

An ever increasing level of awareness of some of the struggles that both physical and mental healthcare workers encounter daily has reached not only the general public but also found its way into academia. Wathen et al. (2021) showed that both mental health workers and physical healthcare providers who participated in a TIC training reported not only a better understanding of trauma- and violence-informed care but also changes to their clinic and treatment room spaces, intake practices, educational, and personal support. This study showed changes that impacted both the individual and the organization. Goddard et al. (2022) and Sundborg (2019) called for a paradigm shift at the practitioner and organization level in order to address the need for and implementation of TIC. Not only is TIC training needed at multiple levels of the workplace, but also in the education and training of those professionals.

More than one study showed the need for changes in the curriculum of both mental health professionals but also those in the physical healthcare field. Henning et al. (2021) pointed to TIC training as one of the needed changes in the education of mental health professionals as a way to safeguard against burnout, vicarious trauma, and compassion fatigue. This sentiment was echoed in a study by Butler et al. (2017) of graduate students in the pursuit of degrees in mental health care showing that this career

choice will place a person in a position to hear, perhaps repeated stories of trauma and abuse. Their study showed participants with higher levels of self-care related activities had lower levels of stress, burnout, and secondary traumatic-stress responses compared to those with lower levels of self-care. Butler et al. (2017) found a correlation between increased levels of self-care and higher levels of compassion satisfaction.

Summary and Conclusion

The focus of this literature review was to describe the conceptual framework of transformational learning as it can be applied to developing the methods of the proposed study. Additionally, to report on the literature on the use of CAM providers, the growing interest in trauma-informed care as an important curriculum that may improve the quality of the provider-patient relationship and transform participants personally and professionally. TLT is a lens from which to look at process of transformation through self-awareness, critical self-reflection, and openness to new ways of being personally and professionally. These changes are seen as important given the growing prevalence of clients and patients presenting clinically with signs and symptoms of psychological trauma.

Trauma-informed care is a relatively new way of interacting with people in a variety of settings. There have been extensive studies conducted with nurses, pediatric physicians, schoolteachers, and mental health providers. Studies have shown an increase in knowledge and assessment of psychological trauma along with an increase in confidence and clinical competence. Student, provider, client, and patient study participants report positive changes in relational interactions after TIC training. What is

missing in the literature are studies of CAM providers describing their experiences of TIC training and working with patients from a trauma-informed perspective. In Chapter 3 I describe the research approach and methods to carry out the study to address this gap.

Chapter 3: Research Method

The purpose of this qualitative study was the exploration of CAM providers' lived experience of transformation personally and professionally after having taken TIC training. Major sections of this chapter include the research design and rationale, the researcher's role, methodology including instrumentation and recruitment strategies, issues regarding trustworthiness, followed by a concise summary.

Research Design and Rationale

The central concept of this descriptive phenomenological study was transformation with the primary population being CAM providers. The research question was "What is the lived experience of CAM providers transformation, personally and professionally, after participating in trauma-informed care training?" Multiple studies in a variety of fields showed transformation is contextual (Schnepfleitner & Ferreira, 2021), dependent upon personal attitude (Bentz et al., 2022), nonlinear, and consists of phases (Wright et al., 2021). Each of the above mentioned studies showed that a shift in meaning making and perspective was indicative of change in participants. However, in the absence of discussing or verbally sharing about the experience, awareness of what or how transformation happened may not occur (Schnepfleitner & Ferreira, 2021). Healthy dialogue is a major tenet of TLT and an integral part of the transformation process, both described in previous sections of this paper. Two additional key aspects of transformation as it relates to TLT are critical self-reflection and individual experience.

In my study, I used descriptive phenomenology to create interview questions, select participants, gather and analyze data, and explore the research question. Giorgi

(2009) described phenomenology as the intuited or internal meaning of an experience through an act of intentional consciousness. The rationale for choosing descriptive phenomenology is to gather information about how the identified population perceived or identified personal and/or professional transformation resulting from learning to become a trauma-informed care provider. The philosophical underpinning of this study was based on Husserlian ideology that individual consciousness and description of an experience should be the focus (see Giorgi, 2009; Neubauer et al., 2019). The identified providers have shown interest in TIC through participation in learning about, understanding, and recognizing psychological trauma in their patients, clients, and themselves. The use of qualitative methods, through the lens of TLT, directed the line of interview questions. These questions gave a better understanding of how learning to be trauma-informed influenced individual CAM healthcare providers personally and professionally.

Another approach I considered using was interpretive phenomenology, which is a valuable and valid method. Neubauer et al. (2019) presented a table with important differentiations that led to my decision. First was the appeal of an ontological assumption in descriptive phenomenology of the internalization and conscious knowing of reality for individuals. This was in contrast to interpretive phenomenology being about an individual's interpretation of the experience. Second, epistemologically, the research observer in descriptive phenomenology maintains bias-free distance, where in interpretive studies the observer is very much part of the process. Third, descriptive phenomenology requires the distillation of perspectives into units of meaning in order to

report the essence of the experience. This is counter to interpretive phenomenology's continued revision and reflection throughout data gathering and analysis.

Role of the Researcher

The focus of this study was transformation through education. The reason for choosing this was personal and professional curiosity that was inspired by my own complex trauma and search for healing. After years of reading, studying, training, and personal therapy, I sought to help others learn how to identify trauma in themselves and in their clinical practice. In 2016, I created a course for massage therapists in TIC at the university where I am an associate professor. Soon after the beginning of the course, students began sharing with me how much they were learning about themselves and their clients. This feedback fueled my curiosity of how other CAM providers are affected, either positively or negatively as a result of training in TIC.

In addition to my experience as a CAM provider and TIC trainer, my role in this research was that of observer as I asked interview questions to providers who met study qualifications. It is important for me to disclose that none of the study participants were past students of mine from the trauma-informed healthcare course. Additionally, I am a member of the target population, having been a massage therapist since 1992 and a chiropractor since 2001 with a certificate in acupuncture. Giorgi (2009) pointed out the role of the researcher is to present material as it is being presented based on participants experience, not my interpretation. Therefore, through journaling during the data gathering process I noted my perceptions, demonstrating reflexivity resulting from my subject knowledge.

Methodology

Participant Selection Logic

The population of interest for this study was healthcare providers who fit into the category of CAM practitioners. This group includes doctors of chiropractic, therapeutic massage practitioners, acupuncturists, and Chinese medicine providers. Additionally, each of the identified population had participated in some form of training in TIC, either through self-study or formal coursework. With few formal courses available specifically designed for CAM providers in this arena, some resorted to reading books and journal articles, watching videos, or participating in webinars. Potential participants were invited using the social media outlet Facebook and snowball sampling, described in more detail below (see Appendix A).

Heterogenous purposive sampling was proposed to invite participants identified as CAM providers (chiropractor, acupuncturist/TCM, massage therapist) who have some type of training in trauma-informed care. An initial target sample size of eight to 12 qualified participants was met, with nine interviewees in total. Saturation was evaluated throughout data gathering and analysis. In their analysis of the number of qualitative interviews it takes to get to saturation of concepts, Guest et al. (2006) recommended six at minimum, where eight to 12 interviews appeared to result in the greatest saturation given the number of interviews. Most phenomenological methodologists focus on data complexity and depth rather than sample size as an indication of an adequate sample (Levitt et al., 2017). Simply put, it is quality over quantity.

Instrumentation

Data was collected through semistructured interview questions I created and connected directly to the conceptual framework and literature (see Appendix B). The six core elements and ten phases of learning of TLT as elaborated in Chapter 2 are a basis of most of the interview questions. The intended inquiry approach was to understand participants' experience of transformation through in-depth, open-ended questioning. Basic demographic questions were discussed with respondents self-reporting and an option to opt in or decline. None declined an interview.

Recruitment, Participation, and Data Collection

Recruitment took place through both the social media outlet Facebook and snowball sampling. I am a member of three Facebook groups made up of CAM providers, mental health workers, and those who are interested in working with people who have experienced psychological trauma. I contacted the administrators for permission to post the invitation (Appendix A) on the pages. In an effort to increase the invitation exposure, I joined three or four chiropractic specific Facebook pages. I posted the invitation twice.

