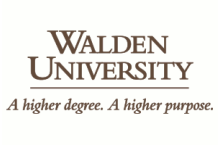

2020

Case Managers' Lived Experiences Working with Trauma Victims

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This is to certify that the doctoral dissertation by

Margaret Donohue

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
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Walden University
2020

Abstract

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by

Margaret Donohue

MS, Buffalo State College, 2001

BS, Buffalo State College, 1989

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Psychology

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Abstract

The purpose of this qualitative, phenomenological study was to explore and understand how case managers' (CMs') experiences listening to trauma stories of trauma victims affects them personally and professionally and what strategies they use to cope with hearing these stories. Constructivist self-development theory provided a framework for understanding the development of vicarious trauma in mental health workers. The central question and subquestions were developed to address the identified problem and purpose of the study, asking how CMs describe their experiences, how hearing trauma stories impacts CMs, and how CMs cope with their experiences of hearing trauma stories of trauma victims. Eight CMs from Western New York participated after meeting the inclusion criteria: a minimum 5 years' experience working in community-based programs with non-for-profit agencies, work with clients with a trauma history, and minimal training in trauma related treatments. Data were analyzed based on Moustakas's methods, and statements were synthesized into themes providing a description of the phenomena. Key themes included frequency of hearing trauma stories, the role of the CM, becoming desensitized, supportive supervisor, and a supportive work environment. The potential impact from this study for positive social change is a broader definition of vicarious trauma, which may allow for further theorizing of vicarious trauma.

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Dedication

"Life…is what you make it"

–Zach Matla February 11, 2005–April 29, 2017

In all that you do, make it a good one.

This dissertation is dedicated to my family and friends, for their unwavering support in helping me make myself, and my life, a good one. Most especially for my parents, Mary Lee and Eugene Donohue, my siblings and in-laws, Bryan and Susan Donohue, Noreen Blanchard, and Michael Donohue. My loving nieces and nephews who provided inspiration, even if they did not know it, Lauren and Austin Enser, Kevin, and Matthew Donohue. Especially, Isabelle and Gabriel Blanchard who always understood when I couldn't play, who constantly asked how my classes were going and if I had completed my homework, and who cheered all my successes. You are my heroes. To my friends, Marialuisa Ybarra and Danielle Hoover. You provided laughter and needed distractions. Finally, my supervisor, co-workers, and many colleagues who were so supportive of my efforts. I appreciate all of you and your constant encouragement more than you may ever realize.

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Table of Contents

List of Tables

Chapter 1: Introduction to the Study

Introduction

Vicarious trauma can be described as the cumulative effects experienced by a therapist as a result of repeated exposure to the trauma of their clients to the extent that it alters that individual's perception of self, others, and work overtime (Wang et al., 2014). Vicarious trauma is the emotions left after witnessing the fear, terror, and pain of a trauma survivor (American Counseling Association, 2014). Vicarious trauma is not a diagnosable disorder identified within the DSM-5; however, the term *vicarious trauma* was first coined by Pearlman and McCann in 1990 (Traumatic Stress Institute, n.d.). Vicarious trauma may be understood as a naturally occurring consequence of trauma work (Howlett, Collin, 2014; Wand, Strosky, & Fletes, 2014). Vicarious trauma is traditionally used to describe the impact of working with trauma survivors on therapists or disaster response workers; however, this does not acknowledge those who may work with trauma victims in a nonclinical environment (Smith et al., 2014).

The mental health field is comprised of both licensed and unlicensed mental health workers who provide support and services to clients with mental health needs in therapeutic settings such as clinics and non-therapeutic settings such as community-based programs. Among the unlicensed mental health workers are case managers (CMs), also referred to as social workers. The case management model grew during the late 1970s and early 1980s out of increasing demands for reduction in Federal Medicare expenditures, which were estimated to rise to 17% of the gross national product by 2007 (Cesta & Flater, 1999). Case management has become an important component of

integrated systems of care. As a client-level approach, it promotes integration of human services across providers (Hausdorf & Swanson, 2014).

CMs may be employed in hospital settings, nursing homes, community-based programs, and insurance agencies. In New York State, CMs provide services to seriously mentally ill adults and children through care coordination and advocate for clients' needs within the larger treatment team (Gellis & Kim, 2004). New York state case management standards include comprehensive assessment of the client, service planning, and crisis intervention (New York State Department of Health, n.d.). Case management standards require frequent, regular face-to-face visits within the home or community environment of the client (New York State Department of Health, n.d.). The role of CMs requires disclosures on the part of the client, which may include details on trauma such as childhood abuses, rape, community violence, or domestic violence (Sullivan, Kondral, & Floyd, 2015). Thus, CMs may be at risk for developing vicarious trauma. This exposure occurs due to the need for CMs and clients to develop a therapeutic relationship in order to support client success (Nath & Alexander, 2012). However, research related to CMs' experiences working with trauma victims is limited. The purpose of this study was to explore the lived experiences of CMs who have worked with trauma victims, which may lead to training that can reduce the negative impact of hearing clients' trauma stories, encourage awareness of the potential risk of developing vicarious trauma in CMs, effect policy changes, and increase vicarious trauma research with CMs.

In Chapter 1, I provide a background for the problem and the study and discuss the social implications of the study. Relevant sections in Chapter 1 include the problem

statement, the purpose of the study, a central question and subquestions, the conceptual framework, assumptions, limitations and delimitations, significance, concluding with a brief summary of Chapter 1.

Background

Forty to 80% of the general population within the United States has experienced a high level of exposure to traumatic events due to environmental factors such as terror attacks, mass shootings, childhood abuse, and sexual assaults (Bride, 2007). Eighty-four percent of these individuals with a history of trauma exposure seek professional, inpatient supports and 82% to 94% seek outpatient supports (Bride, 2007). Trauma stories told by trauma survivors to social workers have a lasting impact on workers' emotional well-being, affecting sense of purpose and vulnerability (Dombo & Bloom, 2016). Vicarious trauma happens from empathetic listening of trauma stories from clients, creating changes at the conscious and subconscious levels (Devilly, Wright, & Varker, 2009). The emergence of vicarious trauma occurs when, through repeated listening to trauma stories, providers like therapists previously developed cognitive schemas come into conflict with traumatic stories, creating new negative schemas (Wang, Strosky, & Fletes, 2014). These schematic changes may alter their view of a safe, caring world to one that is dangerous (Feldman & Kaal, 2007).

Vicarious trauma can result in workers experiencing a variety of symptoms such as anger, sadness, or intrusive nightmares (Dunkley & Whelan, 2006). Several themes have also been associated with trauma work, including emotional and physical changes to schemas, changes to behaviors, and coping with the traumatic work (Cohen & Collens,

2013). The result of indirect exposure to traumatic events may lead to job burnout, secondary traumatic stress, and decreased sexual desire (Branson, Weigand, & Keller, 2014; Cieslak et al., 2014). Retention of child welfare workers, social service personnel, and other human resource agencies is a serious concern, with exposure to clients' trauma being a main factor in job turnover (Middleton & Potter, 2015). Therefore, over the past two decades, the focus of research has been the impact that working with traumatized clients has had on therapists and counselors trained in trauma treatments (Adams, Boscarino, Figley, 2006; Dekel, Hantman, Ginzburg, & Solomon, 2007; Ray, Wong, White, & Heaslip, 2013). This research has assisted therapists in developing strategies for professional health, as identified by the American Psychiatric Association ("Professional Health and Well-Being for Psychologists," n.d.).

Organizations may also play an important role in employees' experiences with exposure to vicarious trauma. To assist trauma victims in avoiding future traumatization, many organizations have adapted a trauma-informed care model (Wolf, Green, Nochajski, Mendal, & Kusmaul, 2014). Trauma-informed care presumes that everyone within an organization, from cliental to management and support staff, have experienced trauma (either directly or indirectly) in their lifetime (Wolf et al., 2014). Trauma-informed care is viewed as beneficial not only for clients but also to those providing services to clients (Wolf et al., 2014). Therefore, this can be used to provide a supportive environment in which employee experiences are validated and normalized, which may assist in mitigating against the effects of trauma exposure (Knight, 2013).

Since the early 1980s, due to initiatives to decrease hospitalization and increase community supports for individuals who are mentally ill, CMs in New York State have worked with seriously and persistently mentally ill clients (Gellis & Kim, 2004). The director of the Niagara County Department of Mental Health, a trained trauma specialist, noted that outside of trained therapists and counselors who specialize in trauma therapy, little research on vicarious trauma exists. But providing supports to seriously and persistently mentally ill clients may place CMs at increased risk of exposure to clients with trauma histories and trauma stories.

To address CMs' risk for vicarious trauma, this study provided an examination of the lived experiences of CMs who work with clients who have experienced trauma. Most research related to CMs focuses on compassion fatigue and job burnout, with little known about the impact of hearing trauma stories upon the CMs (Gellis & Kim, 2004; King, 2009; Kraus & Stein, 2013). However, it is important to understand CMs' experiences to support implementation of trainings for CMs to prevent vicarious trauma and increase awareness of the impact of vicarious trauma. Specialized trainings for working with seriously mentally ill clients can decrease stress and turnover among CMs (Gellis & Kim, 2004).

Problem Statement

The experiences of CMs hearing trauma stories from clients have received little attention in the literature and are not well understood, as most research has been focused on burnout and compassion fatigue (Krus & Stein, 2013; Sullivan et al., 2015). But the American Psychological Association recognizes that professionals may be impacted by

the work they do, including developing vicarious trauma from treating clients who have experienced trauma (Fisher, 2013). A guideline for dealing with exposure to trauma via clients can be found in standard on competence 2.06, Personal Problems and Conflicts (Fisher, 2013). However, this standard does not include those not considered professionals such as CMs, which may explain the lack of research conducted on this population. Research on the impact on CMs from hearing clients' trauma stories may increase trainings and the development of protective factors for these individuals as well as have implications for other non-professional mental health workers such as direct care aides.

Because there are few studies that address the experiences of CMs who work with victims of trauma, the impact on CMs from hearing clients' trauma stories is not well understood. This study addresses this gap with phenomenological methods to gain an understanding of the lived experiences of CMs in hearing the trauma stories of their clients. This study may contribute to furthering research of vicarious trauma to including the CMs population.

