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Case Manager Perceptions of Trauma-Informed Practice and Policy in Human Service Organizations

LaChandra Brooks Prim
Walden University

Walden University

College of Psychology and Community Services

This is to certify that the doctoral dissertation by

LaChandra Brooks Prim

has been found to be complete and satisfactory in all respects,
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Review Committee
Dr. Shari Jorissen, Committee Chairperson,
Human and Social Services Faculty

Dr. Tammy Totten, Committee Member,
Human and Social Services Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2024

Abstract

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MPhil, Walden University, 2021

MS, Faulkner University, 2014

BS, Troy University, 2011

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Services

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Abstract

One of the goals of human service organizations is to provide help to victims of trauma, but they are often the cause of retraumatization to those individuals. The problem that was addressed in this study was the negative repercussions of retraumatization such as feelings of being unsafe, anger, guilt, shame, depression, and secondary trauma due to human service organizations not being based in trauma-informed approaches. The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of trauma-informed practices and policies across organizations and services. Ecological systems theory served as the theoretical framework for this study. Data were collected from eight case managers through semistructured interviews and thematic analysis was used to analyze the data. The resulting themes of this analysis were that there is a deficit/ambiguity in trauma-informed curriculums and trainings in human service organizations, more collaboration is needed with other trauma-informed human service organizations/agencies, and trauma-informed practices should be applied in human service organizations to better support employee wellness. It is recommended, to encourage positive social change, that organizations should increase trauma-informed trainings focusing on consistency in trauma terminology, better identify the difference between trauma-informed policies and trauma-informed practices, and better support case managers to decrease the chance of vicarious trauma so they can better meet the needs of the population they serve and reduce retraumatization.

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Dedication

This study has been the most rewarding feat of my academic career, a labor of love. I dedicate this study to my mother, Shirley Gardner. You may not have always understood why it took so long to get here, but you were always supportive. You birthed a dreamer. You taught me perseverance and you showed me how to be resilient. I am so honored and grateful to call you my mother. I love you.

To my father, the late Gerald F. Brooks, I wish you were here to experience this moment. I hope that I have made you proud. To my siblings, Robert and Chad Mitchell, I am extremely blessed to have the most amazing brothers. We have allowed each other to have space to dream and create the lives we wanted for ourselves with no interference. Yet, if we needed one another, we could always call. I love you both.

To my family, Ken, Kennedy, Cameron, and Kace Prim, I hope this study has created a lasting impression for you. Thank you for giving me the time and space to write undisturbed. I hope it inspires you to live out your dreams and to reach every goal. I hope that it encourages you to keep pushing no matter how hard things get. I love you.

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To all my friends and family who have prayed and listened, I appreciate you more than you will know. Your prayers were felt. They helped me get through some of my darkest moments on this journey. Thank you!

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Chapter 1: Introduction to the Study

Trauma has been linked with an increased likelihood to suffer from physical health problems, mental health issues, substance abuse issues, and financial problems including a cost to the United States economy of $671 billion dollars a year (Coalition for National Trauma Research [CNTR], 2020). Some human service organizations have moved to incorporate trauma-informed practices due to the increased potential for traumatized individuals to be retraumatized by existing standard practices and policies (Loomis, 2018), but these may not be consistent across organizations and services (Carello & Butler, 2015; Champine et al., 2019; Hanson & Lang, 2016). The problem that was addressed in this study were the negative repercussions of retraumatization due to those organizations and systems not being based in trauma-informed approaches (Ezell, 2019; Huefner et al., 2020; Medenhall et al., 2018; Mersky et al., 2019; Salloum et al., 2018).

The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of trauma-informed practices and policies across organizations and services. I sought to understand the level of training and education case managers had before providing services to victims of trauma. I also sought to understand the policies and practices implemented in human services organizations. Thus, the focus was on case managers' perceptions of trauma-informed policies and practices that are used in their organizations. Case managers in human service organizations interact with different levels of ecological systems that influence the perceptions, attitudes, and behaviors that then affect how case managers interact with clients (Cornell University,

2019). The inclusions of trauma-informed policies and practices of a system, or lack of trauma-informed policies and practices, guide how clients are interacted with and may results in positive or negative outcomes for that client (Dember et al., 1999; Purtle, 2018). How case managers are influenced to use, or not use, trauma-informed policies and practices when having interactions with victims of trauma can influence how individuals receive services, directly affecting their health and well-being.

Describing how case managers perceive trauma-informed practices and policies within the organizations they work may help to provide vital information on how to prepare case managers to work with victims of trauma and minimize retraumatization. The data may also help to inform training of case managers on how to best work with clients who have experienced trauma. In addition, it may also provide information about human service case managers' level of preparedness in working with trauma victims and what other measures they feel can be taken to help them be better trauma-informed. Data on their perceptions of the trauma-informed practices and policies within human services organizations may also help organizations better provide a trauma-informed work culture for their employees and clients. In this chapter, I discuss background information related to the study, the research problem, the purpose of the study, and the research question. I also discuss the theoretical framework, the nature of the study, definition of key terms, scope and limitations, delimitations as well as the significance of the study.

Background

Trauma is a distressing or life-threatening event that causes immense fear, horror, or helplessness (American Psychological Association [APA], 2022; Kiser et al., 2008). It

happens when an individual is exposed to an external threat and is unable to cope with having experienced that threat (Bloom, 1999). Trauma changes the way one thinks, feels, remembers, learns, and makes sense of the world because it interferes with brain functioning (Bloom, 1999; Van der Kolk & Saporta, 1991). When symptoms of stress persists at least several weeks or longer and interferes with the individual's personal, family, social, occupational, or educational functioning, it can develop into trauma and possibly post-traumatic stress disorder (PTSD) (Australian Health and Welfare, 2020).

The National Council on Behavioral Health ([NCBH], n.d.) found that 70% of the U.S. population have experienced at least one trauma in their lifetime. In addition, 90% of clients in public behavioral health programs have experienced trauma and 60% of men and 50% of women will experience at least one trauma in their lifetime (NCBH, n.d.; U.S. Department of Veteran Affairs, n.d.). Experiencing trauma costs society in the United States $458 billion per year (Berger, 2019; CDC, 2023). Researchers have also found a direct link between trauma and diabetes, high blood pressure, heart disease, cancer, and chronic obstructive pulmonary disease (NCBH, n.d.).

The most common traumas experienced by women and youth in the United States are sexual assault and child sexual abuse (APA, 2022; U.S. Department of Veteran Affairs, n.d.). Men and boys are more likely to experience trauma related to accidents, physical assaults, combat, disaster, or witnessing death or injury (APA, 2022; U.S. Department of Veteran Affairs, n.d.). Racial and ethnic minority groups and families and immigrant youth and families are more likely to experience trauma due to poverty and discrimination (APA, 2022).

Three types of trauma that individuals may experience include acute, chronic, and complex trauma (McGonagle & Kessler, 1990; Missouri Early Care & Education Connections, n.d.; National Child & Traumatic Stress Network, n.d.; Pain, 2019; Ross et al., 2021). Acute trauma is trauma from a singular life event such as a death, job loss, or separation/divorce, or natural disaster (McGonagle & Kessler, 1990; Ross et al., 2021). Chronic trauma is prolonged exposure to traumatic events such as having a parent that gets violent when they drink which an individual is growing up and experiencing homelessness over and over (McGonagle & Kessler, 1990; Missouri Early Care & Education Connections, n.d.; National Child & Traumatic Stress Network, 2016). Complex trauma is exposure to multiple traumatic events sequentially or at the same time such as losing one's home and then being assaulted when living at a shelter (Missouri's Early Care & Education Connections, n. d.; Ross et al., 2021).

Trauma can happen at any point in an individual's life, but adverse childhood experiences (ACEs) can continue to affect individuals as adults (Van der Kolk, 1991). Some children may experience dissociations (defense mechanisms), which are protective factors for trauma. Dissociation involves disengagement, withdrawal, and daydreaming which are characterized as negative repercussions of trauma (Hunter-Dehn, 2021). These negative repercussions also include intrusive thoughts/recollections, hypervigilance, exaggerated startle, dissociation, mood disturbances, psychological reactivity to reminders, physiological reactivity to reminders, and distorted cognitions amongst many other symptoms (Hunter-Dehn, 2021).

Retraumatization happens when victims experience trauma symptoms from a

previous traumatic event triggered by a new situation or event (Alexander, 2012; Butler et al., 2018). It is related to poor treatment outcomes and more severe symptoms found to be related to trauma (Lawson et al., 2020). The timing of subsequent traumas and the type of traumatic event has an impact on whether the individual feels retraumatized. Retraumatization has also been found to be higher in individuals of color (Butler et al., 2018).

Systems, such having to answer questions about the traumatic event repeatedly to get services or support, that recreate this feeling or environment retraumatize victims (Newgent et al., 2003). Victims can also feel traumatized due to the response they may receive from victim serving agencies (Becker-Blease, 2017; Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). One way that systems retraumatize is by not providing the necessary resources to support victims of trauma (Becker-Blease, 2017; Zgoda et al., 2016). The lack of knowledge, awareness, and training are elements in the healthcare system that may perpetuate retraumatization (Schippert et al., 2021). It is important for these agencies to learn how to support those victims in a trauma-informed manner (Newgent et al., 2003).

The field of human services covers a large umbrella of services ranging from healthcare and counseling services to food and shelter (Human Services Edu, 2022; Martin & Haslett-Knudsen, 2012). Human services case managers deliver services to meet the needs and improve the quality of life of those that they work with (American Case Management Association, 2020; Commission for Case Manager Certification, 2022). Case managers also make sure that provided services are safe, effective, client-

centered, and efficient (Case Management Society of America, 2021; Commission for Case Manager Certification, 2022). The prevalence of trauma, adverse effects, and the cost of trauma has encouraged human service organizations to address trauma by creating trauma-informed programs (Classen & Clark, 2017; Lang et al., 2016). Trauma-informed practice considers the effects of trauma and the role that it plays in shaping human growth and development (Ezell et al., 2018). It is the utilization of relational, organizational, and trauma theory related to the strategies and interventions used in treatment and service delivery (Bent-Goodley, 2019; Shier & Turpin, 2017). The purpose of trauma-informed practice and policy is to consider the multiple facets of trauma and how they relate to the individual so that one does not retraumatize the individual (Maynard et al., 2019; SAMHSA, 2014). Case managers in human service organizations interact with different levels of ecological systems that influence the perceptions, attitudes, and behaviors that then affect how case managers interact with clients (Cornell University, 2019). The inclusions of trauma-informed policies and practices (TIPP) of a system, or lack of trauma-informed policies and practices, are important elements that guide how clients are interacted with and may results in positive or negative outcomes for that client (Dember et al., 1999). How case managers are influenced to use (or not use) trauma-informed policies and practices when having interactions with victims of trauma can have an influence on how individuals receive services, directly affecting the health and well-being of individuals. I found few researchers who studied case managers' perceptions of trauma-informed practice and policies in human services organizations where they provide case management services for trauma victims (Donahue, 2020; Ezell,

2019). Further research was warranted that could explore case managers' perceptions of trauma-informed care (TIC), trauma-informed practice (TIP), and trauma-informed policies within their organizations to address the problem of the negative repercussions of retraumatization experienced at the hands of organizations and systems that are meant to help victims of traumatic events.

Problem Statement

Sixty percent of adults have reportedly experienced abuse or family issues during childhood, and 60% of youth ages 17 and under have experienced or witnessed crime, violence, or abuse (North Dakota Department of Human Services, n.d.). Trauma has been linked with an increased likelihood to suffer from serious health problems, mental health issues, substance abuse issues, and serious financial problems costing the U.S. economy $671 billion dollars a year (CNTR, 2020). Further, organizational practices and treatment settings have been found to be a source of retraumatization for trauma victims (Bloom, 2017; Grossman et al., 2021). Retraumatization is the reexperiencing of trauma symptoms from a previous traumatic event triggered by a new situation or event (Alexander, 2012; Weiss, 2021). The experiences victims have had in courtrooms, child welfare systems, juvenile justice systems, and mental health treatment facilities have been found to elicit painful physical and emotional reminders of the trauma previously experienced that have caused them to interact with that system (Crenshaw et al., 2019; Katirai, 2020; Lamminen et al., 2020; Smith & Bowman, 2009). As a result of this retraumatization, victims of previous traumatic events experience nightmares, intrusive

thoughts or memories, anger, shame, withdrawal, isolation, and/or feelings of being unsafe in addition to various other symptoms (Loughran & Reid, 2018; SAMHSA, 2014).

TIC and TIP models emerged that aimed to change systems of care through psychoeducation on the delivery of services, psychological safety, and victim autonomy (Bryson et. al, 2017). Some public systems are incorporating TIP due to the increased potential for traumatized individuals to be retraumatized by standard practices and policies (Loomis, 2018), but these may not be consistent across organizations and services (Carello & Butler, 2015; Champine et al., 2019; Hanson & Lang, 2016). Therefore, the problem that was addressed in this study were the negative repercussions of retraumatization such as feelings of being unsafe, anger, guilt, shame, depression, and secondary trauma at the hands of organizations and systems that are meant to help victims of traumatic events due to those organizations and systems not being based in trauma-informed approaches. (Ezell, 2019; Huefner et al., 2020; Medenhall et al., 2018; Mersky et al., 2019; Salloum et al., 2018).

There is research regarding the negative outcomes to victims of trauma associated with retraumatization (Bloom, 2017;CNTR, 2020; Katirai, 2020; North Dakota Department of Human Services, n.d.; SAMHSA, 2014), the importance of TIC (Bryson et al., 2017; Hanson & Lang, 2016), TIP (Crenshaw et al., 2019; Ezell et al., 2018; Smith & Bowman, 2016), and trauma-informed policies (Herrenkohl et al. 2019; Rodriguez, 2016; Tuck et al., 2017). However, I found few researchers who studied case managers' perceptions of TIPP in human services organizations where they provide case management services for trauma victims (Donahue, 2020; Ezell, 2019). Further research

was warranted that could explore case managers' perceptions of TIC and TIPP within their organizations to address the problem of the negative repercussions of retraumatization experienced at the hands of organizations and systems that are meant to help victims of traumatic events.

Purpose of the Study

The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of TIPP across organizations and services. I sought to understand the level of training and education case managers had before providing services to victims of trauma. I also sought to understand the policies and practices implemented in human services organizations. I wanted to know whether case managers felt the current policies and practices were beneficial to themselves and victims of trauma. Researchers highlighted numerous implementation efforts of TIPP, but describing case managers' beliefs and attitudes about the practices and policies of their organization helped to inform human service agencies on best practices, policy, and training needs (Bryson et al., 2017; Ezell et al., 2018).

Research Question

What are case managers' perceptions of trauma-informed practice and policy in human service organizations?

Theoretical Foundation for the Study

Ecological systems theory (EST) was utilized as the theoretical framework for this study. EST is used to describe how social, environmental, political, and cultural systems help to shape human development (Guy-Evans, 2020). According to EST, the

individual is affected by five interrelated systems: microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Guy-Evans, 2020). Bronfenbrenner (1979) pointed out how an individual perceives their environment is important to their behavior and development and that this environment includes a variety of environments at different levels and interactions within and between these levels.

Trauma and retraumatization can be experienced within, or across, any of these systems (DeCandia & Guarino, 2015; Zhu et al., 2020). The microsystem is a direct environmental setting surrounding the developing individual. It includes the relationships directly affecting the developing individual such as those in the home (Bronfenbrenner, 1979; Martinello, 2019). The setting encompasses place, time, physical features of the setting, activity, participant, and role (Bronfenbrenner, 1977). One example of trauma at the microsystem level is intimate partner violence (IPV). Negative events within the immediate family would disrupt the microsystem level affecting the relationships in the mesosystem.

The mesosystem is a variety of microsystems interacting with one another (Bronfenbrenner, 1979; Härkönen, 2007; Martinello, 2019). The interaction between the various settings happens when individuals move into a new setting (Bronfenbrenner, 1977). These settings can include the workplace, peer groups, religious groups, social groups, or associations in the neighborhood (Bronfenbrenner, 1977, 1979). IPV victims may have negative experiences seeking services to assist them (Guy-Evans, 2020; Zhu et al., 2020). For example, court proceedings often become very adversarial because the victims often face questioning that feels accusatory (Katirai, 2020). This process causes

retraumatization and victims may choose to forgo court proceedings (Katirai, 2020).

The exosystem are the social structures that indirectly influences the individual's life (Martinello, 2019). Media becomes a part of the exosystem, where the individual is not a direct participant, in that it infiltrates the home via various external methods (Bronfenbrenner, 1979). Media can influence how individuals perceive intimate partner violence because the public has largely relied on the media to understand IPV as a social issue (Carlyle et al., 2014). Men are characterized as naturally aggressive and women who perpetuate IPV are justified for their behavior (Carlyle et al., 2014; Walker et al., 2020).

The macrosystem are institutions or social structures within the society that the individual lives are representative of a larger society and its belief systems (Bronfenbrenner, 1979). Immigrant women who experienced IPV have been found to make decisions about how to deal with the IPV based upon the accurate or misinformation of immigration rules and policies (Alaggia et al., 2012; Murshid & Bowen, 2018). Immigration policies may not be designed with the thought of mitigating factors that lead some individuals to have contact with immigration services (Alaggia et al., 2012; Murshid & Bowen, 2018).

The chronosystem, which was added during the second phase of the development of Bronfenbrenner's model (and the version of EST that I am using), refers to the environmental changes that occur over the individual's life (Guy-Evans, 2020). The chronosystem is focused on time and how relationships can change over time as well as the interaction between systems over time (Eriksson et al., 2018; Martinello, 2020).

Trauma can happen as a single event in time, multiple events on separate occasions, multiple events in one moment, or a single event/multiple events happening over a longer span of time (prolonged exposure to trauma; APA, 2021; Kiser et al., 2008). Time is also relevant to how an individual sees the future as well. It is likely for individuals to feel hopeless and pessimistic about the future because they are unable to think beyond where they are in the moment causing changes to their emotional states or thinking (Pill et al., 2017; Warmingham et al., 2021).

The interactions between each system of the EST are important because they highlight the ecological orientation from a phenomenological perspective (Bronfenbrenner, 1979). The most powerful influence on the individual happens at the microsystem level (Crawford, 2020; Härkönen, 2007). The family helps to shape growth and development by influencing each other's beliefs and behavior (Darling, 2007). The relationship between the individual and its community (e.g., neighborhood, church, and school) has a residual impact on the individual's relationships with their family. Given such, the communication and interaction form a dual relationship which constitutes as a mesosystem. However, the individual does not have to be present or actively participate in a setting for it to exert some type of influence over the individual (Bronfenbrenner, 1977; 1979). Therefore, the experience would take place within the exosystem.

Public policies and laws are designed to influence change at the micro-, meso-, and exosystem levels and activism can influence the policies created at the macrosystem level which should trickle down to all the levels below the macrosystem. However, inconsistencies and conflicting policies can result in retraumatization. For instance,

immigration policies may not be designed with the thought of mitigating factors that lead some individuals to have contact with immigration services (Alaggia et al., 2012; Murshid & Bowen, 2018). Time also plays a role in the effects of trauma over time, traumatic experiences being repeated, and how one heals (Carlson & Dalenberg, 2000; Härkönen, 2007).

Case managers in human service organizations interact with different levels of ecological systems that influence the perceptions, attitudes, and behaviors that then affect how case managers interact with clients (Cornell University, 2019). The inclusion of TIPP of a system, or lack of TIPP, are important elements that guide how clients are interacted with and may result in positive or negative outcomes for that client (Dember et al., 1999; Purtle, 2018). How case managers are influenced to use, or not use, TIPP when having interactions with victims of trauma can influence on how individuals receive services, directly affecting the health and well-being of individuals. Human service professionals who provide services to clients who have been traumatized are influenced by individual factors (family, personal experiences, education, etc.) as well as other levels encountered that the EST explains (Bronfenbrenner, 1979). The client is also interacting with many different levels explained by EST and some of these interactions/levels may or may not cause retraumatization (Guy-Evans, 2020). Therefore, the theory of EST does the most comprehensive job of explaining the topic explored through this study.

Nature of the Study

The nature of this study was a generic qualitative research design. Generic qualitative research is appropriate when used to understand an individual's perceptions

about their experiences (Jahja et al., 2021; Percy et al., 2015). Generic qualitative research provides flexibility in that it does not conform to the constraints of other methodologies yet combines elements of other qualitative methodologies to allow the researcher more flexibility with the design of their research, data collection, and analyses (Jahja, 2021; Kahlke, 2014; Percy et al., 2015). This qualitative research design was used to describe the perceptions about and experiences of case managers in human service organizations related to TIPP. I conducted semistructured interviews with human services case managers. The research design was appropriate for the extraction of themes found in the responses of case managers and the commonalities that can be found amongst various human service organizations.

Definitions

Acute trauma: Trauma from a singular life event such as a death, job loss, or separation/divorce, or natural disaster (McGonagle & Kessler, 1990; Ross et al., 2021).

Case management: A collaborative process that works to meet the needs of clients through advocacy, resource management, and communication (Case Management Society of America, 2021).

Chronic trauma: Prolonged exposure to traumatic events (McGonagle & Kessler, 1990; Missouri Early Care & Education Connections, n.d.; National Child & Traumatic Stress Network, 2016).

Complex trauma: Exposure to multiple traumatic events sequentially or at the same time (Missouri's Early Care & Education Connections, n.d.; Ross et al., 2021).

Retraumatization: Trauma symptoms from a previous traumatic event triggered

by a new situation or event (Alexander, 2012; Butler et al., 2018).

Stress: A psychophysiological response to a real or perceived pressure in the environment (Piotrowski et al., 2019).

Trauma: An extremely distressing or life-threatening event that causes immense fear, horror, or helplessness (Kiser et al., 2008).