Interested individuals contacted me by email or Facebook messenger and I responded with my contact information. During the preliminary conversation I reviewed the study procedures and asked questions regarding their criteria for inclusion. Upon agreement to participate, I emailed the informed consent form for review; and scheduled a time for the interview. Participants reviewed the form and replied to my email with the words "I consent".

Audio data was collected from eligible participants over the internet platform Zoom. I spent 60 to 75 minutes with each participant initially with the understanding that a second interview may be necessary. A coordinated effort was made for flexibility as to date and time of the data collection process.

Participants were allowed to exit the study simply by verbally indicating they no longer wished to participate. At the conclusion of the interview, I sent a summary of the interview for each participant to review. I extended an invitation for participants to add to their interview later if they remembered or recalled relevant details of their experience. None of the participants were required to participate in follow-up interviews.

Data Analysis Plan

Interview questions were categorized to gather brief demographic and general information, connection to the ten phases of learning or core elements of TLT and supporting literature (see Appendix B). Data was collected, analyzed, and coded for patterns and themes using qualitative data analysis software, such as NVivo™. Transcript analysis was also be conducted to allow for better understanding, not just reporting on the most common words or phrases. The purpose of pattern and thematic categorization was used to report generalized findings. The reason for this was support for future use of the information in the development of curriculum and course design. Discrepant cases were dealt with during review of interview recordings while remaining transparent about the process. The information found is presented as a suggested future study in Chapter 5.

Trustworthiness

I represented the trustworthiness of my data collection, analysis and interpretation through consistent and coherent reporting of what participants reported about their experience. The use of interviewing multiple eligible subjects created a full picture of the experience of transformation in CAM providers who have participated in some form of TIC training. Connecting previous research of trauma-informed training with allopathic medical providers, schoolteachers, and mental health professionals to findings in my study contributes to the scholarly value of my research.

Shenton (2004) described strategies that I used to demonstrate trustworthiness in my qualitative study. Credibility allows for a true picture of the phenomenon being studied. Transferability supports the applicability of findings in other settings. Through transparency and a clear presentation of the foundational aspects of the study dependability is addressed. Finally, confirmability is shown through researcher reflexivity and an honest presentation of the participants responses.

Credibility

Semistructured interview questions were developed based on insights gained from the literature and theory and were used as a guide to gather descriptive responses. The use of multiple participant interviews and a range of source documents requested of participants from their TIC trainings allowed for triangulation (see Shenton, 2004; Stahl & King, 2020). I used member checking and debriefing during and at the completion of the interviews to determine congruency of the transcripts to participants reported experiences. Although member checking has been held up to be a sort of gold standard, it

is not without its critics. Motulsky (2021) reported that member checking must be relevant to the study by carefully weighing the pros (i.e., transparency, participant feedback) and cons (i.e., lack of participant replies). The analysis for shared meanings and themes includes the search for discrepant findings and cases demonstrating credibility in my study (see Patton, 2015). Lastly, since I have a high level of familiarity with both the topic and population, I used bracketing to suspend judgment or epoché (see Giorgi, 2009) in order to accurately represent what study participants conveyed, not what I assert.

Transferability

The collection of and reporting on thick, rich descriptors of CAM providers experience of transformation resulting from their learning to be a trauma-informed care provider demonstrate potential transferability (see Shenton, 2004). Proximal similarity (see Patton, 2015) to what was shown in previously cited research of allopathic medical providers, schoolteachers, and mental health providers lend support to the concept. Readers of this study will be able to recognize potential applicability through familiarity of provider descriptions and detailed documentation of the data analysis process. Furthermore, by distilling data to its essence the findings may be useful in the potential creation of curriculum in the education of healthcare providers in multiple fields.

Dependability

The previously mentioned use of triangulation also supports and demonstrates dependability. Additionally, the use of an audit trail throughout the process, shows decisions about coding analysis procedures allowing for maximum transparency. Shenton

(2004) suggested using a theoretical audit trail to show congruence between the interview questions and conceptual framework. Each interview question is directly linked to the core elements or the ten phases of learning from the conceptual framework.

Confirmability

As stated previously, I am strongly associated with both the subject matter and the population of study. The use of my knowledge, experience, and expertise helped participants recognize they were talking with an insider so as not to have to explain common terminology. By recording each interview, using qualitative software for data management and analysis, as well as keeping a process and procedures journal I attempted to mitigate bias and presupposition (see Cairns-Lee et al., 2022). Since the entire transcript of each interview will not be published it was up to me to ask questions that guided rather than lead. The use of a reflexive journal through the process shows data that has arisen from the participants and not from me, the researcher.

Ethical Procedures

First and foremost, it was my responsibility to recruit participants and conduct research honestly and ethically in concordance and compliance with Walden University's Institutional Review Board (IRB). Before the recruitment process began, I completed and submitted an application to obtain approval from the IRB. Before the interview process began, I obtained permission from the IRB, and secured the informed consent from my participants to ensure proper treatment of the human participants in my study. I was obligated to follow all rules and requirements of the IRB.

Treatment of human participants is an ethical obligation when conducting research in the social sciences. Every participant received an informed consent form explicitly stating the purpose and intent of my study. The informed consent was e-mailed to potential participants at least three days before they are scheduled to be interviewed. Instructions were included for them to email back an acknowledgement of having read and understood the document and would like to participate in my study. I did not interview candidates who were unwilling or unable to sign the document. I had few ethical concerns related to recruitment in my study, as participants self-selected and are over the age of consent.

There was minimal risk of harm in my study as participants were not being prompted to speak directly about any of their own psychological trauma. However, since the topic of my study is related to training in trauma-informed care and participants may have experienced trauma themselves, I made resources for post interview support available. For example, there are multiple free, online resources for mental health help: SAMHSA's national helpline (https://www.samhsa.gov/find-help/national-helpline 1-800-662-4357) and CDC's people seeking help (https://www.cdc.gov/mentalhealth/tools-resources/individuals/index.htm) has numbers for crisis intervention, abuse or assault, LGBTQ+, older adults, and veterans or active duty military personnel.

Data collection was through recorded and transcribed interviews which will be deleted immediately upon completion of the research project. These recordings are stored in a private file on my personal, private computer that is password protected. Participants were made aware of how the documentation of their responses will be handled and that

their privacy will be respected and honored at all times. All disclosures were at the discrepancy of the respondents. Data will remain confidential with all names or other identifying aspects removed or otherwise eliminated from the documentation.

Summary and Conclusion

This study was phenomenological in nature exploring the lived experience of CAM providers transformation after taking training in trauma-informed care. The use of descriptive phenomenology within a constructivist paradigm was chosen and rationale has been provided. The role of researcher and potential bias was addressed as have conflicts of interest or power differentials. Methodology sections include recruitment strategies of the population being studied. Specifically, CAM healthcare providers which include acupuncturists and Chinese medicine providers, chiropractors, and massage therapists who have participated in some form of trauma-informed care training. Purposive and snowball sampling was used to interview between eight and 12 qualified participants. Interview questions are connected to the ten phases of learning and core elements of the conceptual framework, TLT. All interviews were conducted and recorded via Zoom. Transcription and reflexive journaling were used to code and analyze responses. Issues of privacy and confidentiality were addressed in an informed consent provided to all participants. Ethical issues were attended to in accordance with Walden University's IRB. In Chapter 4 I present data analysis and study results.

Chapter 4: Results

The purpose of this study was to explore transformation personally or professionally resulting from participation in some type of training in trauma informed care. The research question was "What is the lived experience of CAM providers' personal and professional transformation after participating in trauma-informed care training?" A descriptive phenomenological approach was used to guide data collection and analysis. Major sections of this chapter include the data collection setting, participant demographics, data collection and analysis, presentation of evidence of trustworthiness, followed by results and a concise summary.

Setting

I conducted nine interviews via the web platform Zoom using an app to record and transcribe the questions along with participant responses. All interviews were video recorded and transcribed without complications. There were no issues, and nothing deviated from what was described in Chapter 3.

Participant Demographics

The nine participants included one acupuncturist who is also a massage therapist, one naturopathic physician who is also a massage therapist, one chiropractor, and six individuals who practice or practiced various forms of therapeutic massage. Time in practice ranges from 3 ½ to over 30 years, with the mean time being 11.9 years. Some participants were no longer in direct client or patient contact but were involved in training providers or holding other positions of leadership within their chosen profession. All of them had formal training in TIC and most supplemented that training by continuing to

read books written by experts in the field. The formal trainings include but were not limited to compassionate inquiry, neuro affective relational model (NARM), somatic experiencing (SE), movement-based trainings, HeartMath, and trauma certifications through Laurier University in Canada.