Purpose

The purpose of this study was to explore the lived experiences of CMs who have worked with trauma victims. The focus was on how CMs describe their experiences of hearing trauma stories of these clients. This description will assist in closing the gap in understanding the experience of CMs listening to trauma stories of traumatized clients.

Research Questions

The central question and subquestions were developed to address the identified problem and purpose of the study:

Research question: How do CMs describe their lived experiences hearing the trauma stories of trauma victims?

Subquestion 1: How does hearing trauma stories impact the lives of CMs?

Subquestion 2: How do CMs describe their strategies in coping with the experience of hearing the trauma stories of trauma victims?

Conceptual Framework

The conceptual framework for this study was the constructivist self-development theory (CSDT). CSDT was developed by Perlman and McCann in the early 1990s (Traumatic Stress Institute, n.d.). CSDT is the theory-driven construct for understanding the gradual, covert, and permanent changes that occur in the helping professionals' cognitive schema (Middleton & Potter, 2015). Through CSDT, schemas provide the framework for an individual's beliefs, assumptions, and expectations that continually develop throughout someone's lifetime in the social interactions between the individual, others, and the world around them (Branson, Weigand, & Keller, 2014).

Based on the theory, new information can be continually entered into the person's existing schemas (Cohen & Collens, 2013). If this new information is incompatible with or in conflict with existing schemas, the schemas are modified (Cohen & Collens, 2013). For instance, hearing trauma stories of clients may provide a catalyst for new information, which could cause modifications to existing schema for the unlicensed

mental health worker. Through CSDT, an explanation for an individual who experiences vicarious trauma can be found when original schemas are modified negatively (Cohen & Collens, 2013). The results of these changes to the original schema are distress and a heightened awareness of the reasons for the changes that support the continuation of the new negative schema (Cohen & Collens, 2013). Those who work with trauma survivors may be forced to adjust to these modifications by learning new coping strategies.

CSDT provides a framework for understanding how vicarious trauma is acquired through transference of traumatic stories. Within this study, CSDT provided the framework for understanding how CMs describe their experiences of hearing clients' trauma stories and how they perceive hearing the trauma stories impacts them personally. CSDT will be further explained in Chapter 2.

Nature of the Study

I utilized a phenomenological design for this study. A phenomenological study is used to derive meaning from a person's experience from them describing their experience (Moustakas, 2011). This helps define the studied phenomenon through data provided by participants (Moustakas, 1994). However, the researcher is required to suspend prior knowledge of the phenomenon, which allows the researcher to gain an understanding of a phenomenon through new insights to define the phenomenon from a new perspective (Moustakas, 1994).

The key concept under investigation is the lived experience of CMs hearing trauma stories from trauma victims. Through open-ended interview questions, participants had the opportunity to describe their experiences hearing stories of trauma

from victims who have experienced the trauma. I followed the same semistructured interview format with each participant.

I collected data through interviews with CMs in the Western New York area. I requested permission from each individual participant for audio recording that was later transcribed. Hand-written field notes were also taken, which included time and place of interviews. Transcriptions of interviews along with field notes were analyzed for themes, which were then synthesized to provide a description of the phenomenon of CMs hearing the trauma stories of trauma victims (Moustakas, 2011). I used Moustakas's (1994) seven steps for data analysis: (a) list all expressions which are relevant to the experience, (b) reduce and eliminate to the invariant constituents, (c) cluster and develop themes for the invariant constituents, (d) check the invariant constituents against the records of each participant, (e) construct a textural description for each participant, (f) construct structural descriptions for each participant, and (g) construct a textural-structural description for each participant for the overall meaning and essence of the experience.

Definition of Terms

Case manager (CM): The identified population of nonprofessional mental health workers. These nonprofessional workers provide supports in the community, linking and referring clients to programs that support treatment, provide advocacy for clients, and assist in aspects of daily living ("Case manager," n.d.).

Compassion fatigue: A state in which those who help people in distress experience tension and a preoccupation with those who are suffering (Medscape, 2005). Often used interchangeably with vicarious trauma within the literature.

Compassion satisfaction: A feeling of satisfaction at doing a job well and recognizing the ability to help those in distress (Van Hook & Rothenberg, 2009). This term is often used interchangeably with vicarious trauma within the literature.

Job burnout: Noted as a key factor in CMs leaving their current job due to feelings of depersonalization, emotional exhaustion, and a decreased sense of accomplishment (Sullivan et al., 2015).

Licensed mental health worker: Individuals who meet and hold licenses based on New York State Guidelines ("License Requirements," n.d.).

Mental health workers: Professionals and nonprofessionals who provide supports and services to individuals with mental health needs (www.nysomh.gov, 2016).

Secondary traumatic stress: The emotional, physical, and cognitive impact on those who provide services to trauma survivors (Salston & Figley, 2003). Often used interchangeably with vicarious trauma within the literature.

Trauma: Interpersonal violence and neglect ("Professional Health and Well-Being for Psychologists," n.d.).

Trauma-informed care: According to Wolf et al. (2014), "an organizational change process that is structured around the presumption that everyone in the agency (from clients through agency management) may have been directly or indirectly exposed to trauma within their lifetime" (p. 111).

Unlicensed mental health workers: Individuals who provide supports and services to mentally ill clients who do not hold or meet licensing requirements in accordance with New York State Guidelines ("License Requirements," n.d.).

Vicarious resilience: The resilience process that occurs in therapists as a result of the work they do with trauma victims (Engstrom, Hernandez, & Gangsei, 2008).

Vicarious trauma: Emotional residue that counselors accrue as a result of hearing the trauma stories of trauma survivors (American Counseling Association, n.d.).

Assumptions

Assumptions are aspects of the study that are assumed but not proven to be true (Frankfort-Nachmias & Nachmias, 2008). In phenomenological research, there is an assumption that a shared "essence" to an experience exists within an identified population (Patton, 2002). Through rigorous analysis of the identified experience, phenomenological research identifies commonalities of the shared essence (Patton, 2002). The following assumptions were developed based on a central question and subquestions for identifying the commonalities among CMs.

It was assumed that CMs who agreed to participate willingly gave meaningful and accurate accounts of their experiences. It was also assumed that the participants provided honest responses to questions. Additionally, it was assumed that the participants' trauma clients have disclosed trauma stories to them. This study also included the assumption that I remained aware of my role as the researcher while interviewing participants.

The assumptions provided a basis for the parameters of the study. Within phenomenological research, to develop an accurate description for the phenomenon under investigation, the researcher must obtain detailed description from participants (Moustakas, 1994). Participants who do not fully disclose information may alter data analysis. Additionally, the phenomenological researcher must be aware of the effect of

their presence on the participants during interviews and must work to ensure they are not affecting participants' responses to questions.

Scope and Delimitations

The population consisted of eight CM's from not-for-profit agencies in Western New York who work with clients who have a history of trauma. This population was chosen due to the accessibility of their location. Additionally, the role of CMs is similar within these eight counties (and throughout New York State). The unlicensed mental health workers who were excluded from this study are direct care aides in residential and hospital settings and CMs who work for government agencies. This exclusion was based on job description, employment requirements, and the likelihood for these individuals not hearing trauma stories from clients as well as in recognition of the supports that these workers may be entitled to through unions.

Among the several theoretical frameworks excluded from the present study are cognitive dissonance theory, assumptive world view, and personality traits. Cognitive dissonance theory was excluded, as it has not been explored in research related to vicarious trauma. Assumptive world view has been explored in relation to trauma diagnoses such as post-traumatic stress disorder (PTSD) but not vicarious trauma. Finally, personality traits have been used to describe vicarious trauma within medical personal who are exposed to traumas such as major injury and illness, but they have not been linked to vicarious trauma in relation to hearing trauma stories of survivors, which would occur within the mental health population.

Limitations

All research contains inherent limitations (Marshall & Rossman, 2016). Limitations may be imposed by the location or population under investigation, as these place limits on the researcher's ability to make broad generalizations (Marshall & Rossman, 2016). Limitations may also occur during interviews as a result of distorted responses due to anxiety, emotions, politics, personal bias, or lack of awareness (Patton, 2002). In data analysis, limitations for developing themes is dependent on (a) the ability of participants to fully disclose experiences when sharing information relevant to the phenomenon, (b) the interviewer's insufficient knowledge of appropriate questioning, and (c) the interviewer's inadequate interpretation of the interviewee's responses (Marshall & Rossman, 2016). Either the researcher or participant may affect these limitations.

The effect of these limitations on interviews was addressed through practice interviews, which were conducted to enhance interviewing technique prior to the start of formal interviews. Additionally, because phenomenological research requires researchers to suspend their own ideas of the phenomenon (Moustakas, 1994), I used bracketing, which is a technique used by researchers to put aside their own assumptions (Patton, 2002). Bracketing was used to suspend personal perspective during the interview process and data analysis. To ensure that bracketing occurred, I refrained from judgment of the participants' described responses to hearing their clients' trauma stories. Additionally, I refrained from comparing participants' relaying of clients' trauma stories to my own experiences hearing trauma stories. This was done by making a conscious decision to set aside my own stories prior to beginning each interview process.

Significance

This study adds to the body of research about vicarious trauma and is significant because CMs have not been included in prior studies of vicarious trauma. Understanding vicarious trauma in CMs may result in better supervision practices and improved trainings. For instance, trauma-informed care is focused on clients, despite its design encompassing an entire agency (Wolf et al., 2014). Increased understanding of the benefits of improved trainings and supervision may assist in de-stigmatizing the impact on CMs hearing clients' trauma stories, even where agencies adhere to a model for trauma-informed care.

Data may also be used to assist in developing policy changes affecting factors contributing to development of vicarious trauma such as the number of clients on CMs individual caseloads. Policy makers and stakeholders may require data to bolster policy changes affecting CMs work expectations. A unique aspect of this research is that, in interviewing non-professional mental health workers about their experiences working with trauma clients, an expansion of the definition of vicarious trauma to include this population of the mental health field may occur.