Trauma-informed policies: System level policies that sets the tone and mission of the organization so that practices align with an organization's mission (SAMHSA, 2014).

Trauma-informed practice: The utilization of relational, organizational, and trauma theory related to the strategies and interventions used in treatment and service delivery (Bent-Goodley, 2019; Shier & Turpin, 2017).

Assumptions

The first assumption of this study was that participants would openly and truthfully answer the questions asked in the interview process (Roberts, 2020; Simon & Goes, 2013). Another assumption was that participants met the criteria of the study if they indicate that they do. These things require trust between the researcher and the participants in the study (Wilkins, 2018). The next assumption was that those who participated in the study would understand what trauma-informed practices and procedures are and if they were being implemented in their organization(s). It was also assumed that participants would be comfortable providing sensitive information about their experiences delivering trauma-informed services and the implementation of trauma-informed policies in their organizations as well as their perceptions about those organizational processes and procedures.

Scope and Delimitations

The scope of this study was case managers' perceptions of TIPP in human service organizations. Participants were those who were 18 years of age or older; were a case manager or equivalent position managing the cases of individuals and/or families; currently, or in the past, have worked in a human service organization that has TIPP in place; and who read and understand English. Because of the inclusion criteria of the study, the results of the study could not be generalized to those who would not fulfill those inclusion criteria. I also did not make conclusions that were outside of the parameters of the research question, interview questions, or interpretation of the research in relation to the theoretical framework and literature reviewed as part of the study (Ankale et al., 2020; Simon & Goes, 2013). I did not ask participants about their perceptions of training that they received about TIP. Therefore, I did not know the potential quality of the training that they received about TIP. The scope of the study was considered when interpreting the data and results as well as recommending future research and significance of the study.

Limitations

The study was time consuming due to difficulty recruiting participants who met the inclusion criteria (University of Southern California, 2022). I kept my committee chair informed of any issues that I had recruiting participants so that we could determine additional recruitment sites when needed and when it was appropriate for me to stop data collection. I used snowball sampling to help with this as this recruitment allows for those who participated (or who saw the recruitment materials) to tell others who may be

interested or meet the criteria.

I did not directly recruit participants who met the inclusion criteria of the study through human service organizations or emailing them directly. I posted recruitment materials to social media sites that were human service professional related and included information that those who saw the recruitment materials could forward the study details to others. This resulted in purposeful convenience sampling and snowball sampling to be used for this study. The primary weakness of purposeful convenience sampling is that research findings are only generalizable to the population characterized by the sample selection (Andrade, 2020). Snowball sampling is not random, and it is difficult to know whether the participants reflect an accurate representation of the target population (Naderifar, 2017; Raina, 2015). Despite the weaknesses of these sampling methods, I deemed them to be the most appropriate for this study and considered the limitations generated by utilization of these sampling methods in Chapter 5.

Due to ongoing COVID-19 concerns, I conducted interviews via Zoom. This could be a limitation as it may have resulted in some potential participants who met the inclusion criteria for the study to not participate due to technological issues such as limited internet accessibility. My study results were limited in relation to generalizability of results based on inclusion criteria used for the study.

Another potential limitation was that I did not ask participants about their perceptions of training that they received about TIP. Therefore, I did not know the potential quality of the training that they had received about TIP. However, I asked them if they had undergone training related to TIP as part of the demographic information that

I collected. I did this so that I would at least know if they had received this type of training or not as a lens to help interpret the data collection. However, I did not make any conclusions about the quality of that training in relation to their perceptions about TIP. This is addressed in Chapter 5 as a potential direction for future research.

Significance

According to the Centers for Disease Control (CDC)-Kaiser ACEs Study (Centers for Disease Control, 2023), 61% of adults have experienced at least one ACEs. ACEs include neglect, physical abuse, emotional abuse, sexual abuse, poverty, crime, and violence (Harvard University, 2021). One in every six adults has experienced four or more ACEs. My research study has the potential to add to the body of literature relating to case managers and TIPP within human services organizations. Describing how case managers perceive TIPP within the organizations they work may help to provide information on how to prepare case managers to work with victims of trauma and minimize retraumatization. The results may also be used to help inform training of case managers on how to best work with clients who have experienced trauma and may also provide information about human service case managers' level of preparedness in working with trauma victims and what other measures they feel can be taken to help them be better trauma-informed. Information about perceptions of the TIPP within human services organizations may also help organizations better provide a trauma-informed work culture for their employees and clients.

Summary

In Chapter 1, I provided an overview of the research study. I discussed

background information on the phenomenon being studied and provided a description of the theoretical background for this study. I also identified the research problem, the purpose of the study, and the research question. I provided a brief discussion on the assumptions, scope and delimitations, the limitations, and the significance of the study. Finally, I concluded with a summary of Chapter 1. Chapter 2 will provide a more detailed discussion of the literature and the theoretical framework used to guide my research study.

Chapter 2: Literature Review

Sixty percent of adults and 60% of those 17 and under have experienced abuse or witnessed crime, violence, or abuse (North Dakota Department of Human Services, n.d.). Trauma has been linked with an increased likelihood to suffer from health problems, mental health issues, substance abuse issues, and financial problems (CNTR, 2020). TIC and TIP models were created to lessen the possibility of having assistance services result in more trauma for individuals (Bryson et al., 2017). Though some public systems are incorporating TIP due to the increased potential for traumatized individuals to be retraumatized by current standard practices and policies (Loomis, 2018), these may not be consistent across organizations and services (Carello & Butler, 2015; Hanson & Lang, 2016). The problems that were addressed in this study were the negative repercussions of retraumatization due to those organizations and systems not being based in trauma-informed approaches (Ezell, 2019; Huefner et al., 2020; Medenhall et al., 2018; Mersky et al., 2019; Salloum et al., 2018).

The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of TIPP across organizations and services. Researchers highlighted implementation efforts on TIPP but describing case managers' beliefs and attitudes about the practices and policies of their organization may help to inform human service agencies on best practices, policy, and training needs (Bryson et al., 2017; Ezell et al., 2018). However, further research was warranted that could explore case managers' perceptions on TIC, TIP, and trauma-informed policies within their organizations to address he negative repercussions of retraumatization experienced at the

hands of organizations and systems meant to help victims of traumatic events.

In Chapter 2, I discuss the literature review search strategy for my research study. I discuss the ecological systems theory which was the theoretical foundation for this study. I also discuss the literature review related to key terms, variables, and concepts. Lastly, I provide a summary and conclusion.

Literature Search Strategy

I conducted my literature review search using the Walden University Thoreau search engine using the following databases: Health Services, PsyBooks, PsyArticles, APA PsycNet, Criminal Justice, Health and Environmental Research, Health Services and Sciences Research Resources, Public Administration Abstracts, and SAGE Journals. I also conducted an internet search through Google Scholar. The key terms included were *ecological systems theory, the ecology of developmental processes, the ecology of human development, Urie Bronfenbrenner, systems theory, sociocultural theory, field theory, behavior theory, theory of cognitive development, Jean Piaget, Kurt Lewin, Lev Vygotsky, sensorimotor approach, microsystem, mesosystem, macrosystem, exosystem, chronosystem, human services, social services, mental health services, child welfare, trauma-informed,* and *trauma.* These key terms were used in both the Walden University Thoreau search and the Google Scholar search. The primary date range used in the discussion of the literature related to the stated problem was 2015 to the present. However, I did search for information related to the theoretical framework, EST, back to the creation of the theory to ensure that I included seminal works about the theory.

Theoretical Foundation

EST was the theoretical framework for this study. EST is used to describe how social, environmental, political, and cultural systems help to shape human development (Guy-Evans, 2020). Bronfenbrenner (1979) suggested that how an individual perceives their environment is important to their behavior and development, which involves different levels and interactions within and between these levels. Therefore, the theory of EST was the most comprehensive in explaining case managers' perceptions of TIPP across organizations and services to help inform human service agencies (systems) on best practices, policy, and training needs. EST was appropriate for this study because it can be used to describe how social, environmental, political, and cultural systems help to shape human development (Guy-Evans, 2020). EST describes the interactions within and between each level which individuals may be retraumatized while receiving treatment (Bronfenbrenner, 1979; Guy-Evans, 2020).

Origin and History

EST was first introduced in 1979 by Urie Bronfenbrenner and includes concepts that were influenced by Lev Vytgosky's sociocultural theory, Kurt Lewin's field theory, and Jean Piaget's theory of cognitive development (Bronfenbrenner, 1999). The basic premise is that an individual's environment helps to shape their psychological development including attitudes and behaviors (Lewin, 1946; Piaget, 1976). Bronfenbrenner (1979) understood that the environmental context of behavior was as much important to human development as biological factors. The five interrelated systems (micro-, meso-, exo-, macro-, and chronosystem) were used to explain how

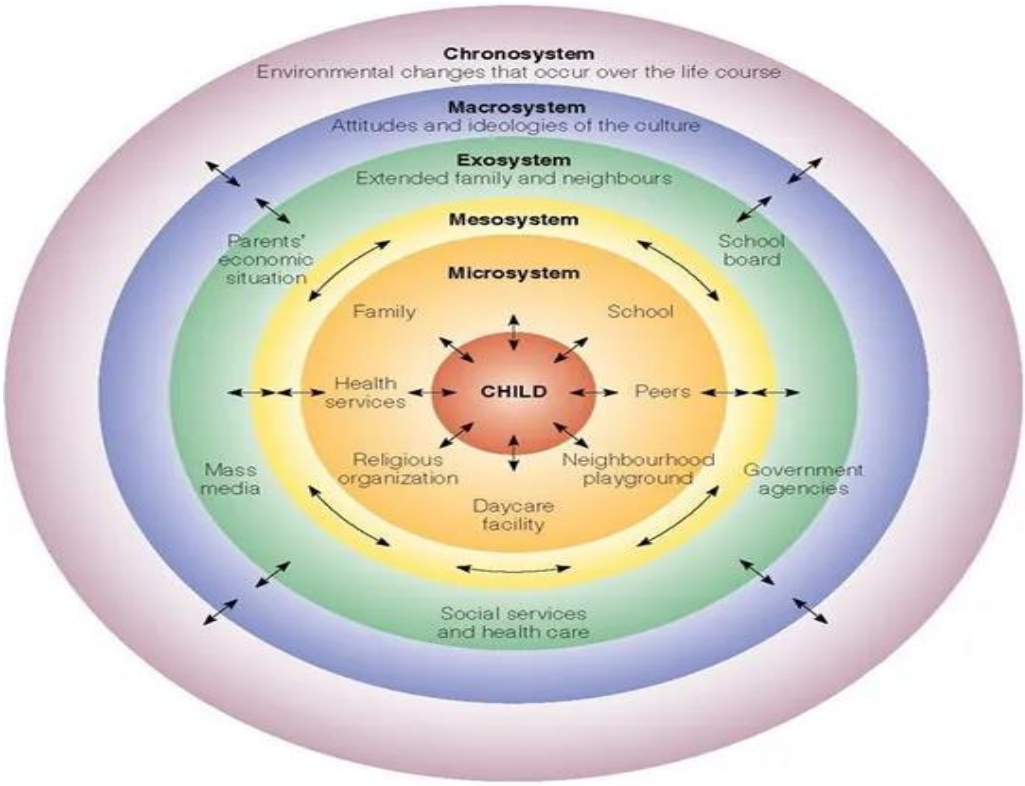
environments affect psychological development.

Components of EST

The components of EST include the individual, microsystem, mesosystem, exosystem, macrosystem, and chronosystem (Bronfenbrenner, 1977). Figure 1 is a visual representation of the components (levels) of Bronfenbrenner's EST. The double arrows represent the reciprocal relationships between the systems.

Figure 1

Ecological Systems Theory Model



Note. From *Bronfenbrenner's Ecological Systems Theory*, by O. Guy-Evans, 2020, Simple Psychology (https://www.simplypsychology.org/Bronfenbrenner.html)

Individual

The individual is the heart of the EST, and human development is part of a much larger context known as ecological systems (Martinello, 2020). There is a reciprocal relationship between all the systems in which the individual belongs as well as those that the individual has no direct contact (Bronfenbrenner, 1977). The individual has just as much influence on people and forces within these ecological systems as these people and forces in the systems have on the individual (Bronfenbrenner, 1979).

Microsystem

The microsystem is a direct environmental setting surrounding the developing individual. It includes the relationships directly affecting the developing individual such as those in the home (Bronfenbrenner, 1979; Martinello, 2019). The setting encompasses place, time, physical features of the setting, activity, participant, and role (Bronfenbrenner, 1977). Bronfenbrenner (1979) defined the microsystem as the activities, roles, and relations experienced by an individual. Experience is an important factor because the perception of events, objects, and the relations experienced by the individual will shape psychological development (Bronfenbrenner, 1979). Thus, these experiences give way to some form of communication with the occurring event, object, or person causing the individual to have influence on the elements within the microsystem. This is then categorized as reciprocity, which is important to the ecological systems model.

Mesosystem

The mesosystem is a variety of microsystems interacting with one another (Bronfenbrenner, 1979; Härkönen, 2007; Martinello, 2019). The interaction between the

various settings happens when individuals move into a new setting (Bronfenbrenner, 1977). These settings can include the workplace, peer groups, religious groups, social groups, or associations in the neighborhood (Bronfenbrenner, 1977, 1979). To further explain the mesosystem, an individual may get a job promotion which causes them to move into a new position with their employer. This transition is what Bronfenbrenner (1977) called a role transition and it creates change in the individual's social position as well as the setting. Bronfenbrenner defined the change in the new setting as an ecological transition. The individual becomes the direct connection between two microsystems, creating a mesosystem (Bronfenbrenner, 1977).

Exosystem

The exosystem refers to the social structures that indirectly influences the individual's life (Martinello, 2019). Bronfenbrenner (1977) explained the exosystem as an extension of the mesosystem. Although the developing individual is not directly involved within this setting, it affects the immediate environment of the individual (Eriksson et al., 2018). Two events must take place within the exosystem (Bronfenbrenner, 1977). In the first sequence, there must be a connection between events in the outside environment and the microsystem of the individual. Second, processes in the microsystem must be linked to developmental changes of a person within the setting (Bronfenbrenner, 1977). An individual's relations and events at work affect the members of his family and in turn affect how they respond and behave with one another.

Macrosystem

Macrosystems are institutions or social structures within the society that the

individual lives are representative of a larger society and its belief systems (Bronfenbrenner, 1979). Society's rules, laws, and public policies implemented by these institutions or social structures affect human development (Bronfenbrenner, 1979; Eriksson et al., 2018). Macrosystems include the beliefs and ideology of a cultural group, which includes some customs or ideologies that are unspoken but widely practiced (Bronfenbrenner, 1977). Cultural beliefs, socioeconomic status, and religion have an impact on the lifestyle and beliefs of an individual and these factors affect the outcomes within a macrosystem (Bronfenbrenner, 1977). Therefore, the developmental changes undergone by individuals who are well off differ from those in a low-income family.

Chronosystem

The chronosystem, which was added during the second phase of Bronfenbrenner's model, refers to the environmental changes that occur over the individual's life (Guy-Evans, 2020). The chronosystem is focused specifically on time and how relationships can change over time as well as the interaction between systems over time (Eriksson et al., 2018; Martinello, 2020). The system of time is noted in terms such as *change*, *time*, *history*, and *development* and time can cover a short or a long period (Härkönen, 2007). An individual's beliefs, values, ideologies, organizational policies, etc. also change over time to reflect developmental change, the acquisition of knowledge, and growth (Eriksson et al., 2018). As it relates to the individual, time is subjective and human growth and development is relative to how the individual is perceiving the event during the moment (Bronfenbrenner, 1977). Whether the event is ongoing or rapid also impacts how the individual perceives the event taking place in the

system and it is not limited to events happening across the various systems (Bronfenbrenner, 1977).

Interactions Between Systems

The interactions between each system of the EST are important because they highlight the ecological orientation from a phenomenological perspective (Bronfenbrenner, 1979). The most intimate and immediate setting is the microsystem, meaning the most powerful influence on the individual happens at the microsystem level (Härkönen, 2007). This influence takes place within the family relationship. If one individual within the environment experiences developmental growth, then so does the other; there cannot be one without the other (Bronfenbrenner, 1977, 1979). The reciprocal relationship can further be explained by discussing the relationship between an individual and their spouse. The family helps to shape growth and development by influencing each other's beliefs and behavior (Darling, 2007).

The individual at the center of the setting begins the interaction with other systems such as their neighborhood, school, family, and religious organizations (Guy-Evans, 2020). Consider the relationship between an individual and their religious institution. The relationship between the individual and the church also has a residual impact on the individual's relationships with their family. The communication and interaction between both microsystems form a dual relationship which constitutes a mesosystem. However, the individual does not have to be present or actively participate in a setting for it to exert some type of influence over the individual (Bronfenbrenner, 1977, 1979). Therefore, the experience would take place within the exosystem. The

experiences individuals have in the workplace also influence their relationships with their families (Darling, 2007). Individuals who have demanding work schedules may spend less time at home. Although this setting does not involve the other members of the family, there is less time spent with the immediate family. Therefore, the absenteeism of the individual will ultimately affect how the family interacts with one another.

Bronfenbrenner (1977) knew that these relationships were important to human development. He went a step further to explain the interactions at the macro level. For example, an individual who has just given birth at a local hospital is encouraged to bond with her newborn but is having some difficulties with breastfeeding. Suppose new policies do not allow for a lactation specialist to support the new mother (Bronfenbrenner, 1977). Such policies can affect child-rearing. When accounting for the element of time to this situation, it can change the way the mother and the baby bonds (Bronfenbrenner, 1977; Darling, 2007). Bronfenbrenner (1979) spoke of time in his early work, but he did not add the chronosystem until the second phase of EST when he realized the importance that time plays in the life of the individual and the interactions with the systems in EST.

Trauma and EST

Trauma occurs when an individual lacks the necessary skills to cope with an external threat that is overwhelming (Hunter, 2016; Music, 2018). Trauma symptoms vary and can be the result of biological, psychological, and social factors and any event causing extreme distress and discomfort can cause trauma (Maercker & Mehr, 2006). How an individual responds to a traumatic event is relative to their perception of the

event (Withers & Maloney, 2021). These events can include sexual violence, physical violence, IPV, witness to crimes or violence, natural disasters, accidents, medical illnesses, death, and divorce among many others (Smith & Patton, 2016).

Trauma and the Microsystem

Trauma relates to the ecological systems theory in the respect that it can be experienced within, or across, any system that an individual functions within (DeCandia & Guarino, 2015). Thus, the interactions that individuals have with/within their environment is a characterization of how individuals experience events in their life (Zhu et al., 2020). Negative life changing events within the immediate family would disrupt the microsystem level.

One example of trauma at the microsystem level is intimate partner violence (IPV). IPV involves violence between two individuals involved in an intimate relationship (Graham-Kevan et al., 2015). Socio-environmental factors like IPV influence human behavior and can lead to negative effects (Chesworth et al., 2019). Issues in physical health, mental health, and behavior are just a few of the negative effects associated with IPV (Chesworth et al., 2019). Chesworth et al. (2019) and Kiser et al. (2019) noted that an individual may be at risk for internalizing and externalizing behaviors which can include trauma symptoms such as depression, anxiety, withdrawal, antisocial behavior, issues with social relationships, issues with affect regulation, sleep issues, and cognitive functioning. In addition to IPV, a family with substance abuse issues, mental health issues, incarceration, and parental-separation or divorce can lead to trauma as well (Chesworth et al., 2019). These trauma experiences directly affect the

relationships at the mesosystem level.

The immediate family may be a source of retraumatization for the victim as well. Family support is said to help the individual cope with trauma and reduce trauma symptoms (Graham-Kevan, 2015; Gibson, 2008). However, when the family is non-supportive, it can cause retraumatization (Celik et al., 2018). Individuals may recant their disclosure of abuse or delay their disclosure (Celik et al., 2018). Researchers state that family rejection and denial are responsible for recantation or delayed disclosure putting them at risk for revictimization (Celik et al., 2018).

Trauma and the Mesosystem

When encountering systems at the mesosystem level, individuals of IPV may have negative experiences seeking services to assist them (Guy-Evans, 2020; Zhu et al., 2020). For example, a victim of IPV may seek services from the legal system. Court proceedings often become very adversarial because the victims often face questioning that feels accusatory (Katirai, 2020). Victims' decisions and actions during IPV can be used against them by their perpetrator's attorney. This process causes retraumatization and victims may choose to forgo court proceedings (Katirai, 2020). It was also reported that the victims may choose to stop disclosing due to the attitudes of the service providers (Katirai, 2020). Even attempting to access services such as finding shelter can be retraumatizing. The victim of IPV may feel stigmatized by having to live in a shelter and the process of registering for shelter services may feel invasive. These experiences affect the way the victims see other agencies in their community. They have difficulty trusting other service providers based on previous experiences (Klest et al., 2019).

Family courts also allow perpetrators to have a relationship with their children (Roberts et al., 2015). This puts the victim at direct risk for revictimization even if a protective order is in place (Roberts et al., 2015). Roberts et al. (2015) noted that 70% of protective orders are breached, less than 10% percent of cases are prosecuted, 51% of victims are revictimized within ten weeks after leaving a shelter, and 30% of women are killed by their perpetrator after separating.

Trauma and the Exosystem

Negative interactions with the media (including social media), government agencies, and other organizations and systems at the exosystem level also have the potential to result in trauma to the individual (Guy-Evans, 2020). Media becomes a part of the exosystem (individual is not a direct participant) in that it infiltrates the home via various external methods (Bronfenbrenner, 1979). Individuals may consume media by television, radio, social media apps, newspapers, journals/magazines, and/or the internet. The information consumed affects the consumer which then has influence on the immediate family (second-order effect) (Bronfenbrenner, 1979). It has also been noted that PTSD is known to be the common negative repercussion of exposure to mass media violence (Neria & Sullivan, 2011). Symptoms of PTSD include but are not limited to recurrent nightmares, exaggerated startle response, avoidance of reminders, and numbing (Neria & Sullivan, 2011).