In order to get a clearer picture of the participants' practice, I asked about patient population and what potential trauma related issues are addressed in their practice. These included individuals and families, no specific populations or issues, female and/or women's health, perinatal and pregnancy, fertility, menopause, breast pain, pelvic pain and dysfunction, sexual trauma, and chronic health issues. Some providers mentioned that they specifically see people with complex trauma and mental health related issues. Two of the providers were educators in the bodywork field, one specifically taught about burnout and secondary trauma.

When asked about why participants became involved in learning about trauma and trauma informed care, responses could be placed in three categories: general curiosity about trauma, unresolved personal trauma, and not knowing how to manage apparent trauma related issues in their clients or patients. Statements were made about difficulty dealing with personal hypervigilance and flashbacks. Participants also expressed feeling ill-prepared to help clients with their trauma reactions and a desire to know more about trauma in both the brain and body.

Data Collection

Invitations were posted on Facebook pages frequented by those in the fields of complementary and alternative medicine. For example, NWHSU Alumni, Somatic

Experiencing, Minnesota Chiropractors, Yoga Teachers of Minnesota, and Chiropractors Worldwide. Qualified participants were instructed to contact me through my Walden email. They were then sent the informed consent to be read, signed, and acknowledged and after doing so a date and time for the interview was secured.

All nine participants answered each question posed by me from my list of interview questions as shown in Appendix B. Each interview lasted between 45 and 75 minutes. After each interview, I reviewed the transcript, wrote, and sent a summarized version to the participant for clarification of the information. There were no variations from what was proposed in Chapter 3.

Data Analysis

In Chapter 3, I initially intended to use NVivo to analyze collected data. However, I found it challenging to use and was having success with the documents I was creating in Microsoft Excel. For management of the data, I created a separate Excel sheet for each interview transcript where I listed the questions in the first column and participant response in the second. Additional columns were added for further coding and analysis which were eventually used to answer the research question.

Phenomenological Reduction

For each interview I looked for possible themes and codes which were placed in columns three, four, and five of their separate spreadsheets. This allowed for identification of and reduction of phrases into meaning units and possible themes. I repeated this same process for each of the nine interviews, re-listening to and re-reading each transcript several times. A brief example is shown in Table 1, using five of the

eighteen interview questions and responses from selected participants. For example, the first interview question was *What type of trauma-informed training have you had? When or how did you get interested/involved in it?* The first pass at coding looked for common responses, e.g., *Compassionate Inquiry (formal), perinatal trauma training (formal), readings (informal)*. Thus, I could distinguish between formal trainings where a certificate or CEU's were provided, versus self-directed studies.

In the data exploration I found words and phrases around learning, understanding, and realizing what trauma is, how it presents clinically, and what had changed or been transformed personally and professionally. The larger themes (third column) became clear as I immersed myself in the data to understand the relationship between practitioners' reasons for participating in training in trauma informed care, the results of their training, and the experiences of transformation.

Table 1

Examples of Participant Responses and Possible Themes

Interview question (column 1)	Participant response (column 2)	Possible themes (columns 3, 4, & 5)
What type of trauma-informed training have you had? When or how did you get interested/involved in it?	I took Compassionate Inquiry in 2019 which I learned about the training from friends and other professionals in my field. Also, I took perinatal trauma training. It's a one weekend course given mostly to Canadian social workers. I also did a lot of reading about SE, IFS, and Hakomi	Compassionate Inquiry (formal) perinatal trauma training (formal) readings (informal) learned of the training through friends and other professionals in the field
How do you define or describe trauma-informed care?	Yeah, I think the biggest thing that lands for me in how I describe that is like trauma and care is really all about choice of like an agency. This is like trauma-informed care is really about giving folks and leaving space for the agency of the patient to really, for them to really choose how their treatment goes. And you know, that doesn't mean that recommendations won't be given, but it means that you can decide to go with that.	all about choice, agency giving folks and leaving space for the agency of the patient to choose how their treatment goes within given recommendations giving patients/clients choice
What sort of assumptions about psychological trauma did you have before your trauma-informed training?	I was like, wait a second, maybe trauma has a broader definition than I thought. Whereas before, I think I had the common understanding that I would say most people do…Like, such a dramatic example that no one could dispute, someone forced into combat or somebody who had been physically or sexually assaulted. Somebody who had survived, you know, buildings coming down in an earthquake or	Trauma has a broad definition somebody who had been in combat or physically or sexually assaulted survived buildings coming down in an earthquake or tornado that trauma didn't apply to her

Interview question (column 1)	Participant response (column 2)	Possible themes (columns 3, 4, & 5)
	a tornado. That was my definition of trauma. And I was like none of those had happened to me. So I was not, I had no trauma.	something traumatic that happened and could not be disputed no one would question the event as traumatic
Describe personal changes you have noticed or experienced as a result of learning trauma informed care	Yeah, I'm definitely a lot more steady and stable.	steady and stable with regular practice of skills
	But it definitely changed the level of care I was able to provide and just experienced and gave people tangible things that they could do.	changed the level of care provided to self and others
	realize like, this works and it's only taking me like one minute and I can do that.	
Based on what you learned from the training you participated in, what are some changes you have made to your practice, policies, or procedures?	Like talking about injuries, you know, are there any injuries that you have that you don't want to	changing the way that I would say things
	discuss with me? Just giving people the ability to say like, yes, I've had an injury, but I don't	making sure that I explain things
	really want to talk about what it was. Having that be an option.	I've changed some of the wording on some of my intake forms, just so that it didn't feel some of it could have been activating for folks at times
	Because sometimes it can be very black and white. Have you had the injuries? Where? That's really all that people are given.	
	And so sometimes it can be hard if you're someone who has, I think, experienced violence or trauma. You feel pressured to	Changes made so people don’t feel pressured to share
	disclose, but it shouldn't ever feel that way.	Choice, agency, and autonomy

As I continued to process the data, I moved from inductive coding to larger categories and themes which proved to be instrumental in seeing the larger picture. Some themes began to become clear, for example how people became interested in learning about trauma. These include statements of a desire to pursue understanding of personal issues, recognition of the connection between physical and emotional health, not having proper tools for what was showing up in the treatment room and wanting more in-depth education around trauma and the physical body. Each question may have had multiple responses from which words or phrases were selected that best illustrated the point. This was part of an iterative process to see how participants described their experiences in their trainings.

Deductive (Top-Down) Analysis using TLT Concepts

In the next pass through the recordings and transcripts I intentionally looked and listened for responses that fit with the concept of transformation as described in the TLT. Rather than moving towards these possible themes and categories using imaginative variation (see Giorgi et al., 2017), I used a deductive or "top-down" process, using 11 key concepts based on the theoretical framework of TLT to guide my investigation. Examples of this process are presented in Table 2.

Table 2

Top-Down Analysis using TLT Concepts

Key concept from TLT	Example units of meaning	Potential categories
Disorienting dilemma	P1: I became really fascinated with how bodies are experiencing pain that's not directly findable in the muscles. P2: I felt in a way ill-equipped to handle when that stuff (trauma) would come up. P3: I learned firsthand the impact of trauma. I have been diagnosed with PTSD multiple times.	• Curiosity • Emergent issues during treatment • Desire for personal healing
Self-examination	P1: I view myself in a totally different way with so much more compassion and so much more space and forgiveness. P2: In my own journey, I was really hard on myself for a long time and I'm learning to be less hurtful to myself. P3: I guess taking on less responsibility for the client's experience and be with my inner process while I'm with somebody.	• Perception of self • Perception of other
Critical assessment of assumptions	P1: The degree to which it (trauma) affects individuals on a day-to-day basis, I really had to see that to get that. P2: That helped me understand that trauma was by and large at the root of this like unexplainable pain that people were coming to massage, maybe wanting to address. P3: I was thinking trauma is A, a mental health problem therefore B, you're going to just have to wait until you're grown up and talk about it.	• Recognition of behaviors of self and others as expressions of trauma. • Shift of perspective related to physical symptoms that are connected to unresolved trauma. • Recognition of personal trauma.