Additionally, this study may demonstrate to community based CMs that vicarious trauma is an occupational hazard, helping to overcome the stigma attached to its symptomology. Findings may provide employers with information for dealing with symptomology, developing strategies to improve awareness, and providing direction in creating supports for employees at risk of exposure vicarious trauma.

Summary

CMs are helpers who provide necessary supports to mentally ill clients. Clients with mental health needs often experience exposure traumatic events such as natural disasters, man-made disasters, and physical, psychological, or sexual abuse. CMs also work with trauma survivors. Therefore, CMs may be exposed to hearing trauma stories of trauma victims. Research has demonstrated that exposure to stories of trauma survivors can lead to the development of vicarious trauma in therapists; however, current research does not include CMs at risk for vicarious trauma. Chapter 1 provided an introduction of this study.

The purpose of this study was to explore the lived experiences of CMs who have worked with trauma victims. This study has the potential to contribute to social change through further theorizing on vicarious trauma, furthering research to include CMs, potentially impacting policy makers, and assisting CMs in understanding the impact of hearing trauma stories of clients. Chapter 2 is a review of current literature. In Chapter 2, I will provide a summary of the literature search, including key search terms, and I will explore CSDT as the conceptual framework of the study.

Chapter 2: Literature Review

Introduction

Research has shown that vicarious trauma can result from listening to victims of trauma relate their experiences; however, studies do not generally focus on CMs (Smith et al., 2014). Vicarious trauma research has focused on those identified as trauma specialists or those identified as having primary contact with individuals who suffer trauma (i.e., law enforcement personnel and crisis-line volunteers; Heglund, 2009; Kinzel & Nanson, 2000). Additionally, beyond the initial development of the term vicarious trauma, a significant amount of vicarious trauma research is quantitative. But understanding vicarious trauma is important to limit any negative impact of the effects of vicarious trauma from workers onto clients. Despite this acknowledgment, research within the United States on those who work with mental health clients who are not professional trauma workers is limited (Michalopoulos & Aparicio, 2012). Thus, little is known about the experiences of CMs in hearing the stories of trauma victims and the impact these experiences have on them.

The purpose of this study was to explore the lived experiences of CMs who have worked with trauma victims. This study contributes to the body of literature on vicarious trauma, helping to eliminate the gap in the literature that indicates a lack of information outside of studies done on professional trauma workers (Michalopoulos & Aparicio, 2012). The remaining sections of Chapter 2 include a literature search strategy and the conceptual framework of CSDT. In the literature review, I synthesize the literature into

themes, identifying the key concepts of vicarious trauma research: predictive factors, coping strategies, and protective factors.

Literature Search Strategies

The literature review was conducted through Walden University library databases. The first databases accessed were PsychInfo, PsychArticles, and ERIC. Initial searches were done during the early stages of exploring vicarious trauma research to identify gaps within the literature. The search was gradually expanded to include PsychExtra, PsychTests, and Thoreau Multi-Database Search. This broader search helped in developing an understanding of the need for further research on the phenomenon of vicarious trauma within the CMs population.

Key search terms included *vicarious trauma, vicarious traumatization, secondary traumatic stress, and secondary trauma.* These terms were initially used independently to generate an overview of the research literature. The results indicated key concepts and the conceptual framework used to study vicarious trauma. The terms *vicarious trauma*, *vicarious traumatization*, *secondary traumatic stress*, and *secondary trauma* were then paired with *in case managers*, *CMs*, *in mental health workers*, *in trauma informed treatment*, *Laurie Pearlman*, and *Charles Figley*. This was done to generate a more comprehensive list of research articles relevant to this study.

Within the Thoreau Multi-Database, the term *vicarious trauma* resulted in 144 articles. When *vicarious trauma* was paired with *CMs*, *unlicensed mental health workers*, or *community based mental health workers* the results were zero. Similarly, when secondary trauma and vicarious traumatization were used with CMs, unlicensed mental

health workers, or community based mental health workers within the Thoreau Multi-Database, there were zero resulting articles. The same combinations were used within Pyshcarticles, PsychExtra, ERIC, and PsychInfo. The results located zero articles.

To overcome the obstacle of lack of research articles for the paired terms of *vicarious trauma* and *CMs*, an additional search was conducted through each of the databases on CMs. The initial search, using the broader term *case manager*, resulted in articles describing the inception of case management within the mental health field and physical health fields. A further search was conducted on the CMs. This search provided information on the current role of CMs. A review of these magazines for the past 5 years showed no current studies of vicarious trauma within the CM population.

A search within Walden University databases using the phrase *phenomenological studies of vicarious trauma* was also conducted on dissertations. There were an identified 170 qualitative dissertations that focused on vicarious trauma. Of these, 55 were identified as phenomenological studies of vicarious trauma, with the population under investigation specified as mental health workers. Additionally, the term *qualitative studies of vicarious trauma* was employed to account for any dissertations that used *qualitative* as a key term in a description of the study to determine whether any other dissertations using qualitative methodologies on vicarious trauma existed within the current dissertation databases. Once the search was completed, the identified populations under investigation were dissected. None of the phenomenological dissertations examining vicarious trauma that were found that focused upon the CMs population.

Conceptual Framework

The conceptual framework for this study is CSDT, which was first proposed by Pearlman and McCann in the early 1990s when they were beginning to identify the phenomenon of vicarious trauma (Traumatic Stress Institute, n.d.). McCann and Pearlman noted that burnout, the psychological effects of working with difficult populations, did not explain the complex changes they witnessed in therapists undergoing during their work at The Traumatic Stress Institute. Additionally, the authors noted that countertransference was not defined to describe the phenomenon of vicarious trauma. Countertransference is described as therapists' own unresolved concerns or unconscious conflicts being activated (McCann & Pearlman, 1990). Countertransference has been used within victimization literature to broadly describe the incorporation of trauma survivors' images, intense thoughts, and painful feelings that often accompanies working with the trauma victim (McCann & Perelman, 1990). However, CSDT provides an explanation for the complex changes to schemas affecting trauma therapists when they hear the violent stories of trauma victims (McCann & Pearlman, 1990). According to CSDT, individuals develop schemas by which they frame their assumptions, beliefs about self and others, and expectations of the world that continually grow and evolve over time (Branson et al., 2014). Changes may occur when these schemas are disrupted with new information that is contrary to established beliefs and that cannot be assimilated into the already existing schemas (Wang et al., 2014).

CSDT is based on a constructive perspective where the clinician assimilates the unique emotional and psychological experiences of trauma of an individual onto

themselves as an adaptive response (Branson et al., 2014). Clients' telling of traumatic events are often accompanied by sensory perceptions, and from this, therapists create their own internal understanding of the trauma, which may result in the alteration of their own personal schemas (Branson et al., 2014). There are five identified needs which CSDT hypothesizes are specifically affected by when an individual experiences trauma: safety, trust, esteem, intimacy, and control (Varra, Peralman, Brock, & Hodgson, 2008). An individual develops schemas based on these factors regarding themselves or others (Varra et al., 2008). Therefore, an individual may develop trauma from a personal perspective or through the perspective of others. Pearlman designed The Trauma and Attachment Belief Scale (previously TSI Belief Scale, revision L) to measure disruptions within these five needs (Varra et al., 2008).

CSDT is the principle theoretical framework identified throughout the research on vicarious trauma (Branson, Weigand, & Keller, 2014; Varra et al., 2008; Wang, Strosky, & Fletes, 2014). In trauma treatment, the licensed therapist becomes exposed to the violent stories of abuse, crime, and other traumatic experiences of the client (Van Hook & Rothenberg, 2009). The repeated exposure to these stories may become internalized by the therapist, altering the therapist's own schemas and worldviews as they begin to see the world from the reference point of the client (Van Hook & Rothenberg, 2009). Thus, professionals should be aware that, through their work with trauma victims, they are susceptible to changes their core beliefs (Knight, 2013).

Since its inception, CSDT has been used to explain the phenomenon of vicarious trauma within the therapeutic environment by professional mental health workers. The

lack of research on vicarious trauma conducted on CMs, however, has resulted in no conceptual framework for exploration of the phenomenon in this population. Therefore, I chose CSDT as the conceptual framework for this study due to the theory's ability to explain the acquisition of trauma by the therapists through exposure to client trauma stories, which leads to vicarious trauma.

CSDT also provided a basis for understanding the ways in which participants' schemas may be altered as a result of hearing trauma stories to answer the research questions. The central question for this study was designed to understand the ways in which CMs describe their experiences working with trauma victims. The first subquestion asks how CMs are impacted by hearing of the client trauma stories. The second subquestion asks in what ways CMs cope with hearing the client trauma stories.

Literature Review

Key Constructs

The primary construct under investigation in this study was vicarious trauma. Throughout the literature, vicarious trauma is often used synonymously with other constructs such as burnout, compassion fatigue, and secondary traumatic stress (Salston & Figley, 2003). Vicarious trauma describes the cumulative effects experienced through repeated exposure to the trauma stories of others over time that may alter the hearer's perception of self, others, and their work (Wang et al., 2014). In contrast, secondary traumatic stress may be the result of a single episode of exposure to trauma experienced by another, which may include not only trauma specialists but the trauma victim's personal social supports like family and friends (Wang et al., 2014). Further, researchers

such as Charles Figley have expressed a preference for the use of the term compassion fatigue over secondary traumatic stress (Wang et al., 2014). Additionally, burnout occurs in response to interpersonal stressors of the job, with symptoms that may include overwhelming exhaustion, detachment from the job, and cynicism (Devilly et al., 2009). For this study, the term *vicarious trauma* was used except in incidents where studies are being described that use one of the synonymous terms.