Regarding the example of IPV, media can influence how individuals perceive intimate partner violence because the public has largely relied on the media to understand IPV as a social issue (Carlyle et al., 2014). Men are characterized as naturally aggressive

and women who perpetuate IPV are justified for their behavior (Carlyle et al., 2014). These characterizations of IPV further creates the notion that women IPV perpetrators must be responding to violence perpetuated against them first. However, this leaves male victims with feelings of shame, embarrassment, depression, anxiety, poorer reported health status, and isolation from social networks (Carlyle et al., 2014). Researchers have supported the claim that men experience more restrictions to services due to stigmas that do not characterize men as victims of IPV (Carlyle et al., 2014).

Trauma and the Macrosystem

The attitudes and ideologies at the macrosystem level are reflective of the culture of larger organizational systems. Experiences with certain cultural groups have the potential to result in trauma and retraumatization (Härkönen, 2007). Public policies and laws are designed to influence change at the micro-, meso-, and exosystem levels and activism can influence the policies created at the macrosystem level which should trickle down to all the levels below the macrosystem. However, inconsistencies and conflicting policies can result in retraumatization.

Immigrant women who experienced IPV have been found to make decisions about how to deal with the IPV based upon the accurate or misinformation of immigration rules and policies (Alaggia et al., 2012). Immigration policies may not be designed with the thought of mitigating factors that lead some individuals to have contact with immigration services (Alaggia et al., 2012). The perpetrator of the IPV may use their non-citizen status as a scare tactic to keep control of their partner. The women may also be fearful that they would become the subject of a child welfare investigation

(Alaggia et al., 2012). Again, their spouses or partners would also threaten to call child welfare as means of control (Alaggia et al., 2012).

Trauma and the Chronosystem

The chronosystem is representative of time which plays a pivotal role in the effects of trauma over time, traumatic experiences being repeated, and how one heals (Carlson & Dalenberg, 2000; Härkönen, 2007). Kiser et al. (2008) explained that people understand traumatic events in terms of the time before and after the event. Trauma can happen as a single event in time, multiple events on separate occasions, multiple events in one moment, or a single event/multiple events happening over a longer span of time (prolonged exposure to trauma) (Kiser et al., 2008). The consequences of prolonged exposure to trauma can include dissociative symptoms, reenactment and revictimization, suicidality, psychosomatic symptoms, and affective and anxiety disorders making trauma from prolonged exposure much more complex (Neria & Sullivan, 2011).

Time is also relevant to how an individual sees the future as well. It is not unlikely for individuals to feel hopeless and pessimistic about the future. Prolonged trauma leaves an individual unable to think beyond where they are in the moment, leaving them to think only of surviving (Warmingham et al., 2021). The brain is in a constant state of survival mode which leaves the individual unable to make rational and logical decisions (Warmingham et al., 2021).

IPV victims may endure prolonged exposure to trauma causing changes in their emotional states or thinking (Pill et al., 2017). Negative moods/states or thinking styles affect how individuals perceive the treatment that they receive when seeking services

(Graham-Evan et al., 2015). Newgent et al. (2003) pointed out that individuals may potentially decline to put themselves through the system because it is not beneficial to them and called this experience a "second insult." IPV survivors may need to seek child custody, child support, an order of protection, or even divorce (Katirai, 2020,). This experience of having to face their abuser in court can be retraumatizing to the victim. Victims may have their character questioned in a trial. Having a judge that lacks empathy and compassion for these victims can cause undo harm and retraumatization as well. Such lack of compassion and empathy results in victim blaming. IPV victims may not report to law enforcement due to unwarranted skepticism, gender bias, minimization, victim blaming, and sexual shaming. These determinants are reported to cause retraumatization (Decker et al., 2019).

Retraumatization

Individuals can be retraumatized by another traumatic or stressful event experienced within any level of ecological systems (Gibson, 2008). Retraumatization can also happen when they encounter a negative experience with the system (criminal, medical, mental health, family, social services, etc.) that they go to for help (Katirai, 2020; Newgent et al., 2003). Victims of traumatic events often find themselves met with attitudes, behaviors, and practices that project blame onto them instead of those that they were victimized by (Katirai, 2020). These actions may not be intentional, but they cause more harm to the victims.

IPV victims who are not believed sometimes recant leaving them vulnerable to revictimization (Newgent et al. 2003; Celik et al., 2018). Non-belief or support can

signify a second insult to victims resulting in decreased emotional stability and victims need social support to buffer trauma symptoms (Graham-Kevan et al., 2015). Outside of non-support or belief, the family members in the immediate setting may experience secondary trauma. This can be detrimental to the immediate family. IPV victims also reported feeling betrayed by the system, not taken seriously, degraded, and a loss of hope (Pratt-Eriksson et al., 2014). If victims do go through with reporting their abuse, the service providers that provide services to the victims can unintentionally retraumatize the victims.

The adversarial nature of court proceedings can also be retraumatizing to the victims (Katirai, 2020). Victims whose cases are dropped because of lack of evidence feel unheard and it was characterized as a new assault (Pratt-Eriksson et al., 2014). Victims feel forced to have to defend their need for sick leave to healthcare professionals and the legitimacy of their abuse to law enforcement (Pratt-Eriksson et al., 2014). Although perpetrators are aggressive, some victims are forced to have their children continue the relationship with the other parent (Roberts et al., 2015). Each of these injustices are being carried out at the mesosystem level.

During the discussion of trauma at the exosystem level, it was noted how the media frames IPV directly influencing the perceptions the public have on IPV (Carlyle et al., 2014). Not only has the media infiltrated the homes of the public, but it has also may cause the individuals in that home to formulate a perception of IPV. These two phenomena are simultaneously affecting the microsystem, mesosystem, and the exosystem (Bronfenbrenner, 1979).

Public policies at the macrosystem level reflect the ideologies and attitudes of larger organizations (Bronfenbrenner, 1979; Eriksson, 2018). In reference to immigration policies and child welfare, it was noted that children had been removed from the home in certain situations and undocumented immigrants feared deportation if they reported (Alaggia et al., 2012). The fear of children being removed from the home and deportation creates this cycle of continued abuse because some victims do not want to risk reporting (Alaggia et al., 2012. Therefore, they stay in abusive cycles and continue to be revictimized by their perpetrators. Instances where child welfare does become involved can further traumatize the children especially if they are removed from the home (Alaggia et al., 2012). Families become distrusting of the systems designed to protect them.

As it relates to the chronosystem, time seems to stand still for IPV victims and they feel that they are constantly reliving their abuse (Roberts et al., 2015). Multiple or ongoing trauma will affect everyone differently because it is subjective (Bronfenbrenner, 1979). The negative repercussion of ongoing trauma is more pervasive in that it may cause dissociations (Neria & Sullivan, 2011). A parent trying to protect themselves and their children from the perpetrator and the system may find themselves in survival mode leaving these individuals feeling hopeless about their future (Pratt-Eriksson et al., 2014; Warmingham et al., 2021).

Literature Review Related to Key Variables and Concepts

In the following sections, I discussed stress and the psychological impacts of stress. I discussed the trauma individuals sustain as a result of such stress. I provided a

summary of the various types of trauma, the prevalence of trauma, and how trauma affects brain development. Finally, I discussed the types of organizations that provide services to individuals of trauma and the reasons individuals may need to seek services from those organizations.

Stress

Stress is a psychophysiological response to a real or perceived pressure in the environment (Piotrowski et al., 2019). A prolonged exposure to stress can cause hormonal imbalances, weakened immune system, and an increased risk of cancer, disease, and death (Piotrowski et al., 2019). However, stress is a normal part of development (Auerbach & Miller, 2021). Individuals most often experience stress from daily tasks such as jobs, relationships, and living circumstances (Auerbach & Miller, 2021).

Individuals usually take some action to mitigate or eliminate that stress as it is an uncomfortable feeling (Auerbach & Miller, 2021). A positive mindset can help to mitigate stress. Individuals utilize it to turn stressful situations into learning moments (Luu, 2022). Family and social support helps individuals to develop coping strategies to combat stress. Family may also provide financial resources during hard times or compassion and empathy for emotional support. Individuals with social support are said to cope better than those who lack social support (Luu, 2022).

Stress is most often associated with fear and anxiety. Fear and anxiety are terms used interchangeably (Auerbach & Miller, 2021). However, some researchers maintain that the two are not interchangeable and there are stark differences between the two (Aly

& Green, 2010; Schulz, 2006) while other researchers noted that the two terms were ambiguous (Perusini & Fanselow, 2015). Anxiety relates to the emotional state that occurs when stress occurs (Auerbach & Miller, 2021; Schulz, 2006). Anxiety is a feeling of dread which could be considered a precursor to fear (Aly & Green, 2010). Fear is a response of imminent danger and is more pronounced than anxiety (Aly & Green, 2010).

Trauma

Trauma is an extremely distressing or life-threatening event that causes immense fear, horror, or helplessness (Kiser et al., 2008). Trauma happens when an individual is exposed to an external threat and is unable to cope with having experienced that threat (Bloom, 1999). Trauma changes the way one thinks, feels, remembers, learns, and makes sense of the world because it interferes with brain functioning (Bloom, 1999; Van der Kolk & Saporta, 1991). Part of understanding trauma is understanding that trauma can be caused by any type of event and what may be traumatic to one individual may not be traumatic to another (SAMHSA, 2014). This is because how the individual perceives the experience is what determines if it will be traumatic to the individual or not. The factors that affect the individual's perceptions are characteristics of the individual, the type and characteristic of the event, developmental processes, the meaning of the trauma, and sociocultural factors (SAMHSA, 2014).

Trauma is very much different from stress, anxiety, and/or fear in that it can be the result of one extreme situation and often results in long lasting negative effects (Van der Kolk & Saporta, 1991). Trauma is a more extreme response to a life-threatening event than just stress, anxiety, and/or fear and the threat to life does not have to be towards the

individual. It may be in relation to seeing the life-threatening experience that someone else experiences (Australian Institute of Health & Welfare, 2020). However, trauma can result from the experience of stress and anxiety. When symptoms of stress persists at least several weeks or longer and interferes with the individual's personal, family, social, occupational, or educational functioning, it can develop into trauma and possibly PTSD (Australian Institute of Health and Welfare, 2020).

Prevalence of Trauma

NCBH (n.d.) found that 70% of the U. S. population have experienced at least one trauma in their lifetime. In addition, 90% of clients in public behavioral health programs have experienced trauma and 60% of men and 50% of women will experience at least one trauma in their lifetime (NCBH, n.d.; U.S. Department of Veteran Affairs, n.d.). Trauma results in outcome that costs the United States $458 billion per year (Berger, 2019; CDC, 2023). Researchers have also found a direct link between trauma and diabetes, high blood pressure, heart disease, cancer, and chronic obstructive pulmonary disease (NCBH, n. d.).

The most common traumas experienced by women and youth in the U.S. are sexual assault and child sexual abuse (APA, 2021; U. S. Department of Veteran Affairs, n.d.). Men and boys are more likely to experience trauma related to accidents, physical assaults, combat, disaster, or witnessing death or injury (APA, 2021; U.S. Department of Veteran Affairs, n.d.). Racial and ethnic minority groups and families and immigrant youth and families are more likely to experience trauma due to poverty and discrimination (APA, 2021).

Types of Trauma

Acute Trauma. Acute trauma is trauma from a singular life event such as a death, job loss, or separation/divorce, or natural disaster (McGonagle & Kessler, 1990). Individuals are likely to recover more quickly after acute traumas than chronic traumas (Keller-Dupree, 2013). Acute trauma has been known to increase corticosteroid levels which can impair cognitive functioning causing individuals to have decreased memory and attention (Bogdanov et al., 2021; Vedhara et al., 2000).

Chronic Trauma. Chronic trauma is prolonged exposure to traumatic events (McGonagle & Kessler, 1990; Missouri Early Care & Education Connections, n. d.; National Child & Traumatic Stress Network, n. d.). Financial difficulties due to job loss, prolonged abuse, marital problems, and poverty are all considered chronic trauma (McGonagle & Kessler, 1990; Missouri's Early Care & Education Connections, n.d.; Yale Medicine, 2021). These ongoing experiences of trauma can be a predictor of negative psychological adjustment as it is persistent (McGonagle & Kessler, 1990).

Complex Trauma. Complex trauma is exposure to multiple traumatic events sequentially or at the same time (Missouri's Early Care & Education Connections, n. d.). Complex trauma is often ongoing, difficult to escape, occurs within a personal relationship, begins in childhood, and is kept secret (International Society for the Study of Trauma and Dissociation [ISSTD], 2020). Complex trauma changes the brain structure because it most often happens during childhood during critical points of brain development. The critical moments of development occur during the formative years (0-8 years of age) and trauma in the formative years most often involves someone with a

position of power or someone the child trusts (ISSTD, 2020). Examples of complex trauma are abuse, sex trafficking, domestic abuse, sexual abuse, and ongoing torture (ISSTD, 2020).

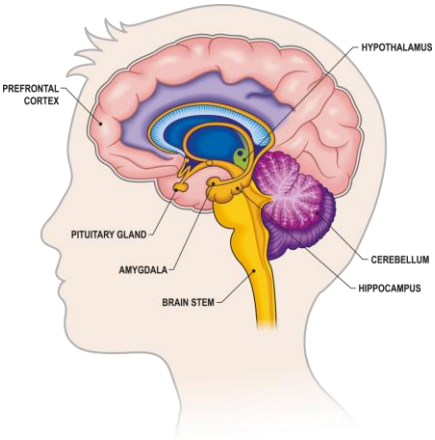
Trauma and Brain Development

Trauma can happen at any point in an individual's life, but ACEs can continue to affect individuals as adults (Van der Kolk, 1991). Poor school performance, lower reading achievement, and decreased verbal IQ can be carried into adulthood and have been found to be related to ACEs (Carrion & Wong, 2012). Part of the reason behind this is that trauma during childhood (developmental years) can cause developmental delays and physical change to how the brain works.

The prefrontal cortex, amygdala, and the hippocampus are three structures in the brain that are affected by trauma (see Figure 2; Carrion & Wong, 2012; McLaughlin, 2014). The amygdala is responsible for detecting and responding to threats in the environment. When activated, individuals can become more aware or hypervigilant to reminders of the trauma. The prefrontal cortex is also responsible for helping to control the reactions of the amygdala. However, the prefrontal cortex may not work properly due to trauma leaving children with pervasive fear and anxiety.

Figure 2

Brain Diagram



Note. From "Adverse Childhood Experiences and the Developing Brain," by E. Lewis, 2019, National Centre for Mental Health (https://www.ncmh.info/2019/08/22/adverse-childhood-experiences-and-the-developing-brain/)

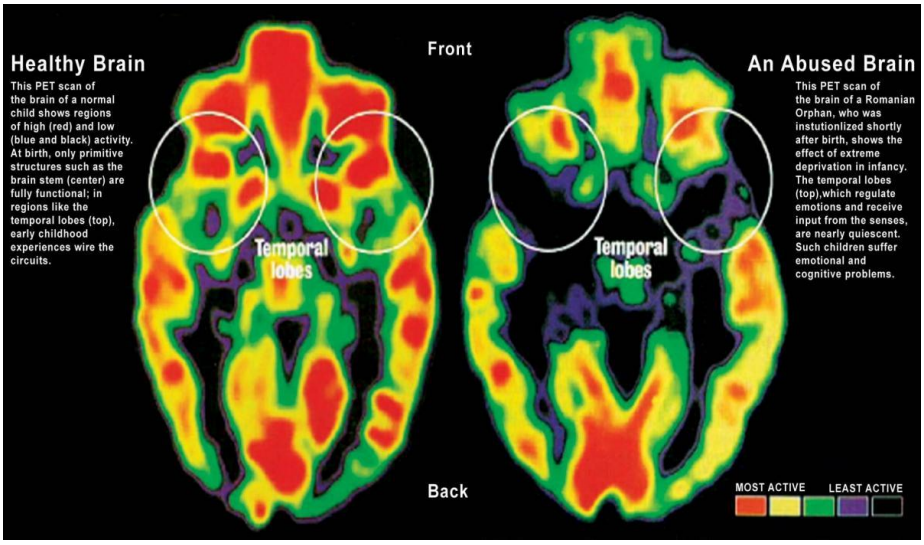
The hippocampus is responsible for learning and memory (Perry et al., 1995; McLaughlin, 2014). Trauma to the hippocampus at such a critical time of development affects how children learn and remember information in their environment (McLaughlin, 2014). Small hippocampus volume has been associated with individuals with depression (Majer et al., 2010). Given such, researchers have linked early adverse childhood experiences to psychiatric and somatic disorders in adulthood (Huang et al., 2021; Majer et al., 2010). The prefrontal cortex, amygdala, and hippocampus are most affected by trauma (Carrion & Wong, 2012; McLaughlin, 2014). Trauma is associated with diminished brain functioning due to the inability to regulate emotions and a heightened sense of danger.

Figure 3 is a visual representation of what the trauma in those areas looks like on

a positron emission tomography scan (Lyons et al., 2018). The prefrontal cortex is located at the front of the brain. The brain on the left shows high activity in the prefrontal cortex as evident in the red and yellow colors on the scan as opposed to the brain of someone who experienced abuse on the right. The brain of someone who experienced abuse shows more green and yellow color which signifies less activity than the healthy brain. The purple and black areas are the least active areas in the brain of someone who has experienced abuse. The brain on the right shows little to no activity in the area (temporal lobes) of the brain that regulates emotion and receives input from the senses (Lyons et al., 2018). The areas of the brain most responsible for performance and achievement, emotional regulation, and memory are the areas with decreased functioning as represented in the abused brain.

Figure 3

Healthy and Abused Brain



Note. From *Report of Act 43 Legislative Working Group for: Childhood Trauma/ACEs,*

by G. Lyons, B., Balint, D. Soucy, A. Donahue, K. Webb, & M. Mrowicki, 2018. (https://tinyurl.com/Vermont-legislature)

Trauma and Emotions

The formative years are a critical time of cognitive, social, emotional, and physical development and it ranges between the ages of 0-8 years of age (Lewis et al., 2006). Trauma during the formative years can cause significant distress because children are unable to properly regulate their emotions (Hunter-Dehn, 2021). Because children have difficulty identifying and understanding their emotions, they become unable to correct the maladaptive behavior(s) (Hunter-Dehn, 2021). Consequently, they may respond to distressing situations by acting out, with aggression and defiance, and mood swings (Hunter-Dehn, 2021; Webb, 2016). Some children may also experience dissociations which are defense mechanisms or a protective factor for trauma.

Dissociation involves disengagement, withdrawal, and daydreaming which are characterized as negative repercussions of trauma (Hunter-Dehn, 2021). These negative repercussions also include intrusive thoughts/recollections, hypervigilance, exaggerated startle, dissociation, mood disturbances, psychological reactivity to reminders, physiological reactivity to reminders, and distorted cognitions amongst many other symptoms (Hunter-Dehn, 2021). Between 12-29% of clients in outpatient clinical settings have been found to experience dissociation (Sook Kong et al, 2018).

Emotional abuse was found to be a predictor of hyperarousal and intrusion symptoms in adults (Lewis et al., 2006). Avoidant symptoms have also been found to be consistent with the victims' ongoing psychological abuse (Lewis et al., 2006). The

severity and length of the traumatic experience has been found to influence the long-term trauma symptoms (Evans et al., 2014).

Betrayal trauma occurs when there is prolonged trauma against a child by a parent or other authority figure that should love the child (McCormack & Issakidis, 2017). Betrayal trauma often leads to feelings of abandonment and distrust (McCormack & Issaakidis, 2017). Researchers found that 63% of the children (2.5 to 7.5 years of age) have insecure attachments with their mothers or caregivers (Hornor, 2008). Attachment issues have also been found to be much higher in high-risk populations (Hornor, 2008). Researchers further discovered that mothers who had been abused in childhood had difficulty with negative emotions and providing feelings of security to their children (Koren-Karie et al., 2004). The children then adjusted their feelings to fit the emotional level of the parent (Koren-Karie et al., 2004). Therefore, childhood trauma affects emotional regulation in children and adults, and it affects adult trauma victims' ability to effectively parent and provide a sense of belonging, self, and sense of emotional security to their children (Koren-Karie et al., 2004). This further demonstrates a pervasive cycle of emotional dysregulation within families.

Retraumatization

Retraumatization happens when victims experience trauma symptoms from a previous traumatic event triggered by a new situation or event (Alexander, 2012). Retraumatization is related to poor treatment outcomes and more severe symptoms found to be related to trauma (Lawson et al., 2020). The timing of subsequent traumas and the type of traumatic event has an impact on whether the individual feels retraumatized.

Individuals who experience trauma in childhood are at an increased risk of being retraumatized in adulthood (Lewis et al., 2006; Matta Oshima et al., 2014). Interpersonal difficulties put individuals at a greater risk for sexual and physical retraumatization (Deitrich, 2007; Matta Oshima et al., 2014). Individuals also run the risk of revictimization due to their inability to identify and cope with dangerous situations (Deitrich, 2007).

Retraumatization has also been found to be higher in individuals of color (Butler et al., 2018). Environmental factors such as poverty, crime, and family violence are factors that increase the risk of retraumatization (Klest, 2012). In addition to environmental factors, individuals run the risk of being retraumatized due to personal characteristics that mark them as easy prey or targets of peer bullying reinforcing retraumatization in the same manner as the previous incident (Brendgen et al., 2019).