Key concept from TLT	Example units of meaning	Potential categories
Exploration of new roles	P1: Now I guide people. We were working on this next thing, and it was really intense for her. She was like efforting a lot and trying to make it happen, and I kind of guided her. P2: Some people are going to show up and say "I'm crooked, fix me" there's my chance to clarify that my question asking is me trying to read the nervous system and see deeper patterns. P3: I often had people who had an emotional release of some sort and were surprised by it, and so this brought a lot more awareness to what those triggers can be.	• Guide and educate clients and patients about trauma and healing • Facilitator in helping clients and patients understand the experience of healing from trauma • Knowing the boundary between retraumatizing and healing
Critical self-reflection	P1: You must be willing to also examine how trauma has impacted me. I'm happy to be able to go to those difficult, terrifying places inside me, those confusing, dark corners, to be willing to trust another professional. P2: I guess I'm sensitive to this because I was doing that as calming stuff, it's just really easy to think we're doing good things and we're not. P3: But now, being in this skin, looking back, I would say I was miserable, and I was guarded, and I never even knew it. I never knew it. It's such a shame.	• Self-awareness and/or metacognition • Awareness of personal effects of experiences of trauma. • Awareness of previous treatments being possible trauma triggers
Connection between discontent and transformation	P1: I used to be like a standard deep tissue massage therapist, and I started to be like, this is so out of alignment. Now I feel a lot more alignment when I'm doing that sort of work with people.	• Phrases of shifting awareness in understanding • Shifting awareness of behavior and approach to area of specialization

Key concept from TLT	Example units of meaning	Potential categories
	P2: I'm starting to feel way beyond the palpable like material tissue, like I can feel the electric buzzing, like expansion. I feel fullness. P3: There's more awareness for myself and also the boundaries I hold. There's more awareness of how much has held me back.	
Individual experience	P1: The concept is there that we have grace, that we have peace, that we have inner joy, that we have all these things that religions claim and I never felt that I actually had access to it. The training gave me access to those things. P2: I was feeling the PTSD flashback for like six, nine months, crying every day. It was really challenging. P3: I remember specifically in grad school, um, where it dawned on me that I might have a trauma history.	• Light-bulb or aha moments
Discourse or dialogue	P1: There is a very small group of RMTs that have done trauma work and some of us chat. P2: Yeah, I have those people. They're in like a special, dear place in my heart. P3: So, there would be a debriefing around that as like a different way of processing.	• Chances to talk about experiences. • Opportunity to connect with like-minded others
Integration of new perspectives	P1: I do often see a link between really intense trauma history and chronic health issues. P2: Learning how to drop out of your head and focus on your heart. It's getting into coherence that shifts your nervous system response. P3: To see the person beyond who they are right at this moment and	• Seeing symptoms and behavior as a reflection of unresolved trauma. • Change of intake document questions • Change in treatment approach

Key concept from TLT	Example units of meaning	Potential categories
	seeing the person as you know the part of the story that they've been living. There's always a reason around the outcome of their choices.	
Awareness of context	P1: I need to understand, not just from a professional able to be in that witness state, to be able to put those pieces together that is what really discharges the nervous system and helps gain agency. P2: Seeing how trauma gets into the body and showing up at how they behave and how their body functions. P3: It's about, what does this client need in this moment and feeling freed up to do that because my own needs are taken care of.	• Increased awareness of how psychological trauma presents • Understanding of what can be done about it.
Change of meaning and purpose	P1: I can now talk about how trauma is processed and how our bodies can sometimes with medical things, as we're working with our bodies can kind of come up and start bubbling at the surface. P2: I'm definitely a lot more steady and stable, it changed the level of care I was able to provide. P3: I am really careful not to push, because if they're not ready then you know, I'm choosing training based on more psychoemotional, psychosomatic care. I'm shifting my approach.	• Seeing shifts in identity as a healthcare provider • Seeing shifts in professional approach to bodywork • Greater understanding of what it means to be a healer (i.e., hold space, patient/client autonomy, less pressure to 'cure')

The deductive process allowed me to find thematic codes using the TLT framework to answer the question of how transformation was experienced and described by participants. Most participants shared that they had experienced significant shifts both personally and professionally. These included (a) greater awareness of how their own experiences of trauma got them interested in becoming trauma informed, (b) that in the training they began reflecting on perceptions and personal beliefs; expressed shifts to a more trauma informed approach when asking questions during the intake process, and (c) changes in personal identity as a healthcare provider. These are detailed with supporting quotes in the Results section.

There were discrepancies regarding the responses from one participant. For example, they would only respond to questions as it related to their own traumatic life experiences. This focus on only their personal trauma may have been helpful for the participant to share but was difficult to connect to the overall meaning of transformation that included both personal and professional impact. This participant also wanted to share the work they were creating in TIC training, suggesting a "disconnect" between the focus of the interview and the participant's desire to share. This is discussed further on in this chapter and in Chapter 5.

Evidence of Trustworthiness

I worked to connect previous research around trauma informed care in allopathic healthcare fields to training in trauma informed care of qualified CAM providers. The interview questions shown in Appendix B were based upon the theoretical framework and generalized findings from the research literature listed in Chapter 2. As described in

Chapter 3, I employed well-regarded strategies to enhance the quality and trustworthiness of the data collection, analysis, and interpretation processes.

Credibility

I used semistructured interview questions as a guide to gather descriptive responses from participants who met the criteria, showing a phenomenological picture of the phenomenon being studied. I verified participants' familiarity with the topic with questions about years in practice, patient or client population, primary issues addressed in practice, and type of trauma informed care training. Initially there was intent to gather documentation related to participants' various trainings, however this was not done as it was deemed irrelevant to the process and self-report of their participation was sufficient. Upon completion of the interview, member checking was done by creating a summary of the interview and sending it to participants for review and feedback. This helped determine congruency of the transcripts, my insights, and participant experiences. Most importantly, I am familiar with both the topic and population, so the use of bracketing and audit trails was essential to accurately represent what study participants conveyed to decrease my pre-conceived views (see Giorgi, 2009). At times, this proved to be challenging because the interviews took on an air of camaraderie and I monitored myself using brackets to stay in the interviewer role.

Transferability

Each participant interviewed provided thick, rich descriptions of their experience both personally and professionally resulting from their learning to be a TIC provider demonstrating potential transferability (see Shenton, 2004). The interview findings show

proximal similarity (Patton, 2015) and lends support to what was described in Chapter 2 in the cited research of allopathic medical providers, schoolteachers, and mental health providers. Chokshi et al., (2020) showed that participants reported feeling more informed and better able to identify the signs and symptoms of psychological trauma. Here, more than one participant reported that it was important to "know that (trauma) is different for everyone, dependent on their experience, and the way they process things" (P5). And that trauma shows up as "syndromes like irritable bowel, autoimmune disorder, chronic fatigue, fibromyalgia" (P4) or "aggressive postures, they're out in front and like chest out, or collapsed posture, depressed energy, noticeably absent tone of their tissue" (P9). Furthermore, participant descriptions and detailed documentation of the data analysis process was done by me to enhance the readers' ability to apply to their own circumstances.

Dependability

The use of member checking supported and demonstrated dependability. The use and description of an audit trail throughout the process helped me keep track of decisions about coding analysis procedures, which I summarized above for maximum transparency. The use of a theoretic audit trail as suggested by Shenton (2004) helped me demonstrate congruence between the interview questions and conceptual framework. Most of the interview questions reflected one or more core elements or one of the ten phases of learning from the conceptual framework.

Confirmability

Because I am linked with both the population of study and the subject matter, my knowledge, experience, and expertise helped participants recognize they were talking with someone familiar with terminology and topic. However, as stated previously, this may have caused me to be remiss in asking participants to more fully describe certain phrases or expressions used frequently in the world of TIC. For example, stating that the provider had some "recognition of adaptive strategies" is familiar to me as I have training in the same model as the interviewee. Another statement that TIC is "about choice and agency" is perhaps more broadly familiar to others in the field. As suggested by Cairns-Lee et al., (2022) I attempted to mitigate bias and presupposition by keeping a reflexive journal and recording the interviews, transcribing responses, and further coding for common key phrases and words.