The population under investigation in this study included CMs. Within the literature on CMs, the focus is on burnout and decision-making rather than on vicarious trauma (Crook & Vinton, 2000; Gellis & Kim, 2013; Kraus & Stein, 2013). For example, Gellis and Kim (2013) studied job stress for mental health CMs and found that work climate and job stressors such as lack of organizational supports and relationship problems with supervisors significantly impact CMs' job functioning. Similarly, Kraus and Stein (2013) found that professional burnout and job satisfaction in CMs is tied to organizational supports. Thus, considering the social context of an organization is important when assessing organizational health, as it may impact both quality of services and staff turnover (Middleton & Potter, 2015). The culture of an organization is defined by its norms, expectations, and the way things are done, whereas the climate of an organization is viewed as psychological and organizational (Middleton & Potter, 2015). Psychological climate refers to a worker's perception of the psychological impact the work environment has on personal well-being (Middleton & Potter, 2015). Caseload size has also been found to directly contribute to CMs experiencing of work-related stress, which is related to a lack of self-efficacy in completing their work (King, 2009). Despite

research on these job-related stresses on CMs, there has been no focus on CMs and vicarious trauma.

Studies of vicarious trauma can be broken into three categories: those exploring risk factors for vicarious trauma, those evaluating symptoms for vicarious trauma, and those studying preventative factors against vicarious trauma or resiliency (Bride, 2007; Chopko & Schwartz, 2009; Devilly et al., 2009; Howlett & Collins, 2014; Mairean & Turliuc, 2013; Oerlemans & Bakker, 2014; Sweifach, Linzer, & LaPorte, 2012). Researchers have explored the phenomenon of vicarious trauma through quantitative and qualitative methodologies (Adams & Riggs, 2008; Dekel et al., 2007; Harrison & Westwood, 2009; Hernandez et al., 2007; Hernandez, Engstrom, & Gangsei, 2010). One positive aspect of the current vicarious trauma research is the large quantity of studies, as vicarious trauma has received much attention after it was first defined in the mid-1990s.

Despite the quantity of vicarious trauma research, the weaknesses inherent within the literature include inconsistency of terminology. Secondary traumatic stress, vicarious trauma, and compassion fatigue are often used interchangeably to describe the impact upon professionals from exposure to their clients' traumatic events (Knight, 2013). Researchers often note which term will be employed within their study, but certain researchers further specify the differences between these concepts. An additional weakness is in the identified populations that are investigated for vicarious trauma, which may in part be due to terminology. Most vicarious trauma research is conducted on professionals, whereas nonprofessionals are explored through compassion fatigue (Iqbal,

2015; Jordan, 2010; King, 2009; Kraus & Stein, 2013). Generating a consistent definition for vicarious trauma may assist in expanding research onto populations yet unexamined.

Vicarious trauma was chosen as the primary concept for this study due to the noted weaknesses in terminology and because of the limitations on the populations studied. Studies of CMs identify similarities to professionals in the hearing trauma stories from clients, yet these studies do not note the changes in schemas may occur and may result in vicarious trauma (Sullivan et al., 2015; Young, 2009). However, CMs may be faced with exposure to vicarious trauma without the benefit of protective factors more often afforded to mental health professionals.

Risk Factors

In studies identifying risk factors, researchers focus on age, personality, personal trauma history, social supports, and years of service (Dekel, Hantman, Ginzburg, & Solomon, 2007; Iqbal, 2015; Jordan, 2010; Mairean & Turliuc, 2013; Zerach, 2013). For example, Van Hook and Rothenberg (2009) noted significant differences between gender and age in reports on compassion fatigue, finding that females and younger workers were more likely to score higher for compassion fatigue. Additionally, there are aspects of personality that may predict vicarious trauma (Mairean & Turliuc, 2012). Data shows neuroticism to be a strong predictor of vicarious trauma, but extraversion and conscientiousness can be predictors for post-traumatic growth.

Past trauma history of the clinician as a predictor for development of vicarious trauma has resulted in conflicting findings within the literature (Dunkley & Whelan, 2006). The assumption is that past personal trauma history left unresolved has already

altered the schema of the counselor, which may leave the clinician vulnerable to development of vicarious trauma (Michalopoulous & Aparicio, 2012). However, empirical evidence related to this hypothesis is inconsistent, perhaps due to different methodologies (Michalopoulous & Aparicio, 2012). Regardless of inconsistent findings, personal trauma history is at least suggestive of future psychological distress when working with trauma clients (Buchanan, Anderson, Uhlemann, & Horwitz, 2006). Those who work in community-based agencies in which caseloads have a high incidence of clients with trauma histories are more likely to report distress (Buchanan et al., 2006).

Caseload size and organizational supports have also been contributing factors for depressed mood and job burnout (Gellis & Kim, 2004; King, 2009). The number of clients CMs are responsible for, as well as client demographics, contribute to caseload management (King, 2009). When CMs experience caseloads in excess of 20-30 clients, it is suggestive of increased work-related stress (King, 2009).

Descriptions of work expectations for this population may place them at risk for exposure, but additional risk factors for vicarious trauma have not been explored in relation to CMs. As a result, there is little to no understanding of how CMs view themselves as being at risk for development of vicarious trauma. Without recognizing the risk factors, CMs may be unable to consciously employ the coping strategies that may act as preventative factors.

Symptomology

Vicarious trauma is also studied by focusing on its symptomology: what happens to the individual who develops vicarious trauma. Middleton and Potter (2015) found that

child welfare professionals' exposure to vicarious trauma may impact their capacity to trust anyone, including their own professional judgement. This in turn may negatively impact the workers' personal lives and hurt them professionally in interactions with colleagues (Middleton & Potter, 2015).

Among the symptoms of vicarious trauma are nightmares, flashbacks, dread, feelings of hopelessness and cynicism, and sadness (Jordan, 2010). Studies on the impact of working with traumatized clients have found that professionals often exhibit signs of extreme emotional distress, being emotionally drained, or have some degree of post-traumatic stress disorder (Figley, 2002). In a study of professionals who worked with parents whose children either died or were severely injured in a fire at a pre-school, conducted by Shannonhouse, Barden, Jones, Gonzalez, and Greensboro (2016), participants reported higher levels of feeling sad, anger, guilt, and a sense of helplessness.

Branson, Weigand, and Keller (2014) studied vicarious trauma in behavioral health clinicians in relationship to a decrease in sexual desire. The authors predicted an inverse relationship between vicarious trauma and sexual desire, and posited that vicarious trauma is a stronger predictor for decreased sexual desire than risk factors such as years of experience, gender, age, and sexual trauma history (2014). The results indicate that vicarious trauma is a significant predictor for decreased sexual desire among behavioral health clinicians (2014). These results demonstrate that the effects of vicarious trauma may impact professionals in unseen ways.

Additional unseen effects of vicarious trauma may include the altering of brain's limbic system. Various studies noted that the impact of hearing trauma stories may derive

from empathetic listening of the professional to clients' recounting of trauma (Adams et al., 2006; Bride, Radey, & Figley, 2007; Tyler, 2012). Empathetic listening occurs when the therapist places himself or herself in the position of the traumatized individual, thus absorbing the trauma as their own (Tyler, 2012). Tyler (2012) noted the impact that trauma, whether it occurs firsthand or vicariously, may affect the limbic system. The limbic system includes the amygdala and hippocampus; the amygdala is the area in which trauma memories are stored (Tyler, 2012). When trauma occurs, the amygdala activates the automatic nervous system and the parasympathetic nervous system (Tyler, 2012). Tyler (2014) postulated that the limbic system, specifically the right-side amygdala, may be linked to the psychological changes that occur within professionals who work with traumatized.

A common defense against trauma linked to the limbic system is disassociation, which includes disengaging from what is viewed as the external world through techniques such as avoidance, numbing, fantasy, and daydreaming (Tyler, 2012). It is posited that when the automatic nervous system and parasympathetic nervous system are activated impairments occur with working memory, impaired decision-making, and the ability to consider options (Tyler, 2012). These detrimental effects may be linked back to symptomologies identified as PTSD, like those experienced by clients, as the brain in these situations does not distinguish between primary and vicarious traumatic experiences.

The American Psychological Association identified potential consequences for ignoring the hazards of occupational stress, including vicarious trauma, as depression,

social/professional isolation, relationship conflicts, suicide, chemical abuse or dependence, job dissatisfaction, unprofessional behaviors, stress-related illnesses, and ethical violations ("Professional Health and Well-Being for Psychologists," n.d.). Within the research literature, vicarious trauma is identified as potentially having an adverse effect on the therapeutic relationship which may present ethical dilemmas to therapists (2010). As posited by CSDT, changes in a therapist's schemas occur as a result of vicarious trauma (2010). Due to these changes, therapists may experience alterations in their perception of self and the world around them, which may in turn impact their competence.

The literature related to symptoms of vicarious trauma focuses solely on the professional population; there is little to no such literature concerning CMs. As a result, there is no understanding of the ways in which the trauma stories of clients affect this population. CMs who may experience the symptoms of vicarious trauma may or may not be aware of the impact it has on their lives, as this area is left unexplored within the research literature.

Protective Factors

Protective factors against vicarious trauma may be attributed to possessing coping strategies which mitigate against vicarious trauma symptomology. The American Psychological Association recommends that risk for development of occupational hazards for professionals, such as vicarious trauma, be taken seriously, with plans for dealing with occupational stress ("Professional Health and Well-Being for Psychologists," n.d.). Themes identified as important, which contribute to decreasing vicarious trauma, include

supervision, peer supports, healthy stable personal relationships, continuing education, rest, exercise, relaxation, and spirituality (Harrison & Westwood, 2009).

Pack (2013) suggested that experiencing vicarious trauma is necessary for professional growth, as through this experience, the individual learns coping strategies and builds self-efficacy. The experience of vicarious trauma requires the individual to self-reflect, leading to vicarious resiliency (Pack, 2013). Self-talk may be used by professionals to remind themselves that intrusive distorted thoughts are not their own, but rather, result from the work they do (Knight, 2013). In this way, recognizing thoughts and feelings normalizes and validates them, taking ones away from the professional for the distorted though (Knight, 2013).

Professionals who seek continuing education related to trauma work may learn ways to decrease the symptomology of vicarious trauma (Trippany, 2004). Additionally, personal coping strategies, such as socializing with friends and involvement in physical and creative activities, creates a balance which may decrease the effects of vicarious trauma (Trippany, 2004). Creative activities can be employed as debriefing techniques for professionals, following interventions for traumatized individuals (Gergerson, 2007). Art therapy, sand play, and poetry writing are described as creative activities that may prove beneficial to therapists in dealing with clients' traumas (Gergerson, 2007). After work activities are those which allow separation from the job for the therapist.