Retraumatization by Social Structures and Processes. Trauma victims can sometimes feel a loss of control, power, or safety during a traumatic event (Boulder County DA's Center for Prevention and Restorative Justice, 2019). Systems that recreate this feeling or environment retraumatize victims (Newgent et al., 2003). Victims can feel traumatized due to the response they may receive from victim serving agencies (SAMHSA, 2014). It is important for these agencies to learn how to support those victims in a trauma-informed manner (Newgent et al., 2003).

One way that systems retraumatize is by not providing the necessary resources to support victims of trauma (Zgoda et al., 2016). The mental health system is important to victim recovery. Many victims who experience abuse during childhood most often have

difficulty trusting as adults. The process of forming the therapeutic alliance can be triggering or retraumatizing because it encourages a relationship of trust which is most often associated with their abuse (Lawson et al., 2020). As mentioned previously, child abuse most often involves a person of power/personal relationship (ISSTD, 2020).

The lack of knowledge, awareness, and training are elements in the healthcare system that may perpetuate retraumatization (Schippert et al., 2021). Dallam's healthcare retraumatization model explains the retraumatization process through four sub-processes: 1) hypersensitivity to threats to safety; 2) exposure to triggers; 3) post-traumatic stress reactions; and 4) avoidant coping (Schippert et al., 2021). Hypersensitivity to threats to safety encompasses the feelings of distrust, vulnerability, powerlessness, loss of control, low self-esteem, and difficulty self-advocating that victims experience while seeking services in the healthcare system (Dallam, 2010). These feelings are evident of trauma and are recreated when individuals are triggered (Dallam, 2010). Exposure to triggers in the healthcare setting may be any stimuli and/or situation that remind an individual of their abuse. Once an individual is triggered, they may experience stress reactions characterized as emotional and physical distress (flashbacks, anxiety, and/or panic) which are described as post-traumatic stress reactions in the Dallam's healthcare model (Dallam, 2010). Individuals will usually find a way to mitigate or alleviate their stress through denial, dissociation, submission, hostility, numbing, and/or healthcare avoidance (Auerbach & Miller, 2021; Dallam, 2010). This cyclical process may cause individuals not to return for services which can be characterized as an avoidant coping mechanism (Dallam, 2010; SAMHSA, 2014; Schippert et al., 2021).

There are numerous ways that the environment, processes, and systems that are in place can result in retraumatization. Various sensory stimuli within a healthcare setting may remind the victim of stimuli from the traumatic event (Dallam, 2010; SAMHSA, 2014). Medical treatment can seem invasive and resemble the loss of control victims experience during traumatic events (Schippert et al., 2021). Victims who experience anxiety due to retraumatization are more likely to avoid doctors and medical settings (Schnur et al., 2017).

Child welfare systems and juvenile justice systems may elicit painful physical reminders of trauma previously experienced for both parents and the child (Crenshaw et al., 2019; Lamminen, 2020; Smith & Bowman, 2019). Juveniles have recalled their experiences of being restrained in the juvenile justice system as scary, hurtful, and it reminded them of other negative experiences (Smith & Bowman, 2019). These are indicative of retraumatization (Alexander, 2012; SAMHSA, 2014). For children in child welfare systems, the act of being removed and placed in multiple foster care homes can be a reenactment of the initial removal from the home with their parent or caregiver (Miller et al., 1981). This experience can be retraumatizing.

Even organizations who are responsible for getting information out to the public may unwittingly add to the potential for retraumatization. The media perpetuates rape culture by portraying rape victims as responsible for their rape (Zgoda et al., 2016). Rape victims may feel reluctant to come forward and potentially experience retraumatization because of this messaging. Thus, victims blame themselves and help-seeking behaviors decrease in response to cultural stigmas (Dodd et al., 2021). If victims choose to continue

with legal prosecution, they may experience retraumatization due to the adversarial nature of court proceedings (Katirai, 2020). Victims may be reluctant to report or they forgo prosecution to avoid humiliation and ridicule throughout the court process (Katirai, 2020).

Human Services

Human Services encompasses a very broad field and is divided into three main sectors: nonprofit or Non-governmental organizations; governmental or public entities; and private sectors (Human Services Edu, n.d.). These organizations aim to improve the quality of life through improved service delivery, accessibility of services, accountability, and the coordination of services with other agencies (Human Services Edu, n.d.). They also focus on prevention and the mitigation of problems such as poverty, housing insecurity, and food insecurity (National Organization for Human Services, n. d.).

Types of Services Provided

The field of human services covers a large umbrella of services ranging from healthcare and counseling services to food and shelter (Human Services Edu, n.d.; Martin & Haslett-Knudsen, 2012). The human services field is divided into three main sectors of nonprofit or non-governmental organizations , governmental or public entities, and private sector organizations (Human Services Edu, n.d.). Within these sectors are specialized fields such as education, healthcare, behavioral/mental health, social services, income maintenance, employment training, rehabilitation, housing, recreation, and social development (Kramer, 2000). Some human service agencies provide financial services based on economic status while others may provide mental health services, food

assistance, protection from abuse, protection orders, and services for individuals with physical disabilities (Martin & Haslett-Knudsen, 2012). Human service agencies also design their services to help individuals find employment, housing and shelter, safety and disaster relief, and youth services (Moffat, 2011). These agencies often perform services with limited resources, limited providers, and limited funding (Kilwein & Smith, 2013).

Nonprofit/Non-governmental Organizations. Non-profit agencies have a mission to fulfill a specific need within their communities or society and they contract with public agencies to deliver those services (Despard, 2016). They are often dependent upon outside sources and donors to help sustain their organization (Despard, 2016). Non-profit organizations are organizations such as the American Red Cross, food banks, battered women shelters, etc. The American Red Cross provides resources for individuals and families affected by disaster, and they help prepare communities for disaster including coordinating blood donations (The National American Red Cross, 2022). Food banks distribute food to community food pantries which provide food to families in their communities (Feeding America, 2022). Battered women shelters provide shelter in an undisclosed location to help protect battered women from their abuser as well as other crucial resources such as counseling (Healthy Place, 2022).

Governmental/Public Entities. Governmental agencies are the largest sector of human service organizations, and they are backed by government funding (Human Services Edu, n.d.). Some governmental agencies that are considered human service organizations are the Department of Health and Human Services (HHS), U.S. Public Health Service, Department of Mental Health, Department of Youth Services, and the

Department of Justice (U.S. Department of Health and Human Services, 2015). These agencies have other entities underneath their umbrella of services that deliver direct services to the community.

State welfare agencies also fall underneath HHS. State welfare organizations are responsible for ensuring social well-being for children, families, individuals, and communities (DHR, n.d.). They are responsible for providing the elderly, individuals with disabilities, and children with protection from abuse, neglect, and exploitation. They are responsible for maintaining a registry for child abuse and neglect and managing cases, caseloads, and various other services (Alabama Department of Human Resources, n.d.). State welfare agencies are also tasked with providing access to state benefits for qualified individuals (U.S. Department of Health and Human Services, 2015). This includes state Medicaid and Medicare benefits, Supplemental Nutrition Assistance Program , Women's, Infants, and Children Program , child/elder abuse protection and prevention, and Temporary Assistance for Needy Families (U.S. Department of Health and Human Services, 2015).

The Substance Abuse Mental Health Services Administration (SAMHSA) is responsible for improving the lives of individuals and their families by mitigating the effects of mental health issues and substance abuse disorders (SAMHSA, 2021). The state levels of this mental health agency are responsible ensuring the mental health and well-being of individuals with mental illnesses, developmental disabilities, and substance abuse issues by providing mental health counseling and evaluations, substance abuse counseling programs, and rehabilitation services (Alabama Department of Mental Health,

n.d.). State mental health departments and private mental health professionals have the duty of supporting clients through the healing process. Mental health professionals foster a therapeutic relationship with their clients to build trust, respect, and honesty (Alabama Department of Mental Health, 2021).

The U.S. Department of Justice is responsible for protecting the safety of the public (U.S. Department of Justice, n.d.). State district attorney offices are often in contact with victims as they prosecute alleged perpetrators (Legal Information Institute, 2021). The district attorney's office may connect victims with other community resources to help meet their needs. They also provide a victim services officer to support the victims through the court process as well as communicating to them their victim rights (Montgomery County District Attorney's Office, 2021). The office may help them seek restitution due to injuries or expenses sustained due to their victimization (Montgomery County District Attorney's Office, 2021). The Office of Juvenile Justice and Delinquency Prevention serves states, local communities, and tribal communities by providing services to youth and their families (OJJDP, n.d.). They advocate for youth who have been victimized and aim to prevent juvenile delinquency. One way this is accomplished is by implementing policies at the federal level (OJJDP, n.d.).

Private Sector Organizations. Private sector organizations are not dependent upon donor funding and often offer the most competitive salaries as they may charge the user (or contracting group) for their services (Zelnick & Abramovitz, 2020). Due to increasing demand to provide much needed services to communities, private sector companies are being sought after to provide services to the public to the point that some

governmental agencies have begun contracting out their services to fill a gap (Sanger, 2001). State welfare agencies contract with private mental health providers to provide counseling for their clients, child support enforcement, and larger health insurance companies have contracted with states to provide their state Medicaid (Nutt, 2006; Waldman, 2012). It appears that the types of services rendered are comparable to non-governmental organizations and governmental/public organizations, but private sector organizations may be able to meet more of the demand as they are better able to hire professionals to meet the needs of the number of users of their services (Zelnick & Abramovitz, 2020).

Human Services Case Managers

Case management is a collaborative process that works to meet the needs of clients through advocacy, resource management, and communication (Case Management Society of America, 2021). Case managers aim to recommend and deliver services to meet the needs and improve the quality of life of those that they work with (American Case Management Association, 2020; Commission for Case Manager Certification, 2022). The philosophy of case management is derived from the idea that everyone benefits when clients are freely able to maintain autonomy, self-management, and reach their peak state of wellness (American Case Management Association, 2020). Case managers are an intricate piece to the services clients receive because they can link them with vital resources (Stanhope et al., 2009). Case managers also make sure that provided services are safe, effective, client-centered, and efficient (Case Management Society of America, 2021; Commission for Case Manager Certification, 2022). A part of their role is

also to assess and monitor the progress of their clients (Alabama Department of Human Resources, n.d.).

Clients Served by Human Service Organization/Programs

Financial Assistance. Individuals with low to moderate income often rely on human service organizations to help with financial stress (Frey et al., 2017). Environmental factors such as poverty would warrant an individual to seek out financial assistance to obtain financial stability (Tretheway, 1997). Temporary Assistance for Needy Families is a federal program that aids needy families in gaining financial stability (Xu et al., 2020). Temporary Assistance for Needy Families is money distributed to low-income families through state welfare agencies (Office of Family Assistance, 2022).

Non-profit organizations, like Catholic Social Services, aim to deliver a myriad of services to individuals in need, but financial assistance is a common service that they provide (Catholic Social Services, n.d.). Emergency financial assistance is provided to pay for utilities, rent, transportation, and medicine (Catholic Social Services, n.d.). Evans et al. (2019) teamed up with Catholic Social Services to administer an emergency financial assistance program to college students. They found that programs were not as effective without a case manager to help address underlying issues of financial stress (Evans et al., 2019). Case managers are better able to identify needed services and act as an intermediary between the client and the provider (Case Management Society of America , 2021).

Housing Assistance. There are many reasons why individuals may need housing

assistance, but approximately 3.5 million Americans experience homelessness each year (Morris & Strong, 2004). The U. S. Department of Housing and Urban Development distributes funds through public housing agencies to help combat homelessness and provide rental assistance to low-income families (U. S. Department of Urban and Housing Development, n.d.). Individuals can apply for public housing or housing choice vouchers (Section 8) which are not limited to public housing (U. S. Department of Housing and Urban Development, n.d.). The U. S. Department of Agriculture (USDA) (n.d.) works with public and nonprofit organizations to provide housing assistance in rural areas. They also work with private lenders to ensure loans for borrowers (USDA, n.d.).

Housing assistance such as transitional housing and rapid rehousing are just a few of the programs offered through nonprofit agencies family and individual needs through federal funding (Family Sunshine Center, n.d.). Transitional housing is utilized to help integrate clients back into the community while they receive additional support services such advocacy, counseling, life skills, and case management. Rapid rehousing is immediate placement into permanent housing if they have no other safety concerns (Family Sunshine Center, n.d.).

Individuals may not be familiar with the processes or know how to access housing services, which makes case management even more important (Morris & Strong, 2004). Case managers are considered frontline workers in human services organizations because they bear the responsibility of identifying housing programs and keeping individuals and families engaged in the services (Stanhope et al., 2009). Stanhope et al. (2009) noted that

prior abuse and trauma affected the mental health of individuals and their engagement in services. Case managers are tasked with anticipating consumer behavior in order to prevent disengagement (Stanhope et al., 2009).

Food Assistance. Food insecurity is an issue of poverty that both rural and urban areas continue to experience (Piontak & Schulman, 2014). The USDA (n.d.) offers programs such as the Supplemental Nutrition Assistance Program (formerly known as the Food Stamp Program), Special Supplemental Nutrition Program for Women, Infants, and Children , and the Summer Food Service Program to combat food insecurity. The Supplemental Nutrition Assistance Program and Women, Infant, and Children's WIC benefits are delivered through state human service agencies, but individuals have to meet certain income criteria to qualify (Alabama Department of Human Resources, n.d.; USDA, n.d.). State human services agencies employ case managers to determine one's eligibility for these food assistance programs and to follow up for recertification. Those individuals who do not qualify for these federally funded programs are left to find other programs to help with food assistance.

In such cases, case managers are an intricate part of navigating resources because they are often the individuals responsible for eliminating the barriers to the access of services (Case Management Society of America, 2021; Stanhope et al., 2009). Case managers may direct individuals to local food pantries. Feeding America is a 200-member organization that distributes food to over 60,000 food pantries nationwide (Feeding America, 2022). Food insecurity affects children, the elderly, and people of color at higher rates than other groups due to systemic inequities, socioeconomic status,

intimate partner violence, and mental health status (Feeding America, 2022; Sun et al., 2016). Sun et al. (2016) suggested that it was imperative for social services to be trauma-informed due to the link between trauma and hunger.

Legal Assistance. Legal assistance helps clients to secure protective orders from a perpetrator, child support, child custody, and legal representation (Bennet et al., 2004; Bouffard et al., 2016; Family Sunshine Center, n.d.). Although victim services are not just for women, women have utilized these services more than men and they reported fewer depressive symptoms when they have benefitted from such services (Bennett et al., 2004). However, Edmond et al. (2013) noted that many individuals are not aware of the services available to them.

Legal services may be offered by legal agencies, bar associations, victim services programs, or law schools at free or low costs (Bouffard et al., 2016). In cases of divorce from a perpetrator, the courts help to protect children and parents by establishing contact and parenting guidelines (Bouffard et al., 2016; Hartley et al., 2013). Legal services can intervene on a victim's behalf if they are experiencing homelessness or housing instability due to victimization (Bouffard et al., 2016; Hartley et al., 2013).

Legal aid may provide the victim with tenant rights and housing procedures, assistance in wrongful termination of employment due to absenteeism, and assistance obtaining unemployment and financial assistance (Bouffard et al., 2016; Hartley et al., 2013). Hartley et al. (2013) argue that case managers can aid their clients by having trained knowledge in civil legal issues so that they are able to see the victim's issues from a legal perspective and refer them for legal representation. Through the legal lens, one is

able to understand why legal assistance is important to victims of trauma and how legal assistance can further assist an individual in securing the aforementioned assistance.

TIPP

TIP considers the effects of trauma and the role that it plays in shaping human growth and development (Ezell et al., 2018). It is the utilization of relational, organizational, and trauma theory related to the strategies and interventions used in treatment and service delivery (Bent-Goodley, 2019; Shier & Turpin, 2017). Trauma-informed policies are system level policies that sets the tone and mission of the organization so that practices align with an organization's mission (SAMHSA, 2014). These policies ultimately create the culture and environment of the organization and its employees (SAMHSA, 2014).

The purpose of TIPP is to consider the multiple facets of trauma and how they relate to the individual so that one does not retraumatize the individual (SAMHSA, 2014). The prevalence of trauma, adverse effects, and the cost of trauma has encouraged human service organizations to address trauma by creating trauma-informed programs (Classen & Clark, 2017; Lang et al., 2016). However, researchers have realized that TIP alone do not boost positive outcomes (Chaffouleas et al., 2016; Maynard et al., 2019). The context in how trauma is addressed and carried out at the organizational level is as much a part of the equation (SAMHSA, 2014).

Components of TIPP

The shift towards TIC began between the 1990s and early 2000s (Classen & Clark, 2017). TIC is a standard of care for anyone working with individuals who have

encountered trauma including mental health and healthcare providers as well as teachers, lawyers, human resource personnel, criminal justice staff, case workers, shelter staff, nursing home staff, front desk personnel, administrative staff, and housekeeping staff as well (Bent-Goodley, 2019; Classen & Clark, 2017; Elliot et al., 2005). The terms *trauma-informed care* and *trauma-informed practice* are interchangeable and involve incorporating:

1. realization of the prevalence of trauma and the effects of trauma;
2. recognition of signs and symptoms of trauma;
3. a comprehensive and integrative response to trauma by individuals, programs, and systems; and
4. preventing retraumatization (Bryson et al., 2017; Classen & Clark, 2017; Portman-Thompson, 2020; Purtle & Lewis, 2017; Sullivan et al., 2018; Tebes et al., 2019).

Realization of the Prevalence of Trauma/Effects of Trauma. Trauma is a well-documented problem (Baetz et al., 2021; Bryson et al., 2017; Isobel & Edwards, 2017; Jankowski et al., 2019; Leitch, 2017; Orapallo et al., 2021; SAMHSA, 2014). It occurs over the lifespan but can begin in childhood (Wolf et al., 2013). Becoming trauma-informed requires that one recognizes that trauma exists and the negative effects of such trauma across time and that it often cannot be resolved in a short period of time (Bargeman et al., 2021; Butler et al., 2011; Wolf et al., 2013). TIP is being considerate of the staff in the care setting as well as the client (Isobel & Edwards, 2017; Leitch, 2017). The failure to recognize trauma history and the effects of that trauma can slow client's

progress or reduce the overall effectiveness of treatment (Butler et al., 2011; Isobel & Edwards, 2017).

Recognition of Signs and Symptoms of Trauma. Trauma-informed organizations understand the complexities of trauma, triggers, and vulnerabilities of clients (Wilson et al., 2013). By doing so, organizations can design trauma specific services to treat the client's current trauma symptoms (Bargeman et al., 2021). They may also be able to guide clients to other necessary services and appropriately interact with clients (Bargeman et al., 2021; Wilson et al., 2013). It is common for victims to respond with intense emotions and reactions to trauma (CDC, n.d.). Therefore, interactions with clients should include listening and encouraging clients to talk about their reactions when they are ready so that their feelings are validated (CDC, n.d.) Human service organizations can build trust by removing or reducing punitive action toward trauma triggered behaviors (Bargeman et al., 2021).

Comprehensive and Integrative Response. Organizations work to properly train staff and incorporate this knowledge into their organizational cultures, practices, and policies (Bargeman et al., 2021). Additionally, a comprehensive and integrative response involves working with clients to tailor a treatment plan specific to the client's needs and a sharing of power (Butler et al., 2011; Wilson et al., 2013). Shared power is equalizing power differentials by combining the knowledge and expertise of the clinician with the lived experience of the client (National Child Traumatic Stress Network [NCTSN], 2016). This approach recognizes that healing takes place within relationships (Wilson et al., 2013). Since trauma causes a disruption in healthy relationships, it is important for

clinicians to build an alliance with the client to foster resilience and psychological safety (Bath, 2015).

Prevention of Retraumatization. Organizations that understand the prevalence and effects of trauma, recognize the signs and symptoms, and provide comprehensive and integrative services are more effective in preventing retraumatization (Isobel & Edwards, 2017; Leitch, 2017; SAMHSA, 2014). Prevention of retraumatization is best achieved when organizations can meet all six principles of TIP (safety; trustworthiness and transparency; peer support; collaboration and mutuality; empowerment, voice, and choice; and acknowledgement of cultural, historical, and gender differences and issues) (CDC, 2023; Isobel & Edwards, 2017; SAMHSA, 2014). I provided more detail regarding these six principles in the next section.

Trauma-Informed Practice/Program Principles

Incorporating the following six principles is important for developing a trauma-informed practice and/or program: (a) safety; (b) trustworthiness and transparency; (c) peer support; (d) collaboration and mutuality; (e) empowerment, voice, and choice; and (f) acknowledgement of cultural, historical, and gender differences and issues (CDC, 2023; SAMHSA, 2014).

Safety. Psychological and physical safety of clients and staff is important in trauma-informed practices/programs (Sullivan et al., 2018; Wolf et al., 2013). Safety can be achieved by creating a welcoming space to promote healthy relationships between clients and human services providers (Levenson, 2017; Wolfe et al., 2013). Securing the property so that only those who are working at the organization or receiving services

have access provides an extra safety measure (Levenson, 2017). Examples include things like having the organization in a safe neighborhood, providing locked doors and limited access, and having security onsite.

Trustworthiness and Transparency. Organizational practices and decisions should be made with transparency to provide individuals and families a sense of trust. Transparency is open and honest decision making and disclosure that increases accountability and it acts as a value to incorporate in policies and evaluate policies (Ball, 2009). When service providers are open with clients, it conveys a sense of transparency, and the client does not have to anticipate uncertainty (Levenson, 2017). This exchange between the client and service provider will promote client autonomy and genuineness (Levenson, 2017).

Trust can be formed over time by fostering safety and ensuring transparency (Levenson, 2017). For example, when a therapist establishes a safe environment during sessions (physical safety and emotional safety), clients may develop trust and will disclose information that they may otherwise had not shared with individuals whom they have no trust (Collin-Vezina et al., 2020). Trust can take time to develop and, if the trust is broken and/or retraumatizing occurs, it can be easily destroyed (Manitoba Trauma Information & Education Centre, 2013).