Based on my own training in TIC and my experience teaching in the field, I had strong suspicions about what I would find. I also suspected that those who had an overall positive experience in their training would be most likely to volunteer. However, there was at least one participant who did have a negative experience and others who shared their discomfort with material presented during their learning. When asked about negative aspects of the training they took, one participant expressed difficulty with the facilitator that triggered old patterns of thinking which intersected with her own beliefs about asking for help. Others stated that some of the content related to childhood abuse and maltreatment was challenging, especially if they had children. All of them stated, in

one way or another, that their overall experience was transformative in a positive way, even if some of the content and material was difficult.

Results

The research question posed by this study was, what is the lived experience of transformation of CAM providers who have participated in some form of trauma informed care training? Participants were asked to reflect on their experiences before, during, and after taking part in training related to trauma informed care.

Results of the Thematic Analysis

The data analysis process (examples shown in Table 1) revealed themes of where and from whom training was received along with changes in how trauma and trauma informed care was viewed, described, and defined. Participants shared that after their training they had a broader definition of trauma and clarity around what it means to be trauma informed. Some stated their new description included agency and choice, others stated it means leaving more energetic, emotional, and psychological space for their clients and patients. Other participants shared that they changed how they address their own personal trauma as well as how they approach clients and patients. The information gathered at this stage of analysis helped lay the foundation for deductive analysis.

Results of the Deductive (Top-Down) Analysis Using TLT Concepts

As shown in Table 2, I used the six phases and ten core elements of TLT to address the question of transformation. Themes of transformation included more stability of self and shifts in the level of care they provided. Changes in addressing their personal trauma and how they approach and work with clients and patients were also expressed.

The results revealed changes to policies, procedures, and practices that gave patients and clients more agency and choice in their treatment. There was an increased understanding of how the body reacts and responds to trauma and what providers can do to address the coinciding symptoms. There was an expanded understanding of what trauma is and what it means to be trauma informed. Furthermore, all participants expressed an increase in self-compassion and for those they serve: this meta-theme of transformation emerged consistently in the data analysis process. This is discussed in detail here, organized by the TLT components.

Disorienting Dilemma

TLT identified this as an uncomfortable internal sensation when faced with a challenge to strongly held thoughts, meaning, or previous assumptions. This was explored in the first interview question, where participants were asked about their participation in trauma-informed training and how they got involved. Answers ranged from feeling ill-equipped to help others to attempts at resolving personal trauma, for example P6 shared,

> When I was practicing chiropractic, I found a lot of women just were not doing well mentally, emotionally like you know and it wasn't just the new mom thing. I found a lot of women are dealing with trauma, capital T trauma, that had never really been addressed and it didn't feel like I had tools to help.

Another said, "I was involved in a head-on collision and most of the right side of my body was broken. I learned firsthand the impact of trauma" (P3). Several participants expressed frustration at realizing they were eliciting a trauma response either accidentally

or on purpose based on their bodywork training but had no way to help manage what was presenting. P2 shared their frustration with prior training in this way,

> Well, this is why it's not working because we're retraumatizing through all this Hakomi stuff. It seems like a good idea on the surface, but no. So that was just a huge light bulb going off for me, was, oh, gosh, all these things that we tend to think are good, are not good.

Self-Examination

TLT stated that self-examination is directly linked to the seeking in the disorienting dilemma and creates an openness to change previously held beliefs. The interview question explored how participants were affected by the material they encountered while in their trainings. All participants had commonalities around the expressive descriptions of how they began to realize what needed to be changed. P4 said,

> I was dating somebody for a while who had all these really interesting somatic symptoms. I wasn't as interested in the same way in trauma-informed care until I was really, you know, deep interrelationally with him and being like, what's actually happening right now? [he was having a lot of symptoms]. So, I started getting interested in polyvagal theory and Peter Levine's work. And I was like, there actually is this explanation from our nervous system to understand some of these things and why they're happening. At first it was about him, but then I started to apply it to myself and people I was seeing in clinic.

P6 shared that they began to see how current and previous training was coming together for them in this way,

> So, all this trauma work is finally giving me the both the insight and the willingness to jump into the abyss of like, okay, what would I actually do without all of my education and, you know, the thousands of hours and years that I've spent in this world.

Most of the participants shared expressive descriptions reveal seeking, self-examination, and openness to change. These statements show self-reflection around what precipitated their involvement in and continued pursuit of trauma informed care training.

Critical Assessment of Assumptions

TLT stated that assessment of assumptions happens when engaging in healthy discourse and includes the challenging of ideas and problematic ways of thinking. The interview question was intended to uncover assumptions about psychological trauma participants held before trauma-informed training. Not everyone had a clear conceptualization of their assumptions. One participant stated “It's not as simple as saying I thought X and then afterwards, I thought not X, or I thought Y. It's more, you know, you didn't know you didn't know” (P2). Another said,

> PTSD back then was very, you know, it was not looked at or recognized for people who had car accidents. So, it was very confusing for me thinking, you know, do I really have this? Because I'm not a veteran. I can understand a veteran, but I was having all these symptoms and these reactions. (P3)

One participant had a more concrete awareness of what changed in their understanding of trauma and abuse, stating “I think maybe the piece that I was assuming was malintent. And the piece that I understand now is like actually a lot of times there

isn't malintent, there's just a lack of capacity" (P4). These quotes reflect how, through their training, participants analyzed their assumptions about trauma, and altered their ways of thinking.

Exploration of New Roles

TLT pointed out that discomfort may arise when roles and responsibilities shift, with awareness being critical for making informed and reflective decisions. The interview question explored new roles that resulted from learning about trauma informed care. P7 stated "So I guess taking on less personal responsibility for the clients experience". Another said, "I need to understand, not just from a professional level, but to be in that witness state, to put those pieces together" (P3). Another interview question was more focused on changes in their role as a professional, in their practices, policies, or office procedures. All but one participant shared that they had made significant changes to their intake forms. P1 shared this,

> Now I ask about their emotions and suggest we take a moment to see how it's showing up in their body. I say, if you're interested, we can look through from that lens and see if your body tells something to you. I never asked this question before, it's a great influence from the training.

Another said, "I did coaching and functional medicine for the last couple of years, and now I'm more in the leadership world. But it definitely changed the level of care I was able to provide" (P6). The shifting of roles and responsibilities happened not only professionally but personally as well, as is demonstrated in these quotes.

Critical Self-Reflection

A core element of TLT requires a person to question assumptions, beliefs, and meaning given to thoughts and behaviors, which elicits transformation of oneself and one's personal worldview. The interview question inquired about the meaning of being a trauma-informed care provider. P9 stated,

> Like it's completely about what does this client need in this moment and feeling freed up to do that. I guess, because my own needs are taken care of and because I've learned the skills of how to regulate and how to contain my own stuff.

P4 put their understanding of what it means to be a trauma informed provider this way,

> It's about choice, but I think it's also about really understanding trauma. So, I think a lot of people will throw around the term trauma-informed provider, and I don't think a lot of people actually know what that means. I think we really have to understand okay, like what is trauma about and how do we actually support people that have been traumatized. So, I think that really means that we need to be attuned exactly into how our actions as practitioners influence the people that we're seeing.

P8 shared, "also knowing how not to harm, how not to intentionally harm, if that makes sense, like making sure that we're creating a very safe space for people". Every participant expressed how their training helped them to be trauma informed and see more of what it means to be present for people who have experienced some type of trauma.

Connection Between Discontent and Transformation

TLT stated that the process of transformation was about recognizing how feelings of discontent are connected to transformation. I asked Participants to describe any personal discomfort and how they were affected by the material, either positively or negatively in learning to be trauma informed. One participant said,

> Towards the end of the training, I had a really triggering session as a practitioner practicing with the colleagues, and it wasn't really grouped well [in the breakout sessions]. While I was aware that that was what's happening, I wasn't really taken care of the way I had hoped for from the instructor. I reached out to the instructor a little bit after, like a week after it happened. I was told it's more like for you to take care of what's happening for you now. So yeah, I wasn't able to express so many things, but finally, I'm coming out, but in a positive way, I'm still in the transitional phase, but hopefully it will come and I'm more expressive. I can stand on my own feet and say things the way I want to say. (P1)

Another participant shared what changed for her with increased awareness of her discomfort by stating,

> I think the way I show up and receive people is much different. It's like my language has changed a lot. I'm learning right now there used to be like real anger or hatred toward narcissism or narcissists. And now I'm like, whoa that doesn't actually feel okay for me to hold anymore. (P4)

P8 shared the way she used her discomfort in the learning process this way,

> It wasn't uncomfortable in terms of it being like, I don't want to learn about that. But it was just really, activating maybe in some ways, but also validating at the same time.