Research has suggested that professionals who possess close relationships with family, friends, or significant others may prevent disruptions to schemas which lead to vicarious trauma (Michalopoulous & Aparicio, 2012). Inappropriate coping strategies

such as isolating behaviors, resulting from disruptions in schemas, may impact professionals with exposure to vicarious trauma (Jordan, 2010). Research has indicated that social supports are a protective factor against vicarious trauma, and professionals are encouraged to proactively engage in social activities (Michalopoulus & Aparicio, 2012; Jordan, 2010).

Social supports are not the only activities which may assist in elevating vicarious trauma. Self-care and leisure activities, such as a healthy lifestyle that includes a balanced diet and exercise, and adequate rest, are also identified in the literature as important steps professionals should take (Jordan, 2010). In a study of job burnout, Oerlemans and Bakker (2014) looked at aspects of daily recovery that assist in lowering job burnout. The results indicated that burnout relates negatively to state of physical vigor, state of cognitive liveliness, and state of recovery, with control variables for age, weekly hours or work, and educational levels not relating to any of these recovery states (Oerlemans & Bakker, 2010).

The implications of this study are that increasing physical activity levels, social activity levels, and cognitive activities, such as continued education, increase recovery from work-related stress, regardless of covariates that have been shown to increase likely development for vicarious trauma (Oerlemans & Bakker, 2010). This ability to bounce back or recover may be attributed to resilience. Resilience is identified as a normal human reaction to stress, in which an individual exhibits' a pattern of positive adaptations against past or current adversities (Hernandez, Gagsei, & Engstrom, 2007). Personal coping strategies may also include spirituality.

Spirituality as a means to decrease vicarious trauma has also received some focused attention within the literature (Zerach, 2013). Spirituality is not easily defined and does not necessarily equate with religion. Possessing a sense of spirituality has been identified as a key factor for mitigating against vicarious trauma (Zerach, 2013). Trippany (2004) noted that those with a sense of spirituality may have a greater sense of connectedness, with one survey noting 44% of counselors surveyed reported spirituality as an effective coping strategy against vicarious trauma. Professionals may also experience a sense of community and feeling of growth. Shannonhous et al. (2016) noted that participants reported a sense of solidarity with the community in which they worked following a fire tragedy at a day care. Participants identified becoming engaged in movements to improve and regulate standards in daycares, heightened spirituality, increased advocacy, and a greater sense of community issues. Themes of transformation included a greater sense of purpose, direction, and increased awareness, with participants providing statements of positive self-growth.

Protective factors may also occur within the work environment. Professionally, it is recommended that workers engage in regular peer supports and supervision, managing a case load with a balance of traumatized and non-traumatized clients, and case conferencing (Harrison & Westwood, 2009). These activities are suggestive of emotional supports which counter professional isolation (Harrison & Westwood, 2009). Ongoing discussions with supervisors should include symptomology, risk factors, and identified protective factors for compassion fatigue, so supervisees may learn to identify impairment, and are more open to discussing concerns as they develop ((Merriman,

2015). Supervisors should create an avenue for supervisees to discuss issues relevant to hearing client trauma stories, without turning these discussions into therapy sessions (Knight, 2013).

In a study of child welfare workers from Central Florida, respondents noted ways in which organizations can assist in reducing worker stress (Van Hook & Rothenberg, 2009). Of the 182 participants identified, the following case load management techniques were identified 22% (N=40) reduce case load, 12.1% (N=24) implement less red tape, 11% (N=20) increase staff (Van Hook & Rothenberg, 2009). In organizational supports, respondents identified increased administrative supports 20.9% (N=38) and offer incentives 11.5% (N=21).

These findings are consistent with recommendations within the literature for agency responsibilities for supervision, staffing, and case load management (Trippany, 2007). Evidence related to incentives suggests that pay increases correlate positively with decreasing psychological stress, as they may lead to feelings of success as a counselor (Trippany, 2007). In a qualitative study of school counselors, it was found that peer supervision was identified as significant in the alleviation of symptoms for vicarious trauma (Parker & Henfield, 2012).

Peer supervision occurs when colleagues and co-workers discuss cases or other work activities. The benefits of peer supervision include providing colleagues with the opportunity to debrief, examining their perspective, and verbalizing reactions to clients' trauma stories (Trippany, 2007). This form of supervision may also provide an

opportunity to hear how colleagues dealt with their own past experiences, offering suggestions (Parker & Henfield, 2012).

Coping strategies may assist not only in buffering against stress, but also in transforming vicarious trauma into vicarious resiliency, or compassion satisfaction. Vicarious resilience, compassion satisfaction, and post-traumatic growth are all terms used to describe the positive effects professionals experience in working with trauma victims (Chopko & Swartz, 2009; Hernandez et al., 2007; Radey & Figley, 2007). Rather than negative changes to schemas that result in vicarious trauma, professionals may manifest positive views from their work, resulting in a deeper appreciation of life and stronger feelings of professional and personal worth (Chopko & Swartz, 2009).

In order to develop a sense of satisfaction, it has been suggested that, instead of avoiding compassion fatigue, to protect themselves against the negative consequences of vicarious trauma, professionals should promote a sense of satisfaction in their work (Radey & Figley, 2007). In a study for development of compassion satisfaction Kjellenberg, Nilsson, Daukantaite, and Cardena (2014) looked at four hypotheses related to trauma work, compassion satisfaction, and compassion fatigue. The first hypothesis, that trauma workers would be both positively and negatively affected by the work they do, was supported (2014).

As to the development of post-traumatic growth, within this finding, the authors noted that while some trauma workers did not experience any growth, others experienced high levels of growth (Kjellenberg et al., 2014). In a qualitative study of vicarious resiliency, Hernandez, Gangsei, and Engstrom (2007) conducted interviews with trauma

workers. The authors reported that themes for the development of vicarious resiliency were tied to victim's ability to demonstrate recovery following a traumatic event Hernandez et al. (2007).

It has also been posited that a positive transformation occurs when therapists learn from clients about coping with adversity (Engstrom, Hernandez, & Gangsei, 2008). Research has suggested that professionals and organizations should actively seek ways to transform vicarious trauma, for the well-being of those who work with trauma victims (Harrison & Westwood, 2009). The activities suggested for this process to occur are continuing education, peer supports, personal supports, a balanced lifestyle, professional supervision, and coping strategies (Harrison & Westwood, 2009). This study looks to understand how CMs view coping strategies in relation to vicarious trauma, a subject not currently addressed within the research literature.

Summary and Conclusions

Three major themes developed from the literature review of vicarious trauma-predictive factors for development of vicarious trauma, the coping strategies used to mitigate against vicarious trauma, and preventive factors for vicarious trauma. Predictive factors are those themes identified as impacting the development of vicarious trauma through CSDT. Coping strategies are those themes identified as means for individuals and organizations to manage symptoms of vicarious trauma. CSDT provides a framework for understanding the benefits of early coping strategies, in how these mitigate the long-term effects of exposure to vicarious trauma. Preventive factors identify areas in which individuals and organizations may proactively minimize exposure to vicarious trauma, by

developing strategies to protect individuals against schema changes. These themes were used as a framework for the literature review. Much is known about vicarious trauma in regard to professionals, such as therapists, who work with trauma victims. As they fall outside of this established literature of professionals, little is known about CMs and their experiences hearing trauma stories. The present study looks to close the gap by exploring vicarious trauma within CMs. Research design, target population, ethical considerations, and role of the researcher will be addressed in Chapter Three.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore the lived experiences of CMs who have worked with trauma victims. The goal was to understand how the experience of hearing stories from trauma victims is perceived by the CMs who work with them. Case management requires comprehensive assessments and regular face-to-face visits with clients (New York State Department of Health, n.d.). Comprehensive assessments include disclosure of client trauma history (Sullivan, Kondral, & Floyd, 2015). Therefore, CMs working within community-based mental health programs may work with clients with a history of trauma. Obtaining assessments as well as regular face-to-face contact may result in CMs' repeated exposure to client traumas. Interview questions were asked in a broad manner to allow CMs to provide details of their experiences and to limit leading responses. The major sections of Chapter 3 are research design and rationale, the role of the researcher, methodology, issues of trustworthiness, and a summary of the chapter.

Research Design and Rationale

The central question and subquestions were developed to address the identified problem and purpose of the study. The goal of the central question that guides the study is generally derived from the desire to understand a phenomenon, which can lead to findings and the basis for future studies (Moustakas, 2011). In this study, the goal was to understand the lived experiences of CMs hearing trauma stories of trauma victims, which can lead to better understanding about vicarious trauma. The following were the research question and subquestions for the study:

Research question: How do CMs describe their lived experiences hearing the trauma stories of trauma victims?

Subquestion 1: How does hearing trauma stories impact the lives of CMs?

Subquestion 2: How do CMs describe their strategies in coping with the experience of hearing the trauma stories of trauma victims?

This study was conducted using a qualitative, phenomenological approach. The goal of phenomenological researchers is to produce a rich, thick description of the lived experiences of participants (Moustakas, 1994), determining what an experience means for them in the context of the phenomenon being studied (Moustakas, 2011). The central phenomenon of this study is the experiences of CMs working with trauma victims and hearing their stories. Thus, a phenomenological approach was best suited to providing a description of a phenomenon from the perspective of the individuals who have lived it. Through this approach, participants were able to provide descriptions of their experiences working with trauma victims.

Role of the Researcher

In phenomenological studies, the researcher discovers a topic and questions that based on their own understanding while suspending judgment and setting aside previous knowledge, which is the process of epoch (Moustakas, 2011). It is also important for the researcher to adopt a phenomenological attitude in order to not make assumptions about the phenomenon but rather consider it from the participants' perspectives (Willig & Stainton-Rogers, 2011). In the process of epoch, the researchers identify their own notions of the phenomenon, put these notions aside, and focus on the thoughts and ideas

of the participants to describe the phenomenon. Further, questions qualitative researchers may ask themselves include (a) what do I know?, (b) how do I know what I know?, (c) what shapes and have shaped my perspective?, (d) with what voice do I share my perspective, and (e) what do I do with what I have found? (Marshall & Rossman, 2016). In my role as researcher in this study, I considered these questions and established epoch through bracketing by using reflexive journaling.