Peer Support. Peer support is when individuals form relationships with those whom they believe can understand what they went through (the other person has experienced trauma as well) (Charuvastra & Cloitre, 2008; Collin-Vezina et al., 2020). Having support from peers that have experienced similar traumas can foster trust through

stable, reliable interpersonal connections that can help clients regulate their emotions (Charuvastra & Cloitre, 2008). It also gives them a sense of hope when they see others who have been through similar trauma "getting better" and having good things happen in their lives.

Collaboration and Mutuality. Collaboration and mutuality are achieved through the acts of valuing the relationship between the clinician and the client and honoring the client's experiences (Pemberton & Loeb, 2020). Collaboration and mutuality are goals for the relationships shared by clients with other clients and organization staff (Collin-Vezina et al., 2020). It infers that the client is the expert in their own life, which ensures that the client is able to maintain autonomy over their treatment (Butler et al., 2011; Wolfe et al., 2014). When clients are receiving services, clinicians make sure that the clients feel heard and they allow the client to take the lead with professional guidance (Butler et al., 2011). Clinicians also encourage self-expression, assertiveness, and a space to challenge belief systems, discussions, and experiences (Pemberton & Loeb, 2020).

Empowerment, Voice, and Choice. Empowerment, voice, and choice help to promote resilience for trauma recovery and self-advocacy (Kusmaul et al., 2015; Wilson et al., 2013; Wolf et al., 2014*). Empowerment* is a state of being empowered to do something: power, right, or authority to do something (Merriam-Webster, 2022). In terms of trauma, empowerment, voice, and choice builds upon the client's strengths and experiences to teach self-advocacy and assist in shared decision making, choice, and goal setting (Page & Czuba, 1999; SAMHSA, 2014).

The concept can employ clients to take control of their lives which also helps

clients to maintain autonomy in treatment because it focuses on the client's strengths (Bargeman et al., 2021; Collin-Vezina et al., 2020). Victims often feel powerless after they have been victimized (Fallot & Harris, 2002). It is important that clinicians recognize the power differential between themselves and their clients to not recreate the feeling of loss of control and help their clients use their power in relationships (Pemberton & Loeb, 2020).

Acknowledgement of Cultural, Historical, and Gender Differences/Issues. Cultural, historical, and gender concepts consider stereotypes and biases and how these can lead to retraumatization (Butler et al., 2011; SAMHSA, 2014). These stereotypes and biases are based on gender, race, religion, sexual orientation, age, geography, and ethnicity (SAMHSA, 2014). Trauma-informed organizations seek to provide unbiased services that are diverse and culturally competent (Pemberton & Loeb, 2020; SAMHSA, 2014).

Organizations that effectively incorporate these concepts create policies and practices that promote the healing of historical trauma and they incorporate the racial, ethnic, and cultural needs of the people they serve (SAMHSA, 2014). Policies rooted in social inequities can be further traumatizing for clients. Populations such as the elderly, children, veterans, religious, ethnic minorities, and the LGBTQ have vulnerabilities that require special attention to their needs (Butler et al., 2011). The stressors related to being a member of these groups should be considered when creating policies at the organizational level (Butler et al., 2011).

Culture/History. Cultural considerations acknowledge the victims' cultural

values, beliefs, and practices (Children's Hospital of Philadelphia, 2021). Historical trauma is the multigenerational, collective experience of psychological and emotional injury of communities and in descendants (SAMHSA, 2014). Ethnic minorities, legal immigrants, and undocumented individuals may feel rejected due to social and political climates that perpetuate rejection of these individuals (Pemberton & Loeb, 2020). Immigrants also face stigmas surrounding mental health (Butler et al., 2011). Histories of violence and human rights abuses create fear (Butler et al., 2011). Native Americans were victims of violent colonization that affected traditional ways of childrearing, family structure, and relationships and disrupted the sense of community within the tribe (SAMHSA, 2014; Stamm et al., 2004). This then leads to the discussion of the cultural concepts of trauma.

Since trauma is subjective, cultural beliefs can have an impact on the meaning that victims make of their trauma (Children's Hospital of Philadelphia, 2021). Some cultures may view trauma as a punishment or a rite of passage (Children's Hospital of Philadelphia, 2021). Stamm et al. (2004) also pointed out that cultural concepts of trauma can be in the past or currently happening. Cultural trauma can include denying a group to engage in religious practices or access to public spaces (Stamm et al., 2004).

Gender/Sexuality. Gender differences and issues reflect the trauma experienced due to sexism and it acknowledges the differences in how males and females experience trauma as well as the different rates at which that trauma is experienced (Epstein & Gonzalez, n.d.; NCCD Center for Girls and Young Women, 2010). Viewing trauma through a gender lens highlights the role of gender in the rate of trauma experienced and

how it is experienced (Epstein & Gonzalez, n. d.; NCCD Center for Girls and Young Women, 2010.). For example, males do not report sexual abuse, sexual assault, physical punishment, or psychological distress as often as girls (NCCD Center for Girls and Young Women, 2010). However, males are more likely to experience non-sexual assaults, accidents, illness, injuries, and witness to death or injury (NCCD Center for Girls and Young Women, 2010). This also applies to gender identity and sexuality. Individuals who are LGBTQ report trauma at a higher rate than other groups (Epstein & Gonzalez, n.d.). Social climate again can play a role in how we see trauma perpetuated against females and the LGBTQ community (Pemberton & Loeb, 2020).

TIPP Implementation and Effectiveness in Human Service Organizations

TIPP in human service organizations begins with changing the organizational culture, implementing agency policies, and then providing training to all staff (Bargeman et al., 2021; Menschner & Maul, 2016). Implementing TIPP at the organizational level includes six key concepts: (a) leading and communicating about the transformation process; (b) engaging clients in organizational planning; (c) training clinical and non-clinical staff; (d) creating a safe environment; (e) preventing vicarious trauma in staff; and (f) hiring a trauma-informed workforce (Menschner & Maul, 2016). Experts recommend that these organizational changes take place before implementing TIP (Menschner & Maul, 2016).

Leading and Communicating Transformation. Leading and communicating about the transformation process requires that leadership support their staff. This also involves communicating why these changes are necessary so that they promote buy-in

from the staff (Menschner & Maul, 2016). Conversations on how to become trauma-informed are needed within different levels of the organization and, without it, change will not last (Bloom, 2017; Bloom & Sreedhar, 2008).

Policy and practice should support staff and the clients that they serve (Bowen & Irish, 2020; Bryson et al., 2017). Human service providers advocate for communities ridden with violence, substance use, and child maltreatment (Kawan & Martinez, 2016). Advocating sometimes includes working with legislators and fighting for coverage of trauma treatment (Kawan & Martinez 2016). Researchers have found it to be rare, or almost non-existent, for policies to reflect all six trauma principles (Bowen & Irish, 2020). Policy mapping could be a solution to better implementing policy changes and ensure that all six trauma principles are in existence throughout the organization (Bowen & Irish, 2020).

The effectiveness of TIPP is dependent upon the prioritization of TIC by leadership staff that supports advanced training, listening, program evaluation for improvements, and aligning policy and practice with principles of TIP (Bryson et al., 2017). Evaluation is the understanding of the effectiveness of practice and improvement (Herbert, 2015). It ensures that there is accountability for program outcomes and it legitimizes marginalized perspectives (Herbert, 2015). Policies and procedures are the core of a trauma-informed organization and should consist of TIP in admissions, screening and assessment processes, informed consent, treatment planning, referrals, confidentiality, discharge, and other services (SAMHSA, 2014). Client needs are consistently changing and new science emerges (SAMHSA, 2014). Therefore, program

evaluation must occur regularly and policies and services should be updated to prevent retraumatization (SAMHSA, 2014).

Engaging Clients in Organizational Planning. A stakeholder committee should be utilized to engage clients in organizational planning because individuals who experienced trauma firsthand are able to provide valuable information (Menschner & Maul, 2016). Sullivan et al. (2018) highlighted evidence that supports the effectiveness of empowerment practices in restoring personal, interpersonal, and social power to domestic violence victims. Empowerment practices provide victims with community resources, support and respect, safety planning, and rights and options (Sullivan et al., 2018). Empowerment practices helped domestic violence victims to have decreased depressive symptoms and increased self-efficacy mainly due to trained staff providing psychoeducation about trauma, normalizing trauma, and identifying new ways to cope (Sullivan et al., 2018). By involving clients in the planning process to reduce retraumatization, they are able to be empowered and give feedback to the organization about how well it is doing and/or what improvements need to be made.

Training Clinical and Nonclinical Staff. Training is necessary for clinical as well as non-clinical staff in relation to the implementation of TIPP (Bargeman et al., 2021; Menschner & Maul, 2016). The training should include an explanation of the reorganization, changes in policies/procedures, the reasoning behind the changes, detailed information about the signs and symptoms of trauma, and specific training about avoiding retraumatization through their actions as they support clients (Bargeman et al., 2021). Provider trauma training and trauma training for front line staff enhances the

effectiveness of TIPP implementation (Baetz et al., 2021; Von Dohlen et al., 2019).

When mental health practitioners are trained properly, they are less inclined to use labels and less rigid in their approaches with clients. They have also been found to listen more and pay more attention to client needs (Dublin et al., 2021). Repeated and direct confrontation with adaptive challenges is important to TIPP effectiveness as well as staff training other staff because they both promote positive changes in knowledge, beliefs, and behaviors (Bryson et al., 2017; Jankowski et al., 2019; Orapallo et al., 2021).

Creating a Safe Environment. Safety is another component important to the implementation of TIPP. As previously discussed, emotional and psychological safety is important when treating victims who have been traumatized (Sullivan et al., 2018; Wolf et al., 2013). Having consistent organizational policies on how reports of abuse will be addressed, de-escalation strategies, and keeping victims informed of rules, procedures, and expectations are important elements of providing safety through consistency (Butler et al., 2011).

Preventing Vicarious Trauma in Staff. Secondary stress is trauma symptoms exhibited as a result of repeated exposure to the experiences and trauma stories of victims (Wolf et al., 2014). Secondary stress experience by staff can be prevented by providing staff with support and supervision (Wolf et al., 2014). Organizations with cultures more supportive of trauma-informed employees are more effective in implementing TIPP changes in the organization (Dublin et al., 2021).

Hiring Trauma-informed Workforce. The allocation of resources and funding are also important to the effectiveness of TIPP (Bryson et al., 2017; Dublin et al., 2021).

When more resources are allocated on the front-end, larger scale organizational changes can produce longer and deeper changes to organizational culture (Bryson et al., 2017; Dublin et al., 2021). Hiring trauma-informed staff is necessary in continuing to implement the other five key concepts and the importance of properly trained staff, including identifying secondary stress in themselves, continues to be reiterated throughout the literature (Baetz et al., 2021; Butler et al., 2011; Dublin et al., 2021; Menschner & Maul, 2016; Von Dohlen et al., 2019; Wolf et al., 2014).

Summary and Conclusions

The cost of trauma in the U. S. is $671 billion a year (CNTR, 2020). Public systems have begun implementing TIPP due to the increased potential that individuals will be traumatized through practices and policies (Loomis, 2018). However, the practices and policies may not be consistent across organizations and services (Carello & Butler, 2015; Hanson & Lang, 2016). Therefore, the research study outlined in Chapter 2 was used to understand case managers' perceptions on TIPP in human service organizations. Case managers' beliefs and attitudes about the practices and policies of their organization helped to inform human service agencies on best practices, policy, and training needs (Bryson et al., 2017; Ezell et al., 2018).

An individual's environment helps to shape their psychological development including attitudes and behaviors (Lewin, 1946; Piaget, 1976). Bronfenbrenner (1979) described the environmental context of behavior through five interrelated systems (*micro-, meso-, exo-, macro-, and chronosystem*). Trauma can be experienced within, or across, any system that an individual functions within (DeCandia & Guarino, 2015). Thus, the

interactions that individuals have with/within their environment is a characterization of how individuals experience events in their life (Zhu et al., 2020). Therefore, it is understood that individuals can be retraumatized by another traumatic or stressful event experienced within any level of ecological systems (Gibson, 2008).

Researchers have indicated that TIPP is instrumental in reducing trauma symptoms (Baetz et al., 2021). Researchers have also shown that staff trauma training is instrumental in promoting organizational safety climate and morale, managerial staff support, teamwork climate and collaboration, and staff compassion satisfaction (Dublin et al., 2021). Furthermore, staff training other staff promoted increased knowledge, positive beliefs, and positive behaviors (Bryson et al., 2017; Jankowski et al., 2019; Orapallo et al., 2021). On the contrary, there is no definitive or universal definition on what TIPP is and how to train students and practitioners in trauma competencies (Baetz et al., 2022; Sullivan et al., 2018). This research helped to identify the relevancy/need for TIPP as it relates to case managers in human services. It also added knowledge to the body of literature that already exists.

Chapter 3: Research Method

The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of TIPP across organizations and services. Researchers have highlighted implementation efforts on TIPP, but describing case managers' beliefs and attitudes about the practices and policies of their organization may help to inform human service agencies on best practices, policy, and training needs (Bryson et al., 2017; Ezell et al., 2018). Further research was warranted on case managers' perceptions on TIC, TIP, and trauma-informed policies within their organizations to address the negative repercussions of retraumatization experienced at the hands of organizations and systems meant to help victims of traumatic events. In Chapter 3, I discuss research design and rationale, role of the researcher, and the methodology. I also discuss issues of trustworthiness and ethical procedures.

Research Design and Rationale

The research question guiding this study was "What are case managers' perceptions of TIPP in human service organizations?" A generic qualitative research methodology was determined to be the best fit for this study. Generic qualitative research is appropriate when used to understand an individual's perceptions about their experiences (Jahja et al., 2021; Percy et al., 2015). Generic qualitative research is flexible, can be applied to existing theories, and provides a background for exploring research questions not suitable for traditional qualitative methodologies (Harris & Phillips, n.d.). The weaknesses of generic qualitative research are lack of theoretical backing, minimal literature defining the approach, and mixing elements of various other

methodologies, which may cause confusion among elements of the research (Harris & Phillips, n.d.). However, because generic qualitative research does not conform to the constraints of other methodologies yet combines elements of other qualitative methodologies, this allows more flexibility with the design of their research, data collection, and analyses (Jahja et al., 2021; Kahlke, 2014; Percy et al., 2015). This qualitative research design was used to collect, code, and analyze data to describe the perceptions and experiences of case managers in human service organizations related to TIPP. It was the most appropriate of the research designs for my study as it does not have the limitations of the other qualitative designs.

A phenomenological research design was considered because it is used to understand the lived experiences of individuals and the meaning individuals make of those experiences (Alase, 2017). But a phenomenological study was not appropriate because its data collection process and analysis is more structured than the general qualitative approach and it requires that the interviewer has a true and deeper understanding of the participants' experiences (Alase, 2017). The most notable element of phenomenological research is that it is used to understand affective, emotional, and intense human experiences (lived experiences) and not the subjective perceptions of participants (Emiliussen et al., 2021; Worthington, 2013). A case study design was also not appropriate because it is more focused on an individual or multiple individuals over a period of time (Creswell et al., 2007; Ebneyamini et al., 2018). Due to the research question posed in this study, it did not require participants to be studied over a longer period of time.

Role of the Researcher

As the researcher, my role was that of an observer-participant (Austin & Sutton, 2015). Observer-participants identify themselves as researchers and interact with the participants but do not claim to be an actual participant (Orellano & Fang, n.d.). My role as the observer-participant was fulfilled by conducting semistructured interviews with the research participants. I was the primary instrument for data collection and analysis. I collected, analyzed, and interpreted the data using the procedures outlined throughout Chapter 3.

To avoid unintentional coercion to participate and/or issues with working or personal relationships, I did not recruit or collect data from individuals with whom I have previous work or personal relationships. I also wanted to ensure that I avoided researcher biases than can be more apt to exist when the researcher has another relationship with the participant outside of the research study (Chenail, 2011). The participants were presented with an explanation of the goal of the researcher and I did my best to remain unbiased and neutral during the data collection, analysis, and interpretation process (Bell-Martin, 2019; Sauro, 2015). Other researcher biases can include prior knowledge of the population being studied, confirmation bias, question-order bias, and leading questions and wording bias (Chenail, 2011; Shah, 2019). Confirmation bias is interpreting data to support the hypothesis or omitting data that does not favor the hypothesis (Shah, 2019). Question-order bias occurs when participants' responses to subsequent questions are influenced by prior questions (Shah, 2019). Leading questions and wording bias prompts participants' responses in the direction of favorable outcomes (Shah, 2019).

I managed researcher bias through bracketing. Bracketing is a process of self-awareness that allows the researcher to be conscious of their biases, past experiences, and emotional reactions (Baksh, 2018; Starks & Trinidad, 2007; Tufford & Newman, 2010). One way to carryout bracketing is to keep detailed notes of my experiences and responses, thoughts, and preconceptions throughout the study (Dörfler & Stierand, 2020; Starks & Trinidad, 2007; Tufford & Newman, 2010; Weatherford & Maitra, 2019). This can be done by keeping a reflexive journal (Patnaik, 2013; Weatherford & Maitra, 2019). The reflexive journal can be used before, during, and immediately after the interview to document attitudes likely to influence data and observations, thoughts, and interpretations following the interview (Patnaik, 2013). When one is aware of their preconceptions, they are able to be more objective so that they do not allow their assumptions to influence data collection and analysis (Döfler & Stierand, 2020; Tufford & Newman, 2010). Finally, I consulted with colleagues and mentors throughout the data analysis process while making note of how my thoughts and ideas evolved and changed (Johnson et al., 2020; Starks & Trinidad, 2007). Utilizing notes or memos can serve as a paper trail to track emerging ideas or impressions of what the data means, how they relate to one another, and how my understanding is shaped by the data (Maher et al., 2018; Starks & Trinidad, 2007).

Methodology

Participation Selection Logic

Population

For this study, I recruited human services case managers who have had training in TIP and/or policy. Human services professionals are social service professionals that

provide an array of services to individuals who may be in need of housing and food (Chron Contributor, 2021). Human services professionals may also work with victims and individuals with disabilities (Chron Contributor, 2021). Human services professionals are employed in nonprofit organizations, for-profit social service companies, and government agencies (U.S. Bureau of Labor Statistics, 2022). Human services professionals can include health education specialists, community health workers, counselors, correctional treatment specialists, probation officers, school and career counselors and advisors, social and human service assistants, and social workers (U.S. Bureau of Labor Statistics, 2022). According to the U.S. Bureau of Labor Statistics (2022), community and social service occupations are expected to grow by 12%, adding 346,900 jobs in the next 10 years.

Sampling Strategy

Participants were recruited using a combination of purposive and snowball sampling. Purposive sampling allows access to individuals with the experience and/or knowledge that the researcher is attempting to gather (Campbell, 2020; Suri, 2011). Snowball sampling was also used to allow for those who have participated (or saw the recruitment materials) to tell others who may be interested or meet the criteria for participation (Naderifar et al., 2017).

Sample Size and Saturation

Saturation is important to reach in qualitative research (Boddy, 2016; Guest et al., 2020; Malterud et al., 2016; Mason 2010). Saturation is reached when new information does not shed any new light on the phenomenon or issue being studied (Hennink &

Kaiser, 2022; Mason, 2010). Researchers have indicated that saturation in qualitative research can be reached with as few as eight participants or it may take many more depending on the topic (Boddy, 2016; Dworkin, 2012; Guest et al., 2020; Mason, 2010). Therefore, I planned to recruit and interview a minimum of eight participants, and I expected to reach saturation by 15 participants. I shared information with my chair and committee as I went through the data collection and analysis process to determine when I had reached saturation and could stop data collection.

Inclusion/Exclusion Criteria

In order to be included in the study, a potential participant must have met all the following criteria:

- Be18 years of age or older;
- Be a case manager or equivalent position managing the cases of individuals and/or families;
- Currently, or in the past, have worked in a human service organization that has trauma-informed practices and policies in place;
- Read and understand English.

Any individuals who did not meet all the inclusion criteria were excluded from the study.

Recruitment

I posted recruitment materials (see Appendix A) on social media sites as well as the Walden University Participant Pool. I attempted to use social media sites that did not require permission of a moderator or organization to post. However, I sought permission beforehand from those social media sites that required permission.

The potential participants reached out to me via email or phone. I then asked them the following inclusion questions:

1. Are you at least 18 years of age?
2. Are you a case manager (or equivalent position where you manage the cases of individuals and/or families)?
3. Do you currently, or in the past, have worked in a human service organization that has trauma-informed practices and policies in place?
4. Do you read and understand English?

If on the phone, if they answered all of the question "yes", I asked them for an email address where I sent them the informed consent form as well as a list of possible dates and times to set up their interview. For those who contacted me via email, I emailed them the list of inclusion questions and asked them to respond with answers to each.

For those that answered "yes" to all of the inclusion items via phone or email, I then emailed a copy of the informed consent form as well as a list of dates/times available for the interview. I asked them to review the informed consent carefully and respond to the email with the words "I consent to participate" if they consented to participate as well as included the dates/times that work for them for the interview. Once I received an email with these things included, I responded with a final interview appointment as well as a Zoom link for their interview appointment.

Instrumentation

Demographics

Demographic items were collected in order to provide a description of the study

sample (see Table 1, Appendix B). All data were reported in aggregate to ensure that individuals could not be identified.

Table 1

Demographic Questions

#	Question	Prompt(s)
1	What is your gender?	Male, female, other, prefer not to answer
2	What is your age?	Actual age in years
3	What is your race/ethnicity?	White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander
4	What is your highest level of education?	No high school diploma, HS diploma/GED, Certificate, Associates degree, Bachelor's degree, Master's degree, Doctorate degree
5	How long have you been a case manager?	Actual number of years
6	Have you undergone trauma-informed practice training at any time?	Yes, no, not sure
7	What type of human service organization do you/did you work for that had trauma-informed practices/procedures?	Government, Non-Profit, Private

Interview

Semistructured interviews were used to gather data from the participants. See Table 2 for the interview questions and prompts.