Participants stated that even though they encountered negative or triggering content they all expressed a recognition of how sitting with the discomfort actually allowed them to be more accepting of their own trauma. This in turn gave them more capacity to be with the discomfort and trauma that presents in their patients and clients.

Individual Experience

In TLT, people's individual meaning structures and perspectives are formed by and based on socialization. This is closely connected to critical self-reflection as well as discontent and transformation. I asked participants to identify "aha moments" during the training that affected their meaning making or perspectives. P5 put it this way,

> So that's why these principles of transference and countertransference are really essential to get a grip on understanding because I'm influencing a session on any given day with any given client on how their manifesting in that moment is going to be different than even if they came back the next week and we're working together again.

P7 shared more than just having an academic experience, he said,

> I guess I was just really impacted by witnessing therapy. I was like well this is really powerful, and I never knew that because I never went to therapy before and then I had some experiences where it felt like this is probably like one of the top spiritual experiences of my life and has nothing to do with spirituality. But maybe

> everything to do about my own humanity in a way, you know, it just felt so that like really, I guess that surprised me. I was like, whoa, the more I authentically process through this stuff, I feel so connected to myself that it's like a spiritual thing almost.

These statements show how participants began to see patterns and beliefs that were getting in the way of being more present for themselves and those they provide care for.

Discourse or Dialogue

TLT encouraged the involvement in healthy discourse or dialogue that focuses on learning material within a context of personal growth and transformation. The interview question I asked were about the type of discourse or dialogue available during or after their training that helped to support a holistic perspective. P2 stated “Those people have a special dear place in my heart, and I feel like I could talk with them anytime. They’re who I’d go to first if I wanted to talk with someone about something challenging”. Another shared “I had personal sessions with assistants and SE and NARM providers, yes, as part of the training. I also reached out to my pastor and a mentor to help with difficult content” (P9).

An additional interview question I asked was about the opportunity to discuss with anyone in the training or afterwards, what was learned or what might have changed as a result of the training. P8 shared that they continue to meet with other training participants, the said,

> Some of us have been in a little chat about some of the stuff that we learned and what we found helpful and so that has been kind of nice to just be like this was a really great workshop. But it was really challenging to do just for myself, you know.

I learned that in each of the formal trainings there were opportunities for dialogue and discourse. However some interviewees stated they did not participate for various reasons. Those who did shared how helpful the process was for continued support during difficulties with content or personal triggers.

Integration of New Perspectives

TLT encourages cycling back through various stages as transformation as an on-going process. Building of competence, self-confidence, and integrating new perspectives requires periodically looking back at the previous stages, as a way to refine and continue personal and professional transformation. My interview question explored changes noticed by participants in their clients as a result of TIC training. One massage therapist described it this way,

> Sometimes there are areas of the body that wouldn't release, there's a different feel of that tissue. There's just a holding there, almost like a buzz. It's like the tissue is just held. I could never really understand why the tissue wouldn't release, now I do. (P8)

P4 sees the process of ongoing changes in herself and expressed it this way,

> I mean, so much, so much. I view myself in a totally different way with so much more compassion and so much more space and forgiveness and just all of those

> things like yeah, I feel it's irreplaceable knowledge and experience. It's not just the like heady stuff, it's really that I get to have a different experience of myself as I learn about all of this.

Two participants shared similar experiences related to what they saw as changes in how their clients and patients were now reacting to clinical work. P5 said “I notice energetic boundaries being less pronounced, they may conform or comply or meet the pressure of the massage with the same amount of protection. Now I am being sure not to use more pressure when they’re pushing back”. P6 shared an increased understanding of patients’ needs since participating in TIC training by stating “people needing more support beyond the adjustment or just helping calm the nervous system”.

With greater awareness and understanding of how trauma presents in themselves and others the protective layers can be removed through continued curiosity and exploration. All of this is a way for these providers to show up with greater compassion and empathy.

Awareness of Context

A core element of TLT is appreciation and understanding of both personal and socio-cultural factors. These are situational and on-going with flexibility in thoughts and ideas around how a person’s worldview came into being. I asked the participants how they define or describe psychological trauma. One participant stated, “I don’t just see trauma as psychological; it affects the psyche and the body and the spirit” (P3). Another shared that their perspective has shifted by saying “psychological trauma that gets into

the body, showing up at how they behave and how their body functions" (P1). Yet another stated that they describe it this way,

> I would not use the qualifier of psychological, I explain it in physiological language, all psychological responses and reactions run on a chemical substrate. Trauma is too much for their capacity at the time to stay connected mentally, emotionally, spiritually. (P5)

These quotes show the concept of psychological trauma and how both provider and their clients make meaning out of traumatic events. Increased conscious awareness about the how and the what of psychological trauma is critical to trauma informed care.

Change of Meaning and Purpose

TLT described how transformation creates a new way of relating to self and others through changes of meaning and purpose. As confidence builds through stages and processes of transformation these changes allow for greater feelings of psychological safety for themselves and their patients. In addition to individual experiences participants were asked about changes of meaning and purpose that may have resulted from or affected their learning. P7 stated "A big shift for me was in chiropractic. I was not fulfilled by my career; the trauma training has created change with that understanding for myself. It got me back into chiropractic but more in the role of leadership". P4 said they were profoundly impacted by what a trauma informed training facilitator shared,

> Something that I think about from that Amber Gray training a lot is she said something that's always stuck with me around our spine is like holding ourselves up in the world. Like what, courage it takes to stand up with a straight spine. And

> I thought about that a lot of like how we collapse to protect ourselves and how it is to actually stand up straight and what the difference is there.

Another question related to meaning and purpose is about changes made to professional practice, policies, or procedures. Nearly everyone made some type of change to these aspects of their work. P1 said, “I am asking questions about bodily sensation. I am shifting my approach to a more trauma-based lens, and I notice that clients are expressing more insight on their behalf about behaviors and health issues”. One of the educator’s interviewed put it this way “It really just changes the culture though mostly. It creates a culture of more acceptance” (P2). Another interviewee said,

> “I can settle my own system enough to let myself get close to a great big God and to get vulnerable with him and to let him speak into my life and have that in place instead of being so guarded. Looking back, I would say I was miserable, and I was guarded, and I never even knew it. I never even knew it. It’s such a shame” (P9).

Participants expressed greater clarity in their purpose as healthcare provider, whether that be directly or as a trainer of other providers. They shared about changes in questions they ask during intake and how they work more collaboratively with whatever psychological presentation the client or patients comes in with.

Summary

The intent of the study was to answer the question: “What is the lived experience of CAM providers’ personal and professional transformation after participating in trauma-informed care training?”. The study of transformation, as noted in Chapter 3, is

contextual (Schnepfleitner & Ferreira, 2021), dependent upon personal attitude (Bentz et al., 2022), and consisting of non-linear phases (Wright et al., 2021). The findings of this study show that shifts in meaning making and perspective happened as a result of personal and professional interest, exploration, and a desire to learn. Participants across the board expressed they were more curious, empathetic, and compassionate both to themselves and the people they serve as a result of their training.

Participants described how curiosity was a driving force in their wanting to learn more about trauma and trauma informed care, but this curiosity was expressed in different ways. Some expressed they wanted to understand their own traumatic experiences, others shared that they found previous somatic trainings limited. In their seeking, participants reported uncovering previously held assumptions that no longer fit with their new perspectives. For example, P2 shared "In my own journey, I was really hard on myself for a long time and I'm learning to be less hurtful to myself". Many participants talked about how they came to recognize that they themselves had been traumatized. P6 said, "I did not recognize or acknowledge my own personal trauma". Others shared that even though they had not been in military combat or through a devastating natural disaster they now accepted they too had experienced traumatic life events.