In my role as a CM, my own experiences were the catalyst for the central and subquestions for this study. As a CM, I hear trauma stories of clients not only during the assessment process but in the natural course of providing case management services. Clients regularly retell trauma stories for care coordination with other providers, crisis planning, and simply to have someone to tell their story to. I have also experienced colleagues recounting their experiences hearing client trauma stories or recounting their experiences of witnessing client trauma, suicide, self-harmful behaviors, or the death of a child.

In this study, my role as researcher consisted of conducting interviews, recording responses through field notes and audio recordings, and analyzing data, providing a structured meaning of the phenomenon based on participants' experiences. Interviewing is an essential element of phenomenological research, which is often informal and interactive between interviewer and interviewee with the use of open-ended questions (Moustakas, 2011). The role of the interviewer is to establish a relaxed and creative climate in which the interviewee feels comfortable providing honest and comprehensive answers to questions (Moustakas, 2011). In keeping with this methodology in my

interview process, I established an atmosphere that is relaxed, developed questions that are open-ended creating room for dialog with participants, created an environment of honesty, created an environment free of judgment, and set aside my own past experiences in order to not cloud or direct the interview.

I also used bracketing to delineate my own personal thoughts, feelings, and observations on the phenomenon of CMs hearing trauma stories from trauma victims. Bracketing refers to the process of suspending personal assumptions about the phenomenon (Creswell, 2013). It is essential for a researcher to put aside judgment and prior knowledge in order to explore the phenomenon from a fresh, new perspective (Moustakas, 2011). Following each individual interview, I allowed myself time to reflect on the process through journaling. Reflective journaling is a way for the researcher to create a personal dialogue on the ideas and experiences that aided in decision-making and problem-solving (Reece, 2014). Reflexive journaling also adds to the credibility of a study, as it provides a written account of the researcher's history, personal interests, and challenges as well as the thoughts and ideas that the researcher had throughout data collection and analysis (Houghton et al., 2012). This method of reflective journaling helped me keep my voice neutral and interpret data from the perspective of the participants in addition to helping me look at my thoughts from data collection during data analysis. Additionally, readers may be able to understand my process, thoughts, and challenges leading to the final description for the phenomenon of CMs hearing trauma stories of clients.

Further, as a member of the larger CMs community within the Western New York region, there are many agencies to which I have no connection, which helped me to avoid any possible relationship, personal or professional, with any of their members. The not-for-profit agency for which I work has multiple programs across all eight Western New York counties. Due to the size of the agency, many of the workers eligible for participation within this study were unknown to me personally or professionally. Therefore, no conflict of interest or power dynamics were at play, as there was no shared connection between me and potential participants. I did not recruit participants from within my department.

Methodology

Participant Selection

The number of participants required for a qualitative study depends on the study itself such as the purpose of the study, what the researcher knows, and how the results will be used (Patton, 2002). Studies with small numbers of participants require in-depth data, whereas large numbers of participants provide breadth within the topic (Patton, 2002). For the purposes of this phenomenological study, eight participants were recruited to provide a depth of information.

Participants were recruited using purposeful sampling strategies. Purposeful sampling refers to participation selection focusing on specific individuals who can inform the study (Creswell, 2013). This sampling strategy allows for the identification of individuals who meet the participant criteria. Because the goal of phenomenological research is to understand individuals lived experiences of a phenomenon, purposeful

sampling helped identify and recruit those who met identified criteria and ensure that participants had similar experiences of a phenomenon.

Snowball sampling was also used to enhance recruitment if not enough participants met inclusion criteria through purposeful sampling. Through snowball sampling, cases are proposed based on individuals known to the researcher who know other individuals who have rich information, would be good interviewees, and are good examples for the study (Patton, 2002). I employed snowball sampling by asking colleagues if they had any knowledge of groups of individuals or agencies which I had not considered through which I would be able to recruit participants.

Through these sampling strategies, eight individuals who work as CMs with clients who have a trauma history were invited to participate in this study. The criteria for participation for this study were as follows: (a) individuals must be working as CMs in not-for-profit agencies, (b) participants must have a minimum of 5 years' work experience as a CMs, (c) participants must be CMs who work with clients who have a trauma history, and (d) participants must have little to no training specific to trauma-informed treatments. The selection of this criteria ensured that participants not only work as CMs but have done so for a sufficient amount of time to have experienced hearing the trauma stories of clients in order to provide data to answer the research questions. The final criteria, for little to no training specific to trauma informed treatments, was intended to minimize any preconception participants may have had in relation to the phenomenon of the impact hearing trauma stories of clients has on them.

Participants were recruited from not-for-profit agencies throughout the Western New York area. Identified agencies had to be providing services to clients and had to be adhering to a trauma-informed care model. A request for cooperation was sent to the CEOs of not-for-profit agencies, followed by emails to potential participants. The recruitment email contained an introduction of myself as the researcher, a description of the study including participation criteria, and my contact information. A request for participation was made to potential participants. Individuals were requested to contact me if interested in participating. Individuals were identified as meeting participation criteria through the answering of two inclusion questions (a) do you possess a college level degree? and (b) have you received any training in trauma, and if so, what? As the researcher, I then scheduled interviews at the convenience of the participants.

Data Collection

Data was collected using semi-structured face to face interviews conducted in a private setting, such as a private room of a library. I developed an interview guide (see Appendix) to provide a general direction for semi-structured interviews. Interview guides were used to summarize the content researchers cover during an interview, allowing for on-the-spot decision based upon the flow of the conversation with the interviewee (Morgan & Guevara, 2012; Manson, 2011). The interview guide is distinguished from an interview schedule in that it does not contain a formal list of questions; rather, the guide contains topics and key words that may be reordered for a semi-structured interview (Manson, 2011).

The semi-structured interviews consisted of open-ended questions. Interview questions (Appendix) explored participant experiences. This style of interviewing allowed participants to provide answers which flow easily, are less formal, and not directed toward an anticipated response. Interview questions addressed the central question and subquestions.

Prior to conducting interviews, participants were informed that participation is voluntary, and they could end the interview at any time. Informed consents for participation were reviewed, and participants were requested to sign two consents, one for their records and one for the study records. Participants were asked for permission to audio record interviews, and notes were taken during the interview. Participants were informed of confidentiality, and all documents would remain locked and in my possession for a minimum of five years. Participants were briefed on the topic of the interview, as well as the purpose for conducting the interview. I conducted each interview, asking each participant the same questions, probes were asked as needed. Each interview lasted between 30 and 60 minutes.

Following their individual interviews, participants were debriefed on the topic of vicarious trauma, and were provided additional information for resources, including referral information for therapists specializing in trauma treatments. Participants were informed that an individual other than me would transcribe the audio recordings. Participants were also informed the professional transcriber had been requested to sign a notice of confidentiality, and confidentiality would be ensured through the encoding of identities prior to the providing of recordings for transcription.

Data Analysis Plan

Data analysis was conducted using Moustakas' methodology, which includes horizontalization (Moustakas, 2011). Horizonalization is the idea that a researcher is receptive to all statements, giving each equal value (SAGE Encyclopedia, n.d.). Moustakas (2011) identifies the following seven steps for data analysis: (a) consideration of all statements relevant to the phenomenon; (b) each relevant statement is recorded; (c) nonrepetitive, nonoverlapping statements are listed; (d) statements which are related are clustered into themes; (e) themes are then synthesized into a textural description of the experience; (f) statements are developed into a structural description of the experience; and (g) a final textural-structural description that gives meaning to the essence of the experience is developed.

These steps were used initially with the description of my own experiences, then applied to the descriptions of co-researchers. Statements which identify the impact of hearing trauma stories on the personal and professional lives of CMs were reflected in themes that focused on subquestion one. Statements identified coping strategies generated themes to answer subquestion two. These themes were then be synthesized to answer the research question.

Issues of Trustworthiness

In qualitative research, the concept of trustworthiness allows the researcher to describe the virtues of qualitative methodology (Given & Saumure, 2012). Criteria for establishing trustworthiness establish rigor in qualitative research (Houghton et al.,

2012). These criteria include credibility, dependability, confirmability, and transferability (Houghton et al., 2012).

Credibility

Credibility of qualitative research is established by the researcher providing a rich, accurate description of the phenomenon (Given & Saumure, 2012). Persistent observation and prolonged engagement may enhance the credibility of the study (Houghton et al., 2012). During interviews, I asked open-ended questions in a semi-structured manner, in order to allow participants', the ability to provide a complete description of their experiences in hearing trauma stories of clients. To further enhance credibility, interviews were audio recorded, and member checking was established. Member checking is a means by which researchers check with participants, in order to determine whether their thoughts and ideas are represented in the way participants intended (Marshall & Rossman, 2016). This is usually accomplished by researchers providing participants with summaries of data asking for, "…reactions, corrections, and further insights." (Marshall & Rossman, 2016, p. 230). Following this method of member checking, I provided each participant with my data, and interpretations of their interviews, which allowed participants to provide clarification where necessary.

To further establish credibility, triangulation occurred during data analysis. Triangulation enhances credibility by confirming data and ensuring data are complete (Houghton et al., 2012). To accomplish triangulation, a comparison of participant stories for common themes occurred to confirm data. Developing common themes further determined whether enough data had been gathered.

Transferability

Transferability is the qualitative equivalent to generalizability (Patton, 2002). Transferability is the ability of the researcher to provide a rich, thick description of the phenomenon, so the reader can readily discern the applicability to their specific contexts, broad and narrow (Given & Saumure, 2012; Houghton et al., 2010). The thick descriptions should include details from raw data; in this way, the reader assess his or her own interpretations (Houghton et al., 2012). In establishing transferability, I provided a description for the phenomenon of CMs experiences hearing the trauma stories of traumatized clients. Details of individual interviews were included, which allows readers to determine whether the content from this study are transferable to their needs (Houghton et al., 2012).