Table 2

Semistructured Interview Questions & Prompts

#	Question	Prompts
1	Describe the trauma-informed policies at your organization.	Tell me more about those policies such as their purposes in the organization.
2	How did you implement these practices?	Give me more information about what you did.
3	What trauma-informed practices were implemented or changed at your organization over time?	Tell me more about how those changes took place.
4	How were you told to implement those changes?	Tell me more about how you carried out those changes.
5	What is the protocol for handling trauma victims or crisis situations at your organization?	Is this typically how they are handled? Why or why not?
6	What types of victims do you feel prepared to work with due to the trauma-informed practices at your organization?	Give me more detail on your reasoning.
7	How well did your supervisors support you in your implementation of trauma-informed practices?	Tell me more about what your supervisors did to support you.
8	What changes, if any, do you feel need to be made in trauma-informed practices (as they are implemented) to better help victims?	Tell me more about those changes.
9	Are you aware of any other trauma-informed practices and/or policies that would benefit your organization?	Tell me more about what they are and how they would benefit your organization.
10	Please share any additional information you think is important to our topic of discussion that I may not have asked.	

Procedures for Recruitment, Participation, and Data Collection

Participation

Upon meeting with the participant for the interview, I reviewed informed consent and confidentiality with the participant. The participant was notified of their right to withdraw from the study at any time with no penalty to them. I then asked the participant if I could start the recording. If they said “no”, I would thank them for their time and ended the interview. If they said “yes”, I moved on to the demographic questions and then the interview questions (see Appendix B).

Data Collection

Interviews were conducted via Zoom. I recorded the audio part of the interview. Participants had the choice to be on video or not but, if they chose to be on video, I did not record the video portion of the interview. Throughout the interview I made handwritten notes of the participants' responses. My notes reflected the responses that may have needed to be probed, clarification needed on a response, or notes of observations noted in the participants' responses.

After the interview questions had been completed, I stopped the audio recording and thanked the participant for their participation. I let the interviewee know that I would have the recordings transcribed and I would email them a copy of the transcript for them to check for accuracy. I let them know that if they did not respond to this email within seven days, I would assume that the transcript was accurate and move on to data analysis. I also let them know that after my final project was approved by the university I would share the overall results by posting a summary at this webpage: https://scholarworks.waldenu.edu/dissertations/. I asked if they had any additional questions, thanked them again for their participation, and ended the interview.

Interviews were transcribed by using Rev (www.rev.com). Once the interviews were transcribed, I listened to the audio recordings to check them for accuracy and made note of any corrections and then emailed the transcript for review. If the participant did not respond, then I proceeded with data analysis.

Data Analysis Plan

I used thematic analysis to analyze the data which allows the researcher to

identify common themes that repeatedly show up in the data (Nowell et al., 2017). Thematic analysis was completed utilizing the following steps for each participants' data (Saldana, 2013).

In Step 1 I familiarized myself with the data by reviewing the participants' transcripts. I then started utilizing generic coding methods to determine which method was best suited for my study. Saldana (2013) recommended starting with a combination of attribute coding, structural coding or holistic coding, descriptive coding, and In Vivo, initial coding, and/or values coding to determine which method yields substantive codes. For Step 2, eclectic coding was used to transition into second cycle coding. Eclectic coding allowed the data to be recoded based upon what was learned from the first coding cycle.

In Step 3, after the first cycle coding, code mapping was used to reorganize, recategorize, and conceptualize the codes (Saldana, 2013). It can be utilized simultaneously with second cycle coding (Saldana, 2013). I also used code landscaping which can be done through an internet tool called Wordle (www.wordle.net). Code landscaping identified frequent words or phrases for potential codes and categories. In Step 4, I transformed the final set of codes and themes into longer phrased themes to theme the data.

For Step 5 I may have needed to transition to second cycle coding depending upon the chosen method of first cycle coding (Saldana, 2013). If second cycle coding was needed, I used a second cycle coding method to reorganize the data into higher-level categories and themes (pattern coding, focused coding, axial coding, theoretical coding,

elaborative coding, or longitudinal coding). In Step 6 I created a top ten list and then narrowed it down to the main three codes, categories, or themes to determine how they relate to one another. In Step 7, I used codeweaving to integrate key code words and phrases in narrative form to identify how they relate to one another. I then applied the touch test to determine how codes and categories could be reworded and transformed into more abstract meanings. Finally, in Step 8 I wrote a final report on my findings.

Issues of Trustworthiness

Trustworthiness in qualitative research refers to the degree of confidence interpretation and the methods used to ensure the quality of a study (Connelly, 2016; Stahl & King, 2020). It is most often measured using the criteria of credibility, dependability, transferability, and confirmability of the study (Gunawan, 2015; Stahl & King, 2020). Meeting the criteria of credibility, dependability, transferability, and confirmability means that one has taken the necessary steps to safeguard against bias and ensure rigor (Gunawan, 2015).

Credibility

Credibility in qualitative studies corresponds to internal validity in quantitative research (Gunawan, 2015; Stahl & King, 2020). Researchers should use prolonged engagement with participants, persistent observation, peer-debriefing, member checking, and reflective journaling to ensure credibility (Connelly, 2016; Stahl & King, 2020). I used member checking and reflective journaling to ensure credibility during the data analysis process.

A copy of the interview transcript was emailed to the participants after I checked

it for accuracy. The participants had the opportunity to check the interview for accuracy and to make any clarifications if needed. The member checking process allowed participants to give an accurate portrayal of their experiences through this process to add credibility to the research study (Candela, 2019).

I also used reflective journaling. Reflective journaling involves keeping detailed notes of my experiences and responses, thoughts, and preconceptions as they unfold throughout the study making for a more objective data analysis process (Johnson et al., 2020; Starks & Trinidad, 2007; Tufford & Newman, 2010). Through reflexive journaling, I recorded my previous knowledge of trauma and/or TIPP gained through my current work in a clinical trauma setting, any thoughts or interpretations that may have a bearing on the data analysis process, and immediate observations from the interviews (Johnson et al., 2020; Patnaik, 2013).

Transferability

Transferability is the generalizability of the results of the study to others outside the sample (Connelly, 2016; Stahl & King, 2020). The findings of the study should have meaning outside of the immediate context of the study (Finfgeld-Connett, 2009; Stahl & King, 2020). I met the criteria of transferability by collecting participant demographics (Appendix B) and reporting those demographics in aggregate (Chowdhury, 2015). I provided a comparison to the population of human service workers so that it could be determined if my sample was in line with the demographics of the larger population.

I also met the criterion of transferability through data saturation. Data saturation is used to describe rich, descriptive data that is repetitive which can be assumed to be the

same or similar across the population studied (Guest et al., 2020; Hammarberg et al., 2016; Hennink & Kaiser, 2020). I worked with my committee members to determine when I had reached saturation in my data.

Dependability

Dependability in qualitative studies commonly equates to reliability in quantitative research (Connelly, 2016; Stahl & King, 2020). I ensured dependability of the research by using an audit trail throughout the study that detail my steps so that the study can be replicated (Anney, 2014; Connelly, 2016; Stahl & King, 2020). The audit trail included interview audio and transcripts, participant demographics, and researcher notes (Anney, 2014). Researcher notes included observations from the interview, thoughts and interpretations about the dialogue between the researcher and participant, and/or any descriptive accounts of the research (Carcary, 2020; Mulhall, 2002). Researcher notes helped to provide insight into the process of the study and the research findings for consistency (Golafshani, 2003; Phillipi & Lauderdale, 2018).

Confirmability

Confirmability refers to the degree to which the research can be replicated by other researchers (Chung et al., 2020; Anney, 2014). Chapter 3 has been a detailed discussion of how to replicate this study that other researchers should be able to replicate. I provided an explanation of the different phases of data coding and theming of the data in chapter 4. I continued to refer to all records, electronic and written, for reference when completing the data analysis, results, and interpretation of those results (Anney, 2014).

Ethical Procedures

Once IRB approval was granted, I recruited participants and collected data following the process outlined earlier in chapter 3. No incentives were provided to participants to participate in the study. I did not interview individuals that I had a current or past professional or personal relationship. No individuals were identified in my study and I used pseudonyms for each participant as well as each participant's place of work (if that information was shared with me as part of the answers to the interview questions). The only individuals who knew the names of the participants and saw raw data (recordings, transcripts) were myself, my committee members, the IRB (if requested), and Rev.com which has a confidentiality agreement.

Informed consent was provided to all participants via email once it was determined that they met the inclusion criteria. Participants were asked to carefully review the informed consent and responded to the email by typing "I consent" if they agreed to participate in the interview. The research study posed minimal risks to the participants. However, the topic of trauma may have been a sensitive subject for individuals to discuss. Research participants were provided information for the crisis textline if they needed to talk to someone. The crisis textline is a free service for all individuals and is available 24 hours a day, 7 days a week. The crisis textline information was provided in the informed consent form and the information was verbally shared with the participants at the beginning of the interview. I also provided participants with the National Suicide Prevention lifeline at 1-800-273-8255 which is available 24 hours a day, 7 days a week through the informed consent form. Participants may also access the

Suicide and Crisis Lifeline by dialing 988 which was included in the informed consent.

Data collected (interview recordings, transcripts, data codings) was kept on a flash drive in a password protected file containing only information from the research study. The flash drive was stored in a locked file cabinet that I only have the access key. Data is kept for a minimum of five years after CAO approval of the study per Walden University IRB guidelines (Walden University, 2022). After this period of time, all data associated with the study will be destroyed.

Summary

The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of TIPP across organizations and services. I provided a detailed description of the research design and rationale and my role as the researcher. I also discussed the research methodology which included participant selection logic, instrumentation, and procedures for recruitment, participation, and data collection. Issues of trustworthiness and ethical procedures were thoroughly discussed. Chapter 4 included the results of the data collected along with tables or charts representative of the themes that emerged from the data.

Chapter 4: Results

The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of TIPP across organizations and services. I sought to understand the level of training and education case managers had before providing services to victims of trauma. I also wanted to understand the policies and practices implemented in human services organizations. I wanted to know whether case managers feel the current policies and practices are beneficial to themselves and victims of trauma. Researchers have highlighted numerous implementation efforts of TIP and policy but describing case managers' beliefs and attitudes about the practices and policies of their organization may help to inform human service agencies on best practices, policy, and training needs (Bryson et al., 2017; Ezell et al., 2018). The research question that guided this study was "What are case managers' perceptions of trauma-informed practice and policy in human service organizations?" In this chapter I discuss the setting, demographics of the sample, description of the data collection and coding of data into themes, and results related to the research question.

Setting

The data collection process began on November 08, 2022, after approval was granted from Walden University's IRB. Social media posts were posted on Facebook, Twitter, and LinkedIn. Recruitment slowed during the Thanksgiving and Christmas holidays and other avenues for recruitment were considered. However, the number of individuals contacting me began to increase after the new year and no other recruitment measures took place. Recruitment ended on May 7, 2023. One participant utilized closed

caption during their interview due to hearing loss. No other participants were impacted by personal or organizational conditions at the time of the study.

Demographics

The sample for this study included eight participants who were interviewed before I reached saturation. Only one of the eight participants was male and only one was Black/African American. Six participants had worked in nonprofit organizations. Five of the eight participants had a bachelor's degree (see Table 3).

Table 3

Participant Demographics

#	Gender	Age	Race/Ethnicity	Highest Level of Education	Years of Experience	Employer Type
P1	Female	51	White	Bachelors	10	Non-Profit
P2	Male	28	White	Bachelors	5	For-Profit
P3	Female	51	White	Masters	10	Non-Profit
P4	Female	42	White	Bachelors	19	Non-Profit
P5	Female	29	White	Bachelors	3.5	Non-Profit
P6	Female	59	White	Masters	7	Non-Profit
P7	Female	28	White	Masters	5	Gov't/Non-Profit
P8	Female	40	Black/African American	Bachelors	2	Non-Profit

Data Collection

I conducted one semistructured interview through Zoom with each participant that ranged from 30–60 minutes. Participants were asked ten open-ended questions (see Appendix B) regarding TIP in the human service organizations in which they worked. After obtaining consent, the interviews were audio recorded using the Zoom platform and transcribed immediately after using Rev.com. Participants were emailed the transcription and given seven days to make any corrections. One participate made a correction to their transcript while the other participants made no corrections.

Data Analysis

Initial Coding

The audio and transcripts were carefully reviewed for accuracy to be sure that I was able to extract meaning from the data. After carefully reviewing the audio and transcripts, I utilized in-vivo coding to begin the initial coding process. I highlighted phrases of information in each interview transcript that were relevant to the interview question asked. I then took the data and input it into an Excel spreadsheet where participant responses were grouped according to the questions asked. Once all the data were grouped relevant to the interview questions, I generated initial codes and created PowerPoint slides to print so that I would have a tangible copy of the information for code mapping. Table 4 contains examples of the initial round of coding.

Table 4

Initial Cycle of Coding Examples

Participant	Quote	Initial Code
P4	Trauma-informed and person-centered or victim-centered go together.	Addressing victims with trauma-informed language
P3	Specialized speakers to work with trauma-informed care policies and direct services.	Training practices
P2	Is this a trauma response?	Understanding trauma behaviors
P3	An annual review of the policies are available to the public and participants.	Creating organizational transparency
P4	We don't initiate anything that's going to bring up any kind of bad feelings or anything like that.	Providing trauma-informed care

Second Cycle Coding

In-vivo coding and initial coding served as a catalyst to transition into second cycle coding. I reviewed each slide and then generated new codes based on the

information gathered. The data were regrouped and categorized. I created a tangible version of code mapping using additional PowerPoint slides that I printed after using code landscaping. Table 5 is a display of the transition from the initial coding process into second cycle coding.

Table 5

Second Cycle Coding Examples

Participant	Quote	Initial code	Second cycle code
P6	We're taught to be empathetic listeners. You don't want to be bringing up all that.	Trauma-informed response	Importance of diverse trauma-informed training practices
P2	Say, okay, what happened to you? Person presenting bad behavior? Are they being defiant? Reactive attachment disorder Look at their background. Client's history How is that affecting your behavior? How is that affecting your circumstances and symptoms? What trauma looks like and how it presents.	Looking at trauma symptomology	
P4	We don't bring up anything that's going to initiate any bad feelings or anything like that. Different reactions and sometimes the parents' reactions aren't what you would think. Trauma-informed and person-centered or victim-centered go together.	Trauma-informed response	
P5	Training on first-person language	Addressing victims with trauma-informed language	
P6	Needs of the participants always come first.	Trauma-informed response	
P8	The participant comes first. Person served.	Trauma-informed response	
P4	Community collaboration	Multiple service needs	Community collaboration/collaboration
P1	Mobile crisis	Multiple service needs	
P2	Defer to 911 Crisis hotline	Multiple service needs	
P3	Law enforcement Sexual assault agencies Collaboration with other agencies	Multiple service needs	

Participant	Quote	Initial code	Second cycle code
P3	Annual Every fiscal year	Training duration or frequency (time) Training requirements	Trauma-informed training practices
P2	Specialized speakers to work with trauma-informed care policies and direct services. Required annual agency training date. Annual retreat. 15 minutes to 2-hour modules. Digital platform Minimum of 80%	Training duration or frequency (time) Training requirements	
P7	Quarterly trainings	Training duration or frequency (time)	
P5	Quarterly trainings	Training duration or frequency (time) Training requirements	
P6	5 or 6 mandatory trainings Ongoing Annual Retreat	Training duration or frequency (time) Training requirements	
P3	An annual review of the policies and available to the public and participants. The leadership staff would review policies and then also if a policy was in question, staff could grieve it. Then through the grievance policy, our leadership team would look at it again. Policies would also be provided on our website. Discrepancy in implementation, they were available to be viewed.	Creating organizational transparency	Creating organizational transparency
P5	Much larger focus on employee wellness. Sensitivity to the trauma that their employees were going through secondhand trauma and burnout and all the associated negative things with that. Employee organization that was focused on employee wellness. Switched to lowering caseloads. Making sure employee mental health services were more readily available. Switch from having sick leave, personal leave to your leave is your leave. We had to revamp some our policies so they were trauma-informed for our employees for treatment, time off; not a typical leave or leave of absence policy.	Employee Support/lack of employee support	Employee wellness focus important

Participant	Quote	Initial code	Second cycle code
P4	Gates on premises	Safety Precautions	
P5	If someone said they felt unsafe, it was just the default that you trust them. It was if you don't feel safe, you're not. Staff positioned in a way that they can get out. I've had to break up fights. We understand that this is often a product of trauma. Case by case basis, which I guess is trauma-informed practice by looking at it through that lens.	Voicing safety concerns Preparedness in unsafe situations De-escalation Looking at trauma Looking at individual cases through a trauma lens	
P1	They trust me to do my job. Always open.	Employee Support/lack of employee support	
P4	Supervisors are not aware of their own burnout	Lack of awareness to burnout	

Final Themes

Code landscaping was utilized through a platform called Word Cloud Generator (monkeylearn.com). I noted in Chapter 3 that I would be using Wordle. Due to paid subscription fees in Wordle, I chose to use Word Cloud Generator. I input text data from the first cycle of coding into the Word Cloud Generator. The 10 most frequent words generated were *training, employee wellness, supervisor, policy, behavior, question, participant, person, trauma*, and *staff.* The words that had no significance were eliminated from emerging themes.

Figure 4

Word Cloud Generator Results

Code landscaping produced emergent themes, which I referenced back to the data to determine which themes answered the interview questions. Pattern coding was used to group similar data under each emergent theme and then used to determine the major themes. I then applied theoretical coding to the remaining list of themes. From that list emerged the final three themes of (a) there is a deficit/ambiguity in trauma-informed curriculums and training in human service organizations, (b) more collaboration needed is with other trauma-informed human service organizations/agencies, and (c) TIP should be applied in human service organizations to better support employee wellness. Examples of the first two rounds of coding and the determination of the final themes can be found in Table 6.

Table 6

Final Themes

Participant	Quote	Initial Code	Second Cycle Code	Final Theme
P2	Person presenting bad behavior? Are they being defiant? Reactive attachment disorder Look at their background. Client's history How is that affecting your behavior? How is that affecting your circumstances and symptoms? What trauma looks like and how it presents. Different reactions and sometimes the parents' reactions aren't what you would think. We're taught to be empathetic listeners. You don't want to be bringing up all that.	Understanding trauma behavior Trauma-informed Response Addressing victims with trauma-informed language	Importance of trauma-informed training practices	Theme 1: There is a deficit/ambiguity in trauma-informed curriculums and training in human service organization
P4	Say, okay, what happened to you? We don't bring up anything that's going to initiate any bad feelings or anything like that. Trauma-informed and person-centered or victim-centered go together. Training on first-person language.	Understanding trauma behavior Trauma-informed Response Addressing victims with trauma-informed language	Importance of trauma-informed training practices	
P6	Needs of the participants always come first.	Addressing victims with trauma-informed language	Importance of trauma-informed training practices	
P5	The participant comes first . .	Addressing victims with trauma-informed language	Importance of trauma-informed training practices	
P8	Person served	Addressing victims with trauma-informed language	Importance of trauma-informed training practices	

Participant	Quote	Initial Code	Second Cycle Code	Final Theme
P4	Community collaboration Mobile crisis	Multiple service needs	Community collaboration/collaboration	Theme 2: More collaboration needed is with other trauma-informed human service organizations/agencies
P1	Defer to 911	Multiple service needs	Community collaboration/collaboration	
P2	Crisis hotline Law enforcement	Multiple service needs	Community collaboration/collaboration	
P3	Sexual assault agencies Collaboration with other agencies	Multiple service needs	Community collaboration/collaboration	
P5	Much larger focus on employee wellness. Sensitivity to the trauma that their employees were going through secondhand trauma and burnout and all the associated negative things with that. Employee organization that was focused on employee wellness. Switched to lowering caseloads. Making sure employee mental health services were more readily available.	Employee Support/lack of employee support	Employee wellness focus	Theme 3: Trauma-informed practices should be applied in human service organizations to better support employee wellness
P3	Switch from having sick leave, personal leave to your leave is your leave. We had to revamp some of our policies so they were trauma-informed for our employees for treatment, time off; not a typical leave or leave of absence policy.	Employee Support/lack of employee support	Employee wellness focus	
P4	Gates on premises	Safety Precautions	Employee wellness focus	
P5	If someone said they felt unsafe, it was just the default that you trust them. It was if you don't feel safe, you're not. Staff positioned in a way that they can get out. I've had to break up fights. We understand that this is often a product of trauma. Case by case basis, which I guess is trauma-informed practice by looking at it through that lens.	Voicing safety concerns Preparedness in unsafe situations De-escalation Looking at trauma behavior Looking at individual cases through a trauma lens	Employee wellness focus	
P1	They trust me to do my job. Always open.	Employee Support/lack of employee support	Employee wellness focus	
P4	Supervisors are not aware of their own burnout.	Lack of awareness to burnout	Employee wellness focus	

Participant	Quote	Initial Code	Second Cycle Code	Final Theme
P8	I think a lot of workers are not being taken care of. They're being pushed to the side.	Employee Support/lack of employee support	Employee wellness focus	
P8	Okay, so we have de-escalation strategies.	De-escalation strategies used to individuals served	Employee wellness focus	

Evidence of Trustworthiness

Credibility

After each interview, I reviewed the data gathered and took notes of my thoughts on the data collected to further establish credibility (Johnson et al., 2020; Starks & Trinidad, 2007; Tufford & Newman, 2010). I also made notes throughout the interviews as well. I found that the interview responses brought up feelings about my own experiences in the field. I was mindful of those experiences and utilized reflexive journaling to control bias. I then referred back to the interview questions and the responses given by each participant taking careful note of the new data gathered.