A majority of participants reported that the training they participated in provided new ways to look at trauma and they learned to be supportive and compassionate. One participant stated, "I realized I had an ethical responsibility to learn how to help people with their trauma" (P9). Integration of their learning was specifically demonstrated with

shifts in both personal understanding of trauma affecting them and their preconceived notions about psychological trauma. P2 stated that before beginning training they "had only an academic understanding, the sympathetic response which inhibits frontal (lobe) capacity which affects their nervous system response". And now works clinically in a manner to "not (put) stuff on people, not telling people what's 'wrong' with them" but to "recognize the reason for physical presentation, that I am not going to fix your posture, it's an expression of personality" (P2). This same sentiment is expressed by other participants who summed up in that they do not see trauma as just psychological, but that it affects multiple aspects of each person. Others expressed their transformation as being willing to both trust themselves and others more deeply.

Changes in clinical practice and their role as provider were evident with nearly all nine participants. Some stated they are now asking directly about trauma, others stated they only discuss the issue if the client or patient brings it up. Others ask more questions about injuries, medications, or surgeries in an open-ended way. P4 said they "ask more questions based on what a person wants for themselves, their strengths, to see their struggles as their strengths". Nearly every interviewee stated their informed consent is more detailed about their individual clinical work, purpose, and intent. P1 added "I let go of some common practices. I am helping people to be more comfortable, create safety, asking intake questions directly, not just on a form". Shifts in identity and their varied approaches to bodywork lead to greater understanding of what it means to be a healer.

Not every interview went exactly as planned. For example, one participant would begin to answer the questions but quickly veer off topic and began talking about trainings

they were creating. In a couple of other interviews, I realized I had not asked clarifying questions to a number of interviewees, partially because I was familiar with the training they had participated in. Both of these examples made analysis difficult at times. However, the majority of study participants were clear and thoughtful in their statements. Participants expressed that through involvement in the trauma informed care learning experience they came to see themselves differently both personally and professionally. They shared how their new understanding allows them to show up and participate in the healthcare provider role with more clarity and a greater sense of purpose, representing the transformation of understanding and practice.

Conclusion

The findings of my descriptive phenomenological study show that CAM providers who participate in some type of training in trauma informed care did experience transformation both personally and professionally. Every participant expressed some type of fundamental change both internally with themselves and externally with others, as being more compassionate and curious. They made changes to how they ask questions during intake, interact with patients and clients during sessions, and how they address trauma when it shows up through physical presentation or as an emotional reaction during treatment. The majority of study participants also stated that they themselves recognize how trauma has impacted their own lives. Through their learning in trauma informed care, they expressed how they experience their new understanding which allows them to show up and participate in the healthcare provider role with more clarity and a greater sense of purpose. In Chapter 5 I present an

interpretation of the findings along with limitations, recommendations, and implications for possible future studies in this area.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this study was to examine the lived experience of transformation personally and professionally in CAM providers who participated in some type of training in TIC. Using a descriptive phenomenological approach, I collected and analyzed data from nine CAM providers. Interviews were done to better understand the types of transformation experienced and how these experiences inform participants, personally and professionally. Recorded transcripts were analyzed using both inductive and deductive approaches to identify common themes. TLT was used as the framework for understanding the transformation process. Major sections of this chapter include interpretation and discussion of the findings, limitations of the study, recommendations and implications, and conclusions.

Summary of Findings

Participants expressed various reasons around their desire to learn about TIC. The most common were curiosity, a yearning for personal healing and exploration of the self, and emergent issues during treatment. What arose from participation in TIC training included recognition of behaviors of self and others as expressions of trauma, uncovering personal experiences of trauma, and acknowledgement of the need for change. Since all participants had directly or indirectly provided healthcare services there was an understanding of a need for a new approach to how they “showed up” in their practice. New perspectives of self and role as provider include guiding, facilitating, and educating clients and patients about trauma and that healing is possible.

Participants shared the importance of speaking with and connecting with like-minded others about experiences and the awareness of the personal effects of trauma. There were descriptions of integration of new perspectives and roles from not knowing how to manage or address trauma to now seeing different approaches in areas of specialization. Participants stated they are now seeing new ways to address physical symptoms and the connection to unresolved trauma. They also shared greater knowing about the boundary between retraumatizing and healing, for both them and those they treat. There were also changes in meaning and purpose related to identity as a healthcare provider, seeing their professional approach to bodywork with a greater understanding of what it means to be a healer. For at least one participant the process of personal transformation seemed incomplete. This was apparent in their responses, which were more about the trauma they personally experienced and not the transformation resulting from their trauma informed care training.

Interpretation of Findings

Findings in the current study are consistent with prior studies conducted with a variety of allopathic medicine providers, schoolteachers, and mental healthcare providers trained in trauma informed care. As presented in Chapter 2, these studies showed an increase in knowledge about and assessment of psychological trauma that lent itself to increased confidence and competence clinically (Chokshi et al., 2020; Dueweke et al., 2019; Goddard et al., 2022). In this study, participants described their increased clinical proficiency as being better able to manage themselves in the face of other's difficulties and by not having their own trauma triggered. Other studies reported positive change in

students learning to be healthcare providers when given instruction on trauma informed care (Chokshi et al., 2020). Participants in this study shared that they have begun asking trauma specific questions in addition to watching for more subtle cues about what their client or patient needs beyond what is verbally stated.

It should be noted that in studies described in Chapter 2, patients reported improved interactions with providers who had gone through some type of trauma informed care training. Although I did not include the client or patient perspective in my study, some participants mentioned noticing differences in client and patient responses to clinically related questions. For example, one participant stated her patients have expressed curiosity about intake questions which help connect the dots between past trauma and current symptoms.

A recent literature search was conducted using the same key words and phrases from Chapter 2 to include dates from 2022-2023. I found no new articles directly addressing the population of CAM providers. There have however, been additional studies published with nurses, schoolteachers, and mental healthcare providers and trauma informed care.

Using TLT as a theoretical framework for organizing and analyzing data, I created interview questions based on the 10 phases of learning and six core elements. TLT was originally developed as an instructional tool (Mezirow, 2008) and has also been used to analyze how adults learn. Interview questions established the disorienting dilemma as adult learners wanting instruction about trauma informed care for themselves, their patients, and clients. Part of their desire to learn more included sharing they had

become disillusioned with previous trainings that failed to address psychological trauma. Some participants shared that they enrolled in trainings because they were curious about not only their own trauma but how clients and patients are affected. They stated that TIC training changed what health related questions they ask in addition to how they address clinical symptoms.

TLT's critical self-reflection was apparent in participants describing ways they managed their personal discomfort that arose during their training. Nearly all participants shared that they used, and many continue to use, discourse and dialogue with those they met during their trainings. Participants expressed a new understanding of their perspective and role as healthcare providers along with how they hold space and are present with patients and clients.

Limitations of the Study

The biggest limitations of the study include concerns about the extent of thematic saturation and my personal and professional proximity to the topic. The issue of saturation is twofold: number of participants, and background of participants. I originally planned for eight to 12 participants, and the final sample of nine participants satisfied the methodological understandings regarding data and thematic saturation (see Guest et al, 2006; Guest et al, 2020).

Regarding the diversity of participants, I unsuccessfully attempted to include a variety of practitioners from different healing methods who met the criteria for the study. I originally intended to have an equal distribution of acupuncturists or practitioners of Chinese medicine, chiropractors, and massage therapists. Instead, I recruited one

acupuncturist, who is also a massage therapist, one chiropractor, and seven massage therapists. There was representation of a variety of TIC trainings but not of providers, which brings up questions of thematic saturation. A suggested way of determining saturation is based on the number of available, willing participants which is bounded by space and time, and determined by the goal of the study (Sarfo et al., 2021). The opt-in, convenience sample resulting from posting the invitation on each Facebook group page twice in addition to asking interviewees to send other potential participants my invitation. Unexpectedly, the attempts to recruit CAM providers, specifically chiropractors and acupuncturists who actually had training in TIC was not successful. An acupuncturist posed the question to me in response to my Facebook page request, “what do you mean by TIC?”. On another Facebook group page, a chiropractor challenged me with “how many traumatized people have you treated?”. To which I politely responded that I was wanting to interview providers, not debate my expertise.

A related and possible limitation of the study is that I am a professor at a university where chiropractors, acupuncturists, and massage therapists are educated. The issue of proximity and familiarity with the primary phenomenon may have resulted in failing to ask exploratory questions about phrases commonly used in TIC field. This could have possibly produced limitations to thematic saturation in creating meaning units and categories.