Dependability

Dependability within phenomenological inquiries refers to the process: that it be systematic and systematically followed (Patton, 2002). Houghton et al. (2012) noted that rigor is achieved through an audit trail, the process by which the researcher outlines decisions made throughout the study, thus providing a rational for the methodology. In analyzing data, I took notes on how themes were identified, broken down into categories, and re-themed. Negative data is data which does not fit into established themes (Creswell, 2013). Further achievement of dependability included disclosure of negative data, which provides an overall, realistic description of the phenomenon of CMs hearing the trauma stories of clients.

Confirmability

Confirmability is the ability of the study to be confirmed or replicated by another person or study (Marshall & Rossman, 2016). Marshall and Rossman (2016) noted that while the replicating of qualitative research is difficult - due to the very nature of qualitative methodologies - the researchers may demonstrate their logical interpretations and inferences. Confirmability is established by the researcher, ensuring that interpretations and findings are supported by the data to the degree to which they reflect participants' intent (Given & Saumure, 2012). Rigor may be achieved by identifying the rational for methodology and the interpretive judgement of the researcher (Houghton, et al., 2012). This may be done through reflexive journaling, which provides a description of decisions, insights, instincts, and experiences during the research process (Reece, 2014). Throughout the interview and data analysis processes, I retained a reflexive journal in which I provided a rationale for my interpretations, impressions, and thoughts on the process.

Ethical Procedures

I gained IRB approval for the study, informed participants of any known risks, and provided participants with a list of resources for support in their area. All participants were provided with a description of the study, and informed consent forms were reviewed and signed. Participants were informed that participation in the study was voluntary, and consent for participation could be withdrawn at any time, without penalty or retaliation.

Permission was requested for data to be collected via audio tape recordings of scheduled interviews. Participants were told that they could ask for the recording to stop

at any time, if they became uncomfortable with questions, became upset during the interview process, or decided to withdraw from the study. I took field notes during the interview process, with my impressions and observations being recorded as part of the data analysis phase of the study.

All data was kept securely in a lockbox, with password protection, during transport from interview sites to my personal residence. Data was then transferred to a separate lockbox in my residence during the data collection and analysis processes. I wrote a brief summary immediately following each interview; these summaries were kept in a separate journal, encoded for confidentiality, and kept in a secure lockbox. Audio recordings were transcribed by an individual other than myself. The professional transcriber signed two notice of confidentiality forms, one for their records, and one for the study's records. Participant confidentiality was maintained through the encoding of identities prior to my providing the audio recordings (i.e., CM1, CM2…). Data will be kept for a minimum of 5 years and will be destroyed through the purging of computer file systems and burning of field notes and audio recordings.

Summary

In Chapter Three, I established the methodology to be used in this study. Data collection and analysis procedures were outlined, and IRB documents for ethical procedures were provided. Additionally, I discussed the means by which dependability and confirmability were established. Chapter Four will provide the details of the study, the setting for interviews, demographics of co-researchers, data collection and data analysis, evidence of trustworthiness, and the results of the study.

Chapter 4: Results

Introduction

The purpose of this study was to explore the lived experiences of CMs who have worked with trauma victims. The central question and subquestions were developed to address the identified problem and purpose of the study:

Research question: How do CMs describe their lived experiences hearing the trauma stories of trauma victims?

Subquestion 1: How does hearing trauma stories impact the lives of CMs?

Subquestion 2: How do CMs describe their strategies in coping with the experience of hearing the trauma stories of trauma victims?

Chapter 4 includes a description of the setting for face-to-face interviews, demographics of participants, and data collection and analysis methods. In this chapter I also address issues of trustworthiness: credibility, transferability, dependability, and confirmability. The chapter concludes with study results and a summary.

Setting

Interviews were conducted in public libraries throughout the Western New York area. Interviews were scheduled in advance with participants at a location and time convenient to them. On several occasions, participants contacted me via e-mail 1 to 2 hours before the scheduled interview time to cancel due to crises that had occurred at work with clients. On two occasions, snowstorms resulting in travel bans prohibited travel. All interviews were re-scheduled in a timely manner.

Demographics

Eight individuals participated in the study. The average years of experience for the participants were between 15-20. Participants ranged in age from 30 to 50 years of age. One participant was male, and the remaining seven were female. One participant was African American and the other seven were Caucasian. Two participants have master's level degrees, one is currently pursuing a graduate degree, and five had bachelor's level degrees. None of the participants had any significant training in trauma therapies. Demographics for individual participants are provided in Table 1.

Table 1

Demographics

Demographic	Participants							
	CM1	CM2	CM3	CM4	CM5	CM6	CM7	CM8
years exp	15-20	10-15	5-10	15-20	15-20	20-25	10-15	10-15
age	40-45	30-35	30-35	35-40	45-50	40-45	35-40	40-45
gender	F	F	F	F	F	F	M	F
ethnicity	white	white	white	white	white	white	white	AA
region	R	U/R/SU	U/SU	R	U/SU	U/SU	U	U
degree	BS	BS	BS+2	BS	BS	MS	BS	MS

Note. F = Female, M = Male, R = Rural, U = Urban, SU = Suburban

There was a basic understanding of trauma and trauma-informed care among participants. Participants were recruited from the eight counties of Western New York. Several of the counties are rural, whereas three contain the primary cities in the region. Two of the participants work in rural areas. CMs from the rural areas described feelings of isolation and a significant amount of alone time due to the amount of travel required. Six participants were from urban areas and faced challenges of safety due to gang violence that may be present in neighborhoods.

Data Collection

Eight individuals agreed to participate in interviews for this study. Participants were recruited through not-for-profit agencies within Western New York. Agencies signed letters of cooperation prior to providing names and e-mail information for potential participants. Snowballing occurred when participants, or individuals known to myself, provided my contact information to a potential participant who was then able to contact me confidentially.

Interviews questions were semistructured and open-ended. Each interview lasted between 30 and 45 minutes. The length of the interviews was dependent on the participants. Some participants answered questions succinctly, and other participants provided greater detail. At the end of each interview, participants were asked if there were any areas they would like to elaborate upon. Additionally, an interview guide provided an outline of interview questions. Primary interview questions were consistent from one interview to the next. On a several occasions, when participants provided greater detail, the flow of conversation allowed for additional questions for the purpose of clarification.

All interviews were conducted in a section of public libraries, which provided a secluded area. I provided participants with potential locations in which interviews could be conducted. For the convenience of the participants, a list of several libraries close to their work environments were provided from which they could choose.

Interviews were scheduled in advance, with participants and me coordinating date, time, and place. On several occasions, changes in schedule occurred and interviews were re-scheduled. These changes were due to the nature of CMs' work, as CMs are

responsible for assisting clients during times of crisis. On one occasion I also had to re-schedule due to unavoidable work responsibilities. However, schedule was able to remain flexible with no disruption to the research.

Data were recorded using two separate audio devices and by the taking of field notes. There was no noted deviation from the data collection plan outlined for this study. Participants were debriefed on vicarious trauma following each interview. At the end their interviews, participants were provided with contact information for therapists specializing in trauma therapy.

Data Analysis

Data analysis was completed using the seven steps outlined by Moustakas (2011). The data analysis process was first used for my own description and then applied to each participant separately. The first step is to consider of all statements relevant to the phenomenon. This was accomplished by reading through individual participant interview transcripts. Second, each relevant statement was then re-read, and notes were taken capturing the essence of each participant's response to the interview questions. Third, non-repetitive, non-overlapping statements were listed. In the next step, codes were developed and clustered into related themes. Themes were then synthesized into a textural description of the experience. The statements were further developed into a structural description; the textural and structural description developed then gave meaning to the essence of the phenomenon.

As the researcher, following each interview, I spent time reflecting on the interview. This allowed me to work through the interview from what the participant said

in response to questions to the impact these responses had on the participant and myself. Brief descriptions of my experiences during the interview were journaled. This allowed me to put aside one interview before conducting the next.

The interview tapes were transcribed verbatim. Each transcribed interview was first read through in its entirety; no notes or analysis of the statements were made at this time. Following the second reading of each transcribed interview, a brief description of the interview was developed and summarized. This allowed me to gain a sense of each interview individually and to put aside any preconceived thoughts or ideas that may have developed. The interviews were then read through for data analysis, with a focus on each individual response. Through this process, individual responses were coded and categorized. Codes were based on words or phrases that participants used in response to interview questions. Codes were developed into themes for each individual participants' responses.

Evidence of Trustworthiness

Credibility

Credibility was established during the interview process through semistructured, open-ended questions. This structure of interviewing allowed participants to elaborate on their thoughts and feelings regarding questions. As the researcher, this structure of interviewing also allowed me to ask further questions as necessary to obtain a full description of the CMs' experiences. In line with the plan for credibility outlined in Chapter 3, all interviews were audio recorded.

A summary of individual interviews was also provided to individual participants for member checking. Through member checking, participants were able to provide corrections or further insight into their interview question responses. Credibility was further established through triangulation. After themes for individual participants were developed, a comparison of common themes for each participant's story occurred, confirming data. Additionally, the development of common themes determined enough data were collected to provide a rich description of the phenomenon of the experiences CMs have in hearing the trauma stories of trauma victims.

Transferability

Transferability was established through providing a rich description of CMs' experiences in hearing the trauma stories of trauma victims. Also provided are details from individual interviews, CMs' reactions to and interpretations of each individual question. Providing a detailed description allows the reader to discern whether the content of this study is applicable to their own needs.

Dependability

Dependability was established through the taking of notes during the data analysis phase. The means by which codes were identified, broken down into themes, and re-themed were included in the notes. Through this process, it is established how decisions were made and the rationale behind these decisions. To provide a realistic description of the phenomenon of CMs hearing trauma stories from trauma victims and further establish dependability, negative data are also included.

Confirmability

Confirmability was established through reflexive journaling. Reflexive journaling was begun during the data collection phase. Following each interview, I reflected on that interview, including the responses of the participant and the environment in which the interview took place. By this process I, as the researcher, provide a rational for my interpretations, impressions, and thoughts throughout the data collection and analysis processes.