I also established credibility by ensuring the interview information was accurate using member checks. Each participant was emailed a copy of their transcript to review for accuracy (Candela, 2019). Two participants responded that their transcripts were accurate. One participant notated one correction in their transcript which I corrected. The transcripts for all other participants were assumed to be correct as they did not respond back after receiving their transcript via email.

Transferability

Transferability was established by providing a detailed description of the research study method in Chapter 3, which I followed throughout my interactions with potential participants, during interviews, after interviews, and through the data analyses. I collected

participant demographics and provided descriptives of my sample to 1) determine if the demographics of my sample were in line with the larger population of human service workers and 2) determine if my sample was generalizable to the larger population described in Chapter 3 as recommended by Chowdhury (2015). I also determined the generalizability of my study results by using purposive sampling where each participant needed to meet the inclusion criteria. A thorough description of the characteristics of the sample was included and the results of this study should only be generalized to those who would meet the inclusion criteria of the study and are similar to the demographics of my sample.

Dependability

I established an audit trail through the recordings of interviews, ensuring transcript accuracy, and ensuring that my researcher notes were accurate before using them during data analysis and interpretation of results. I took careful notes to record my observations from the interviews and my thoughts and interpretations about my dialogue with the participants to ensure dependability (Carcary, 2020; Mulhall, 2002). My notes helped to provide insight into the process of the study and the research findings for consistency (Golafshani, 2003; Phillipi & Lauderdale, 2018).

Confirmability

Confirmability was established through my explanation of the different phases of data coding and theming of the data. I provided a detailed description of how I conducted the study and coded my data so that other researchers could replicate this study and the coding decisions. I referred to all records, electronic and written when completing the

data analysis, results, and interpretation of those results as recommended by Anney (2014). The coding procedure used in this study allowed me to remain objective because I followed specific coding guidelines that I established before collecting and analyzing the data and attempted to control my biases through the use of field notes that I referred to often.

Results

The research question for this study was: *What are case manager perceptions of trauma-informed practice and policy in human service organizations?* The final three themes derived from the data that answer this question were *Theme 1: There is a deficit/ambiguity in trauma-informed curriculums and training in human service organizations*; *Theme 2: More collaboration needed is with other trauma-informed human service organizations/agencies* and *Theme 3: TIP should be applied in human service organizations to better support employee wellness.*

Theme 1: There is a Deficit/Ambiguity in Trauma-Informed Curriculums and Training in Human Service Organizations

All participants were asked to describe the trauma-informed policies at their organization. I received a variation of answers to describe the type of trauma-informed training they received, training duration and requirements, and trauma-informed training that did not always align with "best practices" or what the employees of the organization were directed to do in practice. An example of the misalignment was in the action of P1 who chose to skip question 1 which was: Describe the trauma-informed policies at your organization. Question 1 was used to understand what trauma-informed policies are

already in place at the participants' organizations. P1 may not have a clear understanding of what the trauma-informed policies are at their organization. The participant was asked if they wanted to revisit question one and I read the question aloud again. P1 responded: "We can just leave it as is." The lack of response indicates that the participant was not comfortable discussing the topic of trauma-informed policies supports there being a deficit or some ambiguity in trauma-informed curriculums and training in human service organizations.

It should be noted that participant answers indicated that they did not fully understand the difference or alignments between TIP and trauma-informed policy other than just the recognition that a person has gone through trauma. For example, when asked to describe TIPP at their organization, P2 responded, "A lot of the education presented helped you recognize not just symptoms, but looking at the background, looking at not just what you're seeing the client present with, but what is the client's history." This indicates that the training may be lacking in how to differentiate between TIP and policies when working with a client who has experienced trauma. This was also seen in the response of P5 who stated, "So, we had training on person first language, the mental and physical effects of trauma on children. So, it was the practices, I guess just all of our practices were steeped in it." I found that participants used "practices" and "polices" interchangeably throughout the interviews without really communicating that the two things are different.

Participants also indicated that the basic skills related to identifying signs of trauma were communicated but little other than that. P8 stated, "We don't really have

trauma policy. I mean we have the basic stuff… we do a person-centered plan and we took a look at terminology because some words can be triggering for them and cause behaviors." There also seems to be a lack of documentation related to trauma-informed policies that should be governing TIP in organizations. P6 stated, "We don't specifically have what I would call trauma-informed policies written down…We have core competency training, we're confidential, and the participant always comes first."

Participants did discuss that trauma-informed training is important and there is a need for more trauma-informed curriculums and training in human service organizations. For example, P2 stated, "Education is big. Look at things from a developmental trauma perspective." They discussed issues with training specifications, types of training, trauma recognition, the lens through which case managers and organizations see trauma, and additional education case managers felt they needed. P6 stated that they wished there was trauma more training available.

> I wish there was more training available just on that trauma itself, except for the four or five hours that are mandated…Some people, I think they pick stuff because it looks like it's easy and I just want to get my 16 hours out and I wish people would be more, if it was more across the board, we're getting kind of the same sort of stuff, more consistent.

P3 stated "more education" was needed to better serve victims of trauma and thought their agency would better benefit from adding policies from the Substance Abuse and Mental Health Services Administration (SAMHSA). P3 stated, "People don't tend to see those things that come out of substance abuse disorders as specific to that type of policy

or that type of care." The participant was referring to incorporating policies from substance use disorders in trauma organizations. SAMHSA is a governmental agency designed to promote mental health, prevent substance misuse, and provide treatment and support to ensure equal access and better outcomes (SAMHSA, n.d..).

P8 discussed how important the use of terminology in TIC due to participants not wanting to be referred to in certain ways because it was triggering to them.

> Even with terminology because some individuals were coming saying that I don't like being called this or I don't like being called that… So more so kind of just took a lot of terminology away… I guess I could say that like that because some words can be triggering for them and it could cause behaviors.

Education and training in trauma terminology may provide a more effective way to communicate with the population served as to not retraumatize those individuals.

Theme 2: More Collaboration Needed is With Other Trauma-Informed Human Service Organizations/Agencies

Human service professionals often need to engage in the process of triage to determine what the client's most important needs are to be able to effectively refer to other organizations or agencies. While a human service professional is expected to be able to determine whom to collaborate with, the ability to collaborate between organizations and agencies can be difficult due to the differing training, purpose, and culture of that other organization or agency. Participant 3 responded, "So we would have to triage that, try to determine what other agencies. A lot of this is about collaboration with these individuals because it would be after hours." Participants discussed their

efforts to collaborate with other organizations and services when serving the needs of their respective populations. For example, working with law enforcement was mentioned multiple times.

Despite the identified need to collaborate with other organizations and agencies, the way to accomplish this is often not clear or easy. For example, P1 discussed how training for police officers can actually be counterintuitive to the situation,

> The police didn't understand, deaf culture, didn't understand how animated at times a deaf person can be, especially if they're agitated or upset and they would not have gotten the help, the mental health help that they needed had it not been for us finding out that this person had been arrested. The thing was this person had been arrested for several days in the county jail with no interpreter, no access to a video phone. And that's the sort of thing that needs to change.

Participants spoke of other agencies such as a mobile crisis unit, sexual assault agencies, crisis hotline, and other community agencies as groups that they work and communicate with in order to provide services. The participants identified the need to work with outside organizations/agencies and the need for these organizations/agencies to have knowledge about the respective populations in which they provide this service.

For example, P2 stated, “If I go to a school, educate the school on that, if I'm talking to a psychiatrist, I educate the psychiatrist on that. Yeah, I think a lot of what we do is care coordination. It’s having that group conversation. I think that helps.”

Theme 3: TIPP Should be Applied in Human Service Organizations to Better Support Employee Wellness

The importance of the organization ensuring employee wellness was provided by multiple participants since working with individuals who have experienced trauma can result in burn-out and vicarious trauma being experienced by professionals. P4 stated, "And no matter what it is, everybody seems to need boundary training, including ourselves as helpers who say yes to everything, you know, have to look within… And I think us as providers it's so important as well." This need for self-care and boundaries was supported by P3 who responded,

> So, we actually had to revamp some of our policies so that they were trauma-informed for our employees for treatment time off. Those are the types of policies that can help someone. It's not a typical leave of time, leave of absence policy…So we had to actually change some of our policies when the number, we had an employee assistance program, and annually we would analyze anonymously the types of calls that were fielded over to the employee assistance program. So, what was happening were a lot of substance use disorder cases for employees.

Applying TIP in human service organizations should not just be towards clients but also towards those employees who work with the clients. Boundaries are an important part of creating work life balance and can promote employee wellness (Laker & Roulet, 2021). This was also supported by P5 who stated,

> I also think one thing that the organization got better at as I stayed there longer

> was sensitivity to the trauma that their employees were going through secondhand trauma and burnout and all the associated negative things with that. And there was a much larger focus on employee wellness and really understanding it in a job like this. But I think the way a meaningful change came is there was an employee organization that was focused on employee wellness and so it switched to lowering caseload counts and making sure employee mental health services were more readily available distributing less of therapists who work with therapists… They're quitting cause they can't handle the work.

Participant 8 spoke about how professionals in their organization did not believe that the organization cared for them the same way that they cared for clients.

> The only thing they tell you is send them to the hospital and they pay leave that's paid. When it comes to crisis and trauma and all of that, I think a lot of the workers are not being taken care of. I think that they are being pushed to the side, so if something happens to them, they'll just get somebody in their place. I don't think that they care. I handle employees with care, the work, environmental care. They don't.

There were discussions about the emotional and mental aspects of employee wellness. Physical safety is reported to have an impact on employee wellness and posttraumatic symptoms (Rosenthal et al., 2018). Healthcare workers who are affected by verbal and physical violence miss work and consider leaving their jobs (Rosenthal et al., 2018). However, the participants made statements that referenced physical safety and physical health as well. I revisited P4's statement on safety: "…and so if you don't feel

safe, we have panic buttons in places that you can press alarm systems everywhere that you can press." P4's statement led me to believe that the organization took their employee's physical safety into consideration and the employees are believed when they make statements about their safety. It reinforces the assumption that employees are more likely to remain on their jobs when their physical safety and mental health are a priority.

P5 made a statement that their organization responded with "sensitivity to the trauma that their employees were going through secondhand trauma and burnout and all the associated negative things with that." The organization made sure that "mental health services were more readily available, lowered caseloads, and stopped labeling sick leave." The organization labeled their leave as "personal leave" and employees could use it the way they needed and they were not questioned about it.

P3 responded, "Supervisors are not aware of their own burnout and need for developing." P3's response highlights the need for supervisors to recognize when they are experiencing burnout and how they can continue to develop in the field. Burnout is mental, physical, and emotional exhaustion which supports the theme that TIP should be applied in human service organizations to better support employee wellness.

Summary

The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of TIPP across organizations and services. I conducted eight semi-structured interviews to gather data from participants. The answer to the research question *What are case manager perceptions of trauma-informed practice and policy in human service organizations* was that there is a deficit/ambiguity in trauma-

informed curriculums and training in human service organizations (Theme 1), more collaboration is needed with other trauma-informed human service organizations/agencies (Theme 2), and TIP should be applied in human service organizations to better support employee wellness (Theme 3). In Chapter 5, I discuss interpretation of the findings, limitations of the study, recommendations for future research, and implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this generic qualitative research study was to describe and understand case managers' perceptions of TIPP across organizations and services. Researchers found that victims can feel retraumatized due to the response they may receive from victim-serving agencies (Becker-Blease, 2017; Helpingstine, 2023; SAMHSA, 2014). Researchers have highlighted numerous implementation efforts of TIPP, but describing case managers' beliefs and attitudes about the practices and policies of their organization may help to inform human service agencies on best practices, policy, and training needs (Bryson et al., 2017; Ezell et al., 2018; Helpingstine, 2023). The research question that guided this study was "What are case manager perceptions of trauma-informed practice and policy in human service organizations?" The three themes that were derived from the collected data that answer this question were (a) there is a deficit/ambiguity in trauma-informed curriculums and training in human service organizations, (b) more collaboration is needed with other trauma-informed human service organizations/agencies, and (c) TIP should be applied in human service organizations to better support employee wellness. In Chapter 5, I provide an interpretation of the findings in the context of the theoretical framework as well as the literature review, and I discuss limitations of the study, recommendations, and implications for practice and positive social change.

Interpretation of Findings

Interpretation of Findings in Context of the Theoretical Foundation

EST was utilized as the theoretical framework for this study. There are a variety

of ways that the system levels in this theory explain how individuals interact with the societal systems around them and how these interactions affect the individual (Bronfenbrenner, 1979). Experiences with certain "helper" groups have the potential to trigger and retraumatize victims of trauma if those helper groups are not aware of the potential to retraumatize victims when providing the support (Härkönen, 2007; Pazderka, 2021). When an individual is a victim of some type of trauma, the system level where the trauma occurred is not the only level where the effects of the trauma exist for the individual. Instead, the experience that resulted in the trauma can vicariously exist in other levels and retraumatize victims based on the interactions they have with systems within those other levels (Bronfenbrenner, 1979).

Theme 1: There is a Deficit/Ambiguity in Trauma-Informed Curriculums and Training in Human Service Organizations

The point of care where individuals and families meet with case managers in human service organizations is considered the microsystem level (Abrahamson et al., 2020; Kosnik & Espinosa, 2003). At the microsystem level, clients and case managers interact closely, and there is a high possibility that these interactions could retraumatize clients if the case manager is not cautious in those interactions (Abrahamson et al., 2020; SAMHSA, 2014). This is an intimate relationship where the client is sharing difficult information and is looking for support and "solutions" from the case manager. Participants in my study provided information that indicated that they are not receiving adequate trauma-informed training to provide effective TIC to individuals and families to avoid retraumatization at this level. However, even the training may not fully help the

case manager from being able to completely avoid retraumatizing clients, which can be seen in the statement from P8:

> Even with terminology because some individuals were coming saying that I don't like being called this or I don't like being called that… I guess I could say that like that because some words can be triggering for them and it could cause behaviors.

P4 also similarly stated, "We were mimicking behaviors of perpetrators by not giving them choices, by having curfews which wouldn't allow them work schedules which we thought were for their safety." It is therefore important that case managers receive training on how to recognize the signs of trauma and retraumatization as well as training on how to adjust their interactions with clients if the case manager suspects that the interactions with the client could result in retraumatization. This training should provide a variety of scenarios and address how to adjust in order to meet the individual needs of a client. It may also be beneficial to have training include role play opportunities to put into practice the skills that the case managers are learning about to avoid retraumatization.

Overall organizational practices are found at the exosystem level (Bronfenbrenner, 1977; Martinello, 2019). Case managers who work with individuals and families are responsible for carrying out TIPP that are developed at the exosystem level of the organization but implemented at the microsystem level. The importance that an organization assigns to the concept of TIPP can be seen if the organization has prioritized these practices as part of daily operations and interactions (Bloom, 2006; Galvin et al., 2022). However, sometimes these things are not documented but are "unwritten rules" of the organization. When these types of practices are not documented well, and/or the staff

have not been trained effectively on these practices, then it is easy to forget the importance of these practices and they may not be implemented. For example, P8 stated, "We don't really have trauma policy. I mean we have the basic stuff. If you need help do this or if you have this, they don't really have any." P6 also similarly stated, "We don't have what I would specifically call or trauma-informed policies that, um, that are like written down." P1 indicated that, even if written down, the complexity of the policies can make them difficult to effectively use:

> So, I think trauma-informed policies are very broad, and I think that administrators, legislators, and even advocates get lost in the language of it and maybe don't really understand what it means. And the continuous cycle of trauma-informed policies and care for our communities, it's not an easy fix. It's not something that's going to change with one policy. So, I think that there needs to be more education on what these words really mean.

It was clear that there is confusion and uncertainty about these policies. If a policy and/or procedure are too complex, too vague, or unclear, it can result in an employee to just "do the best that they can" in a situation instead of knowing what to do per policy. This can result in confusion for the case manager when providing services to clients as they are not sure what exactly they should be doing in relation to trauma.

HHS (n.d.) has direct influence over public health policies, laws, education and training, patient rights, and programs and services carried out in human service organizations. The HHS does not have rules regarding TIP, but they support the trauma-informed approach and outline the six key principles to becoming trauma-informed

(SAMHSA, 2020): (a) safety; (b) peer support; (c) trustworthiness and transparency; (d) collaboration and mutuality; (e) cultural, historical, and gender issues; and (f) empowerment, voice, and choice. SAMHSA (2020) contends that mental and physical health is negatively impacted by trauma. Therefore, human service organizations should adopt organizational policies consistent with the state or federal government. As the participants talked about the curriculum and training related to TIP in their organization, there was little consistency seen in curriculums and training across different settings. Participants shared that policies and practices are dependent on the needs of the clients that an organization serves, but they indicated that they would like more of the HHS and SAMHSA tenets put into curriculum and training as well as consistency across human service organizations as a whole (macrosystem). P3 specifically spoke about wanting to include specific policies from SAMHSA:

> So, SAMHSA has some really great policies, but again, because people don't look at the entire picture, they tend to see those things that come out of substance use disorder as specific to that policy or that type of care. And if agencies aren't working with that particular clientele, they're not incorporating some of these things. They're really much more broad-based. So, I think that's a great example of a policy that can be implemented across all of the departments within a state, not just one particular department. Not just health, not just addiction services, not just mental health not just children's services. These should be broad-based policies.

Governmental departments (HHS) and professional organizations (such as SAMHSA)

have policies, procedures, and recommendations of best practices in the field, but these are not always implemented in an individual organization (Huo, 2023). These approaches and stances on TIP, which were referred to by participants, add credibility to the importance of macrosystem-level policies on service delivery and organizational wellness (Bloom, 2016; SAMHSA, 2014). Yet not all organizations are providing available training and education to staff. The lack of necessary training will negatively affect staff and the populations that they serve (SAMHSA, 2014; Milner et al., 2019; Zhenjing et al., 2020).

Theme 2: More Collaboration is Needed with other Trauma-Informed Human Service Organizations/Agencies

There are multiple organizations and agencies that provide support and service to victims of trauma including courts, nonprofit agencies, law enforcement agencies, schools, and hospitals, which function within, and across, the microsystem, mesosystem, exosystem, and macrosystem (Katirai, 2020). In addition, changes take place over time based on these interactions between organization/agencies, how society changes, and these are reflected in the chronosystem (Chiarelli-Helminiak et al., 2022). Participants in my study provided information that indicated more collaboration is needed with other human service organizations to ensure individuals who have been traumatized continue to be supported and have access to adequate services. If not provided with the continuum of care, individuals run the risk of retraumatization, or they may not receive the necessary treatment or support (Meyer et al. 2007; Pittenger et al., 2015). An example of this can be seen in a statement by P1 who provided an example of how law enforcement

retraumatized a victim because they were not knowledgeable about the deaf population and how to best serve them:

> And for social workers, mental health providers, emergency personnel, anybody that's not involved in the community, just learning about the culture that needs to happen…The police didn't understand, deaf culture, didn't understand how animated at times a deaf person can be, especially if they're agitated or upset and they would not have gotten the help, the mental health help that they needed had it not been for us finding out that this person had been arrested. The thing was this person had been arrested for several days in the county jail with no interpreter, no access to a video phone. And that's the sort of thing that needs to change.

The example highlights the importance of collaborating with other agencies that may be more knowledgeable about the populations as they work with this population more often. In this situation, if law enforcement had been able to closely collaborate with another organization that works closely with the deaf community, law enforcement could have done better in providing services and lessened the possibility of retraumatization. EST describes the direct connection between the individual, organization, and the direct environment in a situation which is the microsystem (Crawford, 2020). A positive encounter could foster trust between the organization and the victim, increasing the likelihood of them returning to the organization for further assistance. However, if they have a negative interaction within this microsystem then they may not feel comfortable with the organization in the future (Maiorano et al. 2023).

At the mesosystem level, the interactions are between multiple microsystems

(Bronfenbrenner, 1979). There can be multiple human service professionals interacting with one another to provide adequate care to an individual. It may be deemed important for a doctor to collaborate with their patient's case manager, a mental health provider, an attorney, law enforcement, and/or another agency to coordinate care and ensure that gaps in care do not exist (multidisciplinary teams; Gobet, 2018). For example, P2 stated,

> I don't really know how to help this family. What do you all think? And then the response is this multidisciplinary response. Whereas you've got other social workers on the call, you have other doctors, like medical doctors, there are psychiatrists. There were people who were lawyers that were on the call that actually had background with that. And so, it allows each of us that needs help to get help from different perspectives. And it's really useful.

Collaboration with other agencies has been found to support better outcomes for the client (Drexler, 2020). However, although many agencies/organizations have attempted to adopt a multidisciplinary approach, not all have done so even though it would be helpful to have multiple professionals involved to deliver TIC and offer varying perspectives to limit the gaps in services (Gobet, 2018).

Theme 3: TIP Should be Applied in Human Service Organizations to Better Support Employee Wellness

According to Bronfenbrenner (1979), EST illustrates how social, environmental, political, and cultural systems impact human development. EST best supports the theme on employee wellness because it describes how human service professionals can be impacted by their work environment, how they impact their work environment, and how

they carry the impact of their work into their personal lives (SAMHSA, 2014; Milner et al., 2019; Zhenjing et al., 2020). Human service agencies should apply TIP to better support employee wellness as vicarious trauma is an issue that has been found to result in burnout and attrition of human service professionals (Bloom, 2006; Dombo & Blome, 2016). Many participants in my study discussed not feeling safe and/or not feeling supported by their employer. P8 did not feel like they were protected by their organization from behaviors exhibited from clients and stated, "Some of them just talk or they'll curse at you to being combative and hit…When it comes to crisis and trauma and all of that, I think a lot of the workers are not being taken care of." This participant stated that the organization would send them to the hospital if warranted, but they did not care beyond that point.