Trustworthiness was primarily addressed in this study using transparency of process and member checking. I welcomed feedback using the member check process and sent a summary of the interview to participants, inviting comments, critiques, and

scrutiny of my interpretations. Additionally, reflexive commentary on my part described by Shenton (2004) as reporting the effectiveness of the techniques used in data collection and analysis. Both Shenton and Giorgi et al. (2017) suggested the use of thick, rich descriptions to promote credibility of the findings, and to include direct quotations to demonstrate the richness of the data. To achieve that, I re-iterated questions, followed up with probes, and asked for examples to encourage participants to share meaningfully.

Recommendations

The current research findings suggest that trauma informed care providers deliver better care as they are more self-aware and aware of their patients' trauma and how this unfolds in the treatment process. However, more research is needed to evaluate if clinical effectiveness of CAM providers is improved. For example, a mixed methods case study examining improvements in patient care and treatment outcomes could be conducted, comparing trauma-informed care organizations with those who have not included such training as part of their professional development. Quantitative measures would be used to capture treatment effectiveness, and qualitative interviews could address experiential aspects of the treatment process.

In the current study, most of the practitioners were massage therapists. It was my original intention to include a variety of practitioners, to enhance the opportunity for greater saturation, but this was not the case. I recommend replicating the study, again using CAM providers while focusing specifically on acupuncturists, nutritionists, health coaches, and chiropractors. Other allopathic fields of medicine that have not been studied could be considered as well, e.g., osteopaths, physical therapists, occupational therapists.

In my study at least one participant shared changes made clinically to policies, procedures, and practices as a result of their TIC training. They noticed that patients began responding to intake questions with more insight into their own health issues and the connection to prior traumatic experiences. This finding suggests that further research is needed to study the clinical impact of trauma-informed training. Quantitative measures have been developed (e.g., the Attitudes Related to Trauma-Informed Care (ARTIC) scale (Baker et al., 2016) and TICOMETER (Bassuk et al., 2017)) to assess providers' attitudes post-TIC training.

The current study focused on the transformational experiences of providers as witnessed by the providers themselves. While one or two participants mentioned that their patients noticed differences in clinical questioning this area is recommended as potentially fruitful for research. This would involve conducting a qualitative study interviewing patients about the treatment experience from trauma informed care providers to gain insight about the patient/client experience of trauma informed care.

Implications for Social Change

Overall, the implications for broader social change are numerous. At the university where I teach, there is movement toward a greater understanding of psychological trauma and its effects. I intend to share my research findings with the staff and faculty during an upcoming faculty development day. The findings from my study can be used to promote curriculum development in the training of future CAM providers at this and other health sciences universities. Using the original intention of TLT as a framework for design, instructors can include lessons that follow the ten phases and six

core elements following the structure of TLT for purposeful self-reflection and professional growth in learning to be a trauma informed healthcare provider.

With the increased knowledge of how unresolved trauma affects not only patients and clients but providers, the greater medical and health community – professionals and care recipients – has increasingly recognized that healing is necessary. Canadian physician, lecturer, presenter, and author of several critically acclaimed books on trauma Dr. Gabor Maté, shares in his latest book that trauma exists for everyone, and that healing is possible (Maté & Maté, 2022). Thus, my study is one part of the greater efforts to increase the awareness of the need for TIC training for everyone.

In addition to becoming more knowledgeable and compassionate, the effects of TIC training may lower the rates of burnout in the healthcare field thereby improving retention and job satisfaction. To support this effort, I intend to create a workbook to be used for training of CAM practitioners, both current students and licensed providers. The hope is that it will be used to facilitate transformation and reduce the perpetuation of trauma within practitioners, providers, clients, and patients.

In addition to sharing the results from my study and teaching a course specifically about trauma informed healthcare in the massage program, I have added two sections of what it means to be trauma informed into the mental health course I teach in the program. I have been in conversation with the dean of the acupuncture and Chinese medicine program about adding a course in trauma informed care. All of this contributes to future CAM healthcare providers being better equipped to address and manage patients and clients presenting with symptoms of unresolved trauma.

Conclusion

"Traumatized individuals, which includes most of us to differing degrees, need both top-down and bottom-up approaches that address nervous system imbalances as well as issues of identity." – Larry Heller (2012)

Learning to be trauma informed involves both an intellectual or top-down understanding and a bottom-up or somatic approach to what trauma is. This study adds to the growing body of information about not only the psychological effects of trauma but also the physiological effects. By learning how trauma presents itself clinically – as physical, psychological or behavioral symptoms – providers of all types can begin to facilitate deeper levels of healing for those they care for. Additionally, those providers can see that healing for themselves is not only possible but necessary. One of the reasons I chose the topic of trauma informed care and how CAM providers are transformed because of participating in trainings is directly related to changes I have witnessed, and experienced personally.

Although I am in private practice as both a chiropractor and a mental health counselor I believe my role as a teacher has implications for the greatest impact. In my office I can be with one patient and help them transform. In the classroom, whether in person or online, whether it is in front of one student or 100, I can share my expertise which they can use to affect each person they treat. It is truly a ripple effect that can support the healing of trauma throughout the field of complementary, alternative, and integrative medicine and ideally, the world.

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Appendix A: Social Media Posting

Researcher seeking complementary and alternative medicine (CAM) providers who have taken formal (certification, academic coursework, etc.) or informal (webinars, self-study, etc.) training in trauma-informed care.

- Acupuncturist and/or Chinese medicine provider
- Doctor of Chiropractic
- Massage Therapist

I am a PhD student in the school of Psychology at Walden University looking to interview 8-12 volunteers who fit the above category.

- Interviews will be held and recorded via Zoom, lasting approximately 60-90 minutes.
- Questions are related to any change or transformation personally or professionally after completing trauma-informed care training.
- If you are interested, you may private message (PM) or e-mail me

Appendix B: Interview Questions

Interview Question	**Demographics, Connection to Conceptual Framework (Ten Phases of Learning and/or Core Elements), and General Information**
To get started, tell me about your practice? Probes: type of CAM provider; length of time in practice; primary population; etc.	
I am curious about your experience with trauma-informed care? Probes: how did you get interested in trauma-informed care? what kind of training(s)? *Request to provide documentation related to trainings – books, webinar titles, syllabi, training manuals, etc.*	
What was the most positive part of your training? Was there another positive experience?	
What was most negative or uncomfortable in your experience with trauma-informed care training?	(10 phases) Disorienting dilemma
What assumptions about psychological trauma did you hold before you began training/learning about TIC?	(10 phases) Disorienting dilemma Self-examination Critical assessment of assumptions
During your training, did anything surprise you? Probe: "or confuse"	(10 phases) Disorienting dilemma Self-examination Critical assessment of assumptions
Tell me about any personal discomfort you may have experienced over the course of your learning.	(10 phases) Disorienting dilemma Exploration of new roles (core) critical reflection
Describe how you were affected by the material in learning to be trauma-informed.	(10 phases) Recognition of connection between discontent and transformation (core) critical reflection
Describe any "aha moments" during the training that may have effected your learning?	(core) Individual experience
What type of self-reflection and/or dialogue was part of your learning?	(core) Critical self-reflection Discourse/dialogue

Did you discuss with anyone what you noted changed in yourself? Probe: for example	
Based on what you learned from the trauma-informed care training you participated in, what was the biggest change have you made to your practice, policies, or procedures.	(10 phases) Integration of new perspective (core) awareness of context
Describe personal changes you have noticed or experienced as a result of learning trauma-informed care.	(10 phases) Integration of new perspective Competence, and self-confidence (core) Change of meaning and purpose
Describe any changes you have noticed in your clients or patients that may be the result of your learning about trauma-informed care.	(core) Integration of new perspective
Based on your experiences, what do you think it means to be a trauma-informed care provider?	SAMHSA. (2018). Sundborg, S.A. (2019). American Psychological Association. (2015).
If you were to share what you've learned with an interested colleague, what would you recommend to them as a path to become a trauma-informed provider?	APA. (2022). SAMHSA. (2018). Lotzin, A. et al. (2018). Lewis et al., (2019)
Is there anything else you'd like to share?	