Due to not having the appropriate support or programs to deal with the stressors of serving human service organization clients, many case managers may develop their own destructive behaviors, often turned inwards, due to the vicarious trauma and the secondary traumatic stress they experience (Ashley-Binge & Cousins, 2020). Individuals may experience anxiety and depression (SAMHSA, 2020) which can disrupt the family unit creating stress in the home (Piotrowski et al., 2019). The development of substance abuse issues is common in employees who work with individuals who have experienced trauma (International Society for Traumatic Stress Studies, 2016). This was evidenced in this study as in the statement of P3, "So what was happening were a lot of substance use disorder cases for employees." P3 also reported that their organization changed their policies to accommodate the staff because they were experiencing substance use

disorders. The organization no longer made a distinction between sick time and annual time (exosystem level policy change).

P3 further stated, “Supervisors are not aware of their own burnout and need for developing.” The trauma-informed approach is a top-down concept meaning that it will begin with the organization and transfer to all other staff. Case managers are not directly involved in the relationship supervisors have with directors/and or the organization. However, case managers are affected by supervisor burnout and professional development at the mesosystem level. This can be seen in the statement of P5 who reported, “They’re quitting cause they can’t handle the work.”

Human service professionals who are not happy and have low morale may be more likely to take their work issues and problems home with them (to their microsystem). When employers value their employees, employees have better outlooks on their jobs and their productivity is better (Abbott, 2022; SAMHSA, 2014). It may be beneficial for employers to encourage work-life balance for their employees, better manage client caseloads, establish self-care in the workplace, and hire staff that are supportive to each other as well as clients (Abbott, 2022; SAMHSA, 2014). Employee assistance programs (EAP) were created to meet the needs of employees experiencing a wide array of stress-related symptoms that affect job performance (APA, 2006). EAP programs at the exosystem level can affect changes in the microsystem and the mesosystem of an employee by addressing the stressors in the workplace and providing support to employees to better deal with those stressors (Bronfenbrenner, 1977; Newman & Newman, 2020).

Interpretation of Findings in Context of the Literature Review

Theme 1: There is a Deficit/Ambiguity in Trauma-Informed Curriculums and Training in Human Service Organizations

Researchers indicated that TIC and TIP are terms used interchangeably throughout the field (Bryson et al., 2017; Classen & Clark, 2017; Portman-Thompson, 2020; Purtle & Lewis, 2017; Sullivan et al., 2018; Tebes et al., 2019). This study highlighted case manager perceptions of TIPP in human service organizations. There was also an emphasis on the social structures and processes that retraumatize victims. I found that case managers in my study did not think that they were receiving enough trauma-informed training. According to Schippert et al. (2021), the deficits/ambiguity in trauma-informed curriculums and training puts case managers at risk of retraumatizing victims. The effectiveness of TIPP is heavily dependent upon the prioritization of TIC by leadership staff that supports advanced training (Bryson et al., 2017).

Throughout the study, I found that participants also used the terms trauma-informed practice and trauma-informed policy interchangeably. When asked to describe TIP in their organization, P2 responded, “A lot of the education presented helped you recognize not just symptoms, but looking at the background, looking at not just what you're seeing the client present with, but what is the client's history.” P2’s response added credibility to support the theme but further highlighted that participants may not understand the difference or alignment between TIP and trauma-informed policy. The response referred to recognizing symptomology, but there was no real description of

practice or policy.

Researchers reported that TIP are important in ensuring trauma is addressed appropriately to boost positive outcomes for clients (Chaffouleas et al., 2016; Maynard et al., 2019; SAMHSA, 2014). When human service professionals do not understand the difference, or alignment, between TIP and trauma-informed policy, it can be concluded that they lack the necessary training or there is some confusion on what these terms mean. Therefore, the lack of knowledge and training can cause retraumatization for clients inadvertently (Schippert et al., 2021).

Participants also expressed a need for more trauma-informed training which indicates that they are aware of the potential for retraumatization of their clients and want to know how to avoid this. For example, P6 stated,

> I wish there was more training available just on that trauma itself, except for the four or five hours that are mandated…Some people, I think they pick stuff because it looks like it's easy and I just want to get my 16 hours out and I wish people would be more, if it was more across the board, we're getting kind of the same sort of stuff, more consistent.

This statement is consistent with the findings of researchers who indicate that training is necessary for clinical and non-clinical staff in relation to the implementation of TIPP (Bargeman et al., 2021; Menschner & Maul, 2016). This statement also shows that there are deficits/ambiguities in trauma-informed training and curriculums because some participants were not sure of whether they had TIPP at their organization. For example, P8 responded, “We don’t really have trauma policy. I mean we have the basic stuff… we

do a person-centered plan and we took a look at terminology because some words can be triggering for them and cause behaviors." P6 provided a similar response regarding the ambiguity within their organization about having official trauma-informed policies and procedures, "We don't specifically have what I would call trauma-informed policies written down…We have core competency training, we're confidential, and the participant always comes first." Again, one may assume that there is a deficit/ambiguity of TIPP in human service organizations due to the lack of knowledge of trauma-informed policies in their organization.

Theme 2: More Collaboration is Needed with other Trauma-Informed Human Service Organizations/Agencies

Collaboration has been identified as one of the six principles of TIP (CDC, 2023; Isobel & Edwards, 2017; SAMHSA, 2014). Collaboration promotes education and the sharing of knowledge (Green & Johnson, 2015). Participants in my study identified situations in which more collaboration is needed with other trauma-informed human service organizations as services are currently very departmentalized. For example, P2 stated, "If I go to a school, educate the school on that, if I'm talking to a psychiatrist, I educate the psychiatrist on that. Yeah, I think a lot of what we do is care coordination. It's having that group conversation. I think that helps."

Relationships are very important to the collaboration process. Relationships with other organizations should prove beneficial to helping trauma victims heal. Researchers emphasized that trust is developed through stable, reliable interpersonal connections (Charuvastra & Cloitre, 2008; Collin-Vezina et al., 2020). The research findings further

support the scholarly research that healing takes place within relationships (Wilson et al., 2013; Leibman, 2020). Since trauma causes a disruption in healthy relationships, it is important for clinicians to build an alliance with the client, as well as other professionals, to foster resilience and psychological safety for that client (Bath, 2015; Liebman, 2020). Efforts to collaborate can be counterintuitive if the organizations/agencies are not properly trained. P1 provided an example of how an individual was affected by a collaborative agency:

> And for social workers, mental health providers, emergency personnel, anybody that's not involved in the community, just learning about the culture that needs to happen…The police didn't understand, deaf culture, didn't understand how animated at times a deaf person can be, especially if they're agitated or upset and they would not have gotten the help, the mental health help that they needed had it not been for us finding out that this person had been arrested. The thing was this person had been arrested for several days in the county jail with no interpreter, no access to a video phone. And that's the sort of thing that needs to change.

P1's response was a significant case of retraumatization. The example of communication with the agency highlighted deficits in trauma-informed training which supports the need for collaborative organizations/agencies to be trauma-informed. This finding supports the scholarly research that the lack of knowledge, awareness, and training are elements in the healthcare system that may perpetuate retraumatization (Schippert et al., 2021).

Theme 3: TIP Should be Applied in Human Service Organizations to Better Support Employee Wellness

Psychological and physical safety of clients and staff is important in human service agencies and organizations as the staff can be affected vicariously because of the information and interactions they have with clients who have experienced trauma (Sullivan et al., 2018; Wolf et al., 2013). Safety and wellness for employees and clients can be achieved by promoting the development of healthy boundaries between clients and human services providers (Levenson, 2017; Wolfe et al., 2013). For example, P4 stated, "And no matter what it is, everybody seems to need boundary training, including ourselves as helpers who say yes to everything, you know, have to look within… And I think us as providers it's so important as well." When boundaries are not well established, it becomes easier for the trauma to transition from the client to the human service provider which can result in the boundaries continuing to erode to the point where the provider cannot effectively work with the client (Lee & Miller, 2013; Walker, 2004). P4 stressed the importance of having case managers not saying yes to everything, which can help with work-life balance. Work-life balance is important to achieving employee wellness and boundaries are also very important to achieving this for employees (Laker & Roulet, 2021).

Unfortunately, individuals who work in helping professions are often driven by the desire to help others and this can result in them being less effective in their work due to diminished boundaries which can lead to stress and burnout (Chiarelli-Helminiak et al., 2022; Lee & Miller, 2013). It is important for an organization to not only worry about the

well-being of those that they serve but also their employees. The implementation of such policies reinforces boundaries and employee wellness so that human service professionals may achieve work-life balance. P3 stated that their organization made sure "mental health services were more readily available, lowered caseloads, and stopped labeling sick leave." However, P3 shared that these policy changes only came as a result of substance use cases amongst case managers, which suggests organizations may be reactive instead of proactive. If an organization is reactive to the needs of their employees it also may mean that they are not following trauma-informed policies and procedures for their clients (Menschner & Maul, 2016). TIP is being considerate of the staff in the care setting as well as the client (Isobel & Edwards, 2017; Leitch, 2017). Organizations with cultures more supportive of trauma-informed employees are more effective in implementing TIPP changes in the organization (Dublin et al., 2021). P5 reported that case managers were quitting. P5 stated, "They're quitting cause they can't handle the work." According to P5, case managers at their organization were experiencing work-related stress.

Limitations of Study

The ability to recruit research participants in a timely manner who met the inclusion criteria was a potential limitation discussed in Chapter 1. It was a partial limitation for the study as recruitment for this study began just before the Thanksgiving holiday. I was recruiting throughout Thanksgiving, Christmas, and the New Year and responses were few. After those holidays, recruitment picked up and I was able to get the necessary number of participants to meet saturation.

A second limitation for the study was the weaknesses of purposeful convenience

sampling because it can result in a sample that would produce a potentially homogeneous sample which then limits who the results can be generalized to (Andrade, 2020). Eight participants were interviewed before I reached saturation and was given permission to end data collection. Only one of the eight participants was male and only one was Black/African American. Six participants had worked in non-profit organizations. Five of the eight participants had a bachelor's degree. Because the sample of participants was homogeneous, generalization of the results needs to be done cautiously and future researchers should attempt to address this limitation.

Another limitation of the study was that participants often used the terms *trauma-informed practice* and *trauma-informed policy* interchangeably. It was assumed that participants would understand that TIP and trauma-informed policy were different as understood by the researcher, but it was apparent that the participants did not necessarily differentiate the two as I did. I attempted to mitigate the extent of this limitation by providing a thorough explanation of how I conducted the different levels of coding and arrived at the final themes that answered the research question and then interpreted those results. However, future researchers should attempt to address this limitation as well.

Recommendations

I would first recommend that future researchers attempt to access and gather data from a more heterogeneous sample. The participants in my sample were very similar to one another (homogeneous) and this could have resulted in my reaching saturation in the data prematurely when compared to a more differentiated pool of participants. Therefore, the results of my study may not be generalized to the population of human service case

managers outside of those that are similar to the sample from my study.

Another recommendation is due to participants having used the terms trauma-informed practice and trauma-informed policy interchangeably. Participants did not make a distinction between the two terms, which may have influenced the findings of this study. Future researchers could help to understand the confusion in the use of trauma-informed terminology and how to make the distinction between the two by providing definitions of the two terms before collecting data. Providing these clarifications to participants may result in data that is more specific and more actionable for researchers and organizations.

While I attempted to describe and understand case managers' perceptions of TIPP across organizations and services through my study, there is still additional information that should be gathered by future researchers. Examples would include specific types of training that case managers receive related to TIC and the quality of those trainings. An additional recommendation for future research is related to the quality of implementation of these policies and practices within human service organizations. It would also be recommended to conduct research with participants who are clients of these organizations to study if the organizations are truly using these trauma-informed policies and procedures as intended and how they are impacting the clients that are served by the organization.

Implications

Implications for Positive Social Change

The problem that I attempted to address in this study, by providing additional

understanding and knowledge of case managers' perceptions of TIPP in human service organizations, were the negative repercussions of retraumatization such as feelings of being unsafe, anger, guilt, shame, depression, and secondary trauma at the hands of organizations and systems that are meant to help victims of traumatic events due to those organizations and systems not being based in trauma-informed approaches (Ezell, 2019; Huefner et al., 2020; Medenhall et al., 2018; Mersky et al., 2019; Salloum et al., 2018). Case managers are able to mitigate retraumatization through the appropriate use of TIPP, which may provide trauma victims with support and encourage the healing process (Levenson, 2017; Purtle, 2020). Furthermore, human service professionals may be able to ward off the effects of vicarious trauma creating better work-life balance (Abbott, 2022; SAMHSA, 2014). Work-life balance promotes longevity in the workplace and also makes it possible for professionals to better serve their clients (Brough et al., 2020; SAMHSA, 2014).

My results indicated there is a deficit/ambiguity in trauma-informed curriculums and training in human service organizations. Inadequate training leads to uncertainty in skills and strategies needed to respond to individuals with trauma (Berliner & Kolko, 2016; Cook et al., 2019). Results also indicated that more collaboration was needed with other trauma-informed organizations/ agencies. Lastly, the results indicated that TIP should be applied in human service organizations to better support employee wellness. Developing curriculums and trainings that provide more clarity or distinctions with trauma-informed terminology may alleviate confusion for human service professionals and can lead to confidence in their skills and abilities to assist individuals with trauma.

Developing a standard trauma-informed process for human service organizations that outlines specific measures to becoming a trauma-informed organization in addition to the key concepts may standardize training procedures and terminology usage amongst human service organizations and professionals creating more institutions of care that are trauma-informed. Specific measures to becoming a trauma-informed organization may also be inclusive of TIP that support employee wellness. It does not leave employers to determine the standard for employee wellness, but rather implements a base model for employers to address employee wellness with human service professionals who run the risk of vicarious trauma.

Implications for Practice

Retraumatization has been found to have negative repercussions for victims of trauma (Loughran & Reid, 2018; Pazderka et al., 2021; SAMHSA, 2014). The results of my study support the work of previous researchers who indicated that TIP may not be consistent across organizations and services (Carello & Butler, 2015; Champine et al., 2019; Hanson & Lang, 2016). My participants shared that there are deficits/ambiguity in trauma-informed curriculums and training, more collaboration is needed with other trauma-informed human service organizations, and a need to apply trauma-informed training practices to better support employee wellness. These are important takeaways for human service professionals, organizations, and the overall human service profession.

There is a need at many different levels to address the deficits/ambiguity that exist in trauma-informed curriculums and trainings. Increased training about TIPP may help case managers better respond to trauma victims and prevent retraumatization (Brand,

2016; Purtle, 2020). In addition, the information shared by participants in this study indicated that there was a need to not only increase the amount of training on TIPP but also to improve the quality of that training to better service clients. Increased quality of trauma-informed curriculums and trainings that are consistent across the helping professions may also be beneficial in helping human service, and other, organizations collaborate with one another (Beck et al., 2022).

The potential to increase collaboration (quantity and quality) with other trauma-informed human service, and helping, organizations is the second implication of practice for my study. The results of this study could be used to help human service organizations determine the areas of practice where collaboration is needed and how collaboration can be beneficial to trauma populations. Beck et al. (2022) supported the collaboration of trauma-informed agencies that share a common goal of serving a population. The researchers shared that interagency training spaces provide for participants to be highly trained and to take that training back to their organizations to invoke change at the organizational level (Beck et al., 2022). Thus, collaboration is an important implication for developing more consistent training across organizations in one locale which ensures that the collaborating agencies are being trained the same to avoid miscommunication and gaps in practice.

Finally, there is a potential implication for practice in relation to my finding that there is a need to apply trauma-informed training practices to better support employee wellness. Employee wellness is important when serving clients affected by trauma as the professionals themselves can suffer from vicarious trauma from these interactions

(Ashley-Binge & Cousins, 2019; Bloom, 2006). My results could be used to help human service organizations understand how to promote employee wellness in the organization since employee wellness can positively or negatively impact the quality of services that human service professionals provide to clients who have experienced trauma (Krekel et al., 2019; Sutton et al., 2016). Employee wellness may also help to create better work environments by supporting each other in the workplace (Krekel et al., 2019; Sutton et al., 2016).

Conclusion

It is my hope that this research will help organizations develop policies that best fit their employees while supporting victims. It is also my hope that case managers will acquire the necessary knowledge to advocate for themselves and the individuals whom they serve. I also hope this research expands the knowledge across the field to prevent the negative repercussions of retraumatization. Human service professionals understand the need to have TIPP in human service organizations (James, 2020). However, there are discrepancies in how TIP are carried out and what trauma-informed policies are in place to support the implementation of such practices (Benton et al., 2024; Long et al., 2022). This was evidenced in my study where there seemed to be some confusion on whether some organizations had TIPP or not. Furthermore, there were discrepancies in the use of the term "trauma-informed" by my participants. Agencies should increase trauma-informed curriculums and trainings that provide more consistency in trauma terminology. Also, agencies should train their staff on TIPP within their organizations and provide a clear distinction between the two so that staff have a better understanding of how to meet

the needs of the population they serve. More trauma-informed training that aligns with best practices and trauma-informed curriculums consistent across all organizations are needed to better support case managers in the field and prevent retraumatization of clients.

In addition to more trauma-informed trainings and curriculums, collaboration with other trauma-informed organizations/agencies was proven to be an important factor in care coordination and preventing retraumatization for victims. Organizations/agencies that work with each other should aim to have similar standards, practices, and policies when serving clients to ensure that communication between them is consistent and miscommunication does not occur that could result in gaps in service. These organizations/agencies should also aim to provide a trauma-informed work environment for their employees.

There is a need to support the well-being of case managers in human service organizations. Organizations are asking human service professionals to provide a service to those who have experienced trauma but have yet to fully consider the effects of those interactions for their own employees (Keesler, 2020). They have not fully considered that their employees could have once been a part of the populations that they are serving. Trauma-informed organizations have the potential to meet the needs of their employees who experience vicarious trauma in a way that is supportive and caring. An organization that prioritizes the health and well-being of its employees will be more likely to retain employees and mitigate vicarious trauma.

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Appendix A: Social Media Participant Invitation

Research participants needed!!!

About the study:

- 60-minute video interview that will be audio recorded.
- To protect your privacy, study will be published using fake names.

You may qualify if:

- You are 18 years of age or older;
- Currently or in the past have worked as a case manager in a human service organization (or equivalent position where you manage the cases of individuals and/or families);
- Currently, or in the past, have worked in a human service organization that has trauma-informed practices and policies in place;
- Read and understand English.

The study is about case managers' perceptions of trauma-informed practices and policies across organizations and services. The information you provide in this research study will be confidential and only used for the purposes of the study. This research is part of a dissertation study conducted by xxx, a doctoral candidate at Walden University. If you are interested in participating, please contact xxx at xxx@waldenu.edu

Appendix B: Interview Protocol

Hello, my name is xxx and I am a doctoral student at Walden University. I'm working on a research study titled *What are case managers' perceptions of trauma-informed practices and policies in human services organizations?* Thanks for agreeing to participate in this study. I would like to first review informed consent with you at this time. You have the right to withdraw from the study at any time. You also may choose to skip a question should you feel it is necessary. The research study should cause minimal discomfort. If you experience any distress related to the interview, you may reach out to the National Suicide Prevention Hotline at xxxx. This number is available 24 hours a day, 7 days a week. You may also contact the Crisis textline via text at xxxx. It is also available 24 hours a day, 7 days a week. However, the Crisis textline does not have a telephone number for you to speak with someone directly. The interview will take approximately 60 minutes and it will be audio recorded. A transcription of the interview will be emailed to you. Please respond to the email with any corrections or clarifications. After 7 days, I will proceed the next steps. The study will be published using fakes names to protect the identity of participants. Do you have any questions in reference to the information I just shared with you? Do you consent to continue with the research study at this time?

We will get started with some demographic questions at this time:

#	Question	Prompt(s)
1	What is your gender?	Male, female, other, prefer not to answer
2	What is your age?	Actual age in years
3	What is your race/ethnicity?	White, Black or African American, American Indian or Alaska Native, Asian, Native Hawaiian or other Pacific Islander
4	What is your highest level of education?	No high school diploma, HS diploma/GED, Certificate, Associates degree, Bachelor's degree, Master's degree, Doctorate degree
5	How long have you been a case manager?	Actual number of years
6	What type of human service organization do you/did you work for that had trauma-informed practices/procedures?	Government, Non-Profit, Private

Now, we will get started with our interview questions:

#	Question	Prompts
1	Describe the trauma-informed policies at your organization.	Tell me more about those policies (their purposes in the organization).
2	How did you implement these practices?	Give me more information about what you did.
3	What trauma-informed practices were implemented or changed at your organization over time?	Tell me more about how those changes took place.
4	How were you told to implement those changes?	Tell me more about how you carried out those changes.
5	What is the protocol for handling trauma victims or crisis situations at your organization?	Is this typically how they are handled? Why or why not?
6	What types of victims do you feel prepared to work with due to the trauma-informed practices at your organization?	Give me more detail on your reasoning.
7	How well did your supervisors support you in your implementation of trauma-informed practices?	Tell me more about what your supervisors did to support you.
8	What changes, if any, do you feel need to be made in trauma-informed practices (as they are implemented) to better help victims?	Tell me more about those changes.
9	Are you aware of any other trauma-informed practices and/or policies that would benefit your organization?	Tell me more about what they are.
10	Please share any additional information you think is important to our topic of discussion that I may not have asked.	

We have reached the conclusion of our interview. Is there any information that you

would like to share regarding the topic that we did not discuss today? Thank you for your time today. When the interview has been transcribed, I will forward the transcript to you so that you may check it for accuracy. Please make any corrections or clarifications and email them back to me. If no response is received after 7 days, I will assume that the transcription is correct to proceed with the study. Thanks again.