During the data analysis phase, as each individual interview was read, notes were written in a journal to summarize the essence of each participant's response. Interviews were read through again with initial impressions and codes developed. Finally, codes were grouped into themes which best capture the essence of the phenomenon, as described by each individual participant.

Results

The research question 'How do CM' describe their lived experiences hearing the trauma stories of trauma victims?' was explored through interview questions regarding past experiences. Several themes emerged by which CMs experiences of hearing trauma stories from trauma victims are described (a) Frequency of hearing trauma stories, (b) Under what circumstances trauma stories are heard, (c) The role of the Case Manager, (d) An expected part of the job, (e) CMs not there are a therapist, (f) CMs not feeling as though they can do enough, and (g) Learning as a Case Manager you cannot fix the problem.

The following excerpts from participants' interview responses describe the themes of frequency, and under what circumstances hearing client's trauma stories occur:

CM3: "umm…probably more often it would be the same stories but with new details added in and I don't know how to put it, probably once or twice a month that's…"

Interviewer: "You only see them twice a month?"

CM3: "Right."

CM1: "I would say probably frequently…sharing their stories and probably maybe sometimes forgetting that they shared their story."

CM4: "It's almost every time I visit."

The frequency with which CMs hear trauma stories from clients, while dependent upon the individual client and family, is a regular occurrence within their caseloads. Disclosure, or the telling of the story, may be more dependent upon the circumstances. When asked how clients tell their trauma stories, CMs described it as occurring naturally as part of the job, as well as the client or family needing to talk about the trauma.

The following excerpts describe the themes for role of the CM and an expected part of the job:

CM5: "Umm…it depends. I mean, some kids and some families are very open from the get-go, sometimes the stuff that they kind of bleed out a little bit here and there."

CM4: "…I can think of one in particular. Every time I see her she tells me the same story- every time. And it never changes; it's the same story, and I know that she's going to tell me the story."

Interviewer: "Is there umm a specific way that they disclose it?"

CM4: “She’s usually getting into trouble at home, and she says well it’s because___ and it leads into that story.”

Interviewer: “So… the hearing the trauma is more just self-disclosure. It’s not part of an assessment that you’re necessarily doing, they’re just kind of offering information because as the conversations goes on it just comes up?”

CM4: “In my role, yes.”

The themes “not there as a therapist” and “learning as a CM you cannot fix the problem” are described in the following excerpts from participant interviews:

CM2: “…because I’m not in that position to be helpful in a social worker role or their therapist or anything like that.”

CM5: ‘Knowing what my role was, not being the therapist per se.”

CM6: “It’s constant boundary issues with clients. Umm…in that I have a hard time accepting the fact that as a case worker or care manager, I can’t always fix everything.”

CM1: “And depending on my role. Because my role before was a social worker…now what I’m doing is more case management.”

The descriptions provided by CMs identify their experience in hearing client trauma stories, while not being able to actively provide therapy.

The first subquestion, ‘How does hearing trauma stories impact the lives of CMs?’, was explored primarily through interview questions regarding the participants’ professional and personal lives. The themes which emerged by which CMs describe the impact of hearing client’s trauma stories are (a) Becoming Desensitized, (b)

Understanding Your Personal Prejudice, (c) Learning to Hide Your Emotions, (d) Not Judging Victim or Perpetrator, (e) Understanding your personal history/experiences, and (f) Building on Past Experiences to Provide Support. The first personal history may relate to either distant past such as childhood experiences, or recent past experiences, such as the birth of a child.

The following excerpts from participant interview transcripts provide a description for the themes used to describe the impact of hearing trauma stories on CMs:

CM4: "I always feel sad, and sympathetic and sometimes you can't help but feel a little, angry at the person who committed the trauma…because…I grew up with some of that same trauma."

CM6: "I'm hyper-vigilant about my own kids, knowing where they are and who they are with."

CM5: "Umm…it just sits with you and it can be painful, again, especially if you've gone through some similar things so…"

Two participants became emotional when describing the impact hearing trauma stories had on their personal lives; both expressed surprise at this reaction.

CM2: "…I don't know I could, like I could leave it at work better and now I find myself getting like more emotional sometimes."

Interviewer: "So…just for clarification…you could leave it at work better before you had your son?"

CM2: "Yes...I find myself getting more emotional more often."

The participant further related how thinking about one specific former client was especially difficult:

CM2: “I think about that kid and I think about my son and I’m like, if that happened to that kid, what could happen to my child…See…I’m getting emotional again.”

Interviewer: “How does hearing these trauma stories impact your personal life with your significant other, family, friends, alone time?”

CM1: “Significantly…sorry.”

CM1: “Sorry. I try not to but…it does.”

The participant was unable to elaborate on these feelings but was able to continue with the interview and provide a description of coping strategies used in dealing with hearing trauma stories from clients, as asked through subquestion two.

CM4: “But the third or fourth time we’re a little desensitized to the trauma and it just becomes another story…”

CM2: “I don’t know if I feel…or if I’m jaded now or what…”

CM6: “When I first started it was different then it is now, now I’m probably more jaded.”

Subquestion Two, ‘How do CMs describe their strategies in coping with the experience of hearing trauma stories of trauma victims?’, was explored primarily through interview questions regarding the participants’ professional and personal lives. The themes of (a)Self-Care, (b) Learning how to Separate Work from Home, (c) Understanding the Need to do things for Yourself, (d) Supportive Work Environment, (e)

Supportive Supervisors, and (f) An Administration which understands the role of the CM emerged to describe the coping strategies developed by CMs in hearing client trauma stories. The theme of self-care may be a positive coping strategy or a maladaptive coping strategy, but it was a strategy which the CMs identified as working to meet their personal needs. CMs descriptions for the themes of self-care and supportive work environment were closely linked, as identified through the following participant interview excerpts:

CM2: "We are in an very interesting situation, as in my direct supervisor and our program director do not have a background in mental health…So when we have supervision, it's with an outside licensed therapist…Honestly I wouldn't say I talk to them very much about anything…Really, any conversations about trauma and how its making me feel, usually I talk with my direct co-workers or my husband…"

CM1: "Paxil….I smoke cigarettes, my daughter, my pets."

CM5: "For myself, I've had to take breaks from the job…umm…I think that's the biggest thing…a couple of co-workers that know about my past history so that's been helpful. But you know supervisors haven't, and they've been very supportive. At the same time, it's tough, because I know people try to help and do what they can for me, at the same time, you know, I'm a little resistant to help…"

Case managers identified a supportive team environment itself as a coping strategy; one that is friendly, comfortable, and where some joking can occur:

CM6: "Having co-workers who understand you, that you know each other personally, helps."

CM7: “I don’t see hearing the trauma stories as impacting me. I have had two amazing, supportive supervisors, who have always been there, so I don’t take it home. And at home I have things I like to do with my down time, spend time with my wife and friends.”

CM6: “I spend time with my kids, just doing things that I enjoy and not thinking about it.”

CM3: “I…wine…hiking…umm trying to get to the gym more often…Wine’s the big one I think.”

Interviewer: “Is there anything else that you feel would be relevant or to clarify or provide more details on…?”

CM3: “I mean…I definitely feel like there should be more opportunity for employees to work through it.”

Interviewer: “Within…”

CM3: “Themselves, as well as more training on how to help clients in the moment, in the role that we are supposed to be helpful in…”

CM3: “…office workers experiencing it doesn’t really get acknowledged other than ‘It’s your job’ and it’s not, you know, there is no follow up…”

Summary

Case managers’ descriptions of their lived experiences in hearing the trauma stories of trauma victims can be divided into two themes. The frequency with which trauma stories were told to them by the client, the family, or co-workers re-telling the trauma stories of their clients, and their role as CMs. While CMs report hearing trauma

stories through these means as a regular occurrence, they also identified the role of the CMs as not providing counseling. The experience of hearing client's trauma stories can leave CMs feeling as though they have not done enough to help, while simultaneously identifying the clients', or co-workers', need to discuss trauma.

CMs described their experiences of hearing trauma stories as impacting their professional and personal lives, in the themes of their own personal history and becoming desensitized to hearing trauma stories. CMs described personal history in two ways: distant past and personal childhood trauma, and recent past, as in the birth of a child. Personal history may play a role in CMs becoming de-sensitized to hearing client's trauma stories, in that CMs find the need to distance themselves from the story.

CMs described strategies in managing how they cope in their personal lives with hearing client's trauma stories, as both positive and maladaptive methods. One CM noted the use of Paxil to assist in sleeping, while others identified drinking wine or simply avoiding related thoughts. CMs recognized these as poor coping mechanisms. All CMs identified a positive supportive work environment as a primary means for coping with hearing client's trauma stories as impactful at both work and home environments. While only one CMs noted regularly having supportive supervisors, all CMs identified positive peer supports within the work environment.

In Chapter 5, I have provided a concise interpretation of the findings in relation to the peer-reviewed literature and conceptual framework identified in Chapter 2. Additionally, Chapter 5 will provide a description of the limitations of the research,

provide recommendations for future research within the field, and discuss implications for social change.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The purpose of this phenomenological study was to explore the lived experiences of CMs who have worked with trauma victims. The study's focus was on how CMs describe their experiences of hearing the trauma stories of these clients. This description addresses the gap in the literature in understanding the experience of CMs from listening to the trauma stories of clients. Interviews were conducted face-to-face in a semi-structured interview format. Each interview lasted between 30 and 60 minutes. Participants were recruited from across the Western New York region, which consists of eight counties. Interviews were conducted at libraries throughout the region, serving to accommodate the needs of the participants. Participation criteria included being a CMs with a minimum 5 years' experience working as such, working for a not-for-profit agency within Western New York that adheres to a trauma-informed model, and having limited training or experience in trauma related treatments. Data analysis was conducted through interpretation of participants' interview responses. Codes were generated and developed into themes, which provide the description of the phenomenon of how CMs described their lived experiences hearing trauma stories from trauma victims.

Chapter 5 provides an interpretation of findings as they relate to Chapter 2, limitations of the study as described in Chapter 1, and recommendations for further research as described in Chapter 2. Implications for positive social change are also provided. The final conclusion section provided a description of the key essence of the study.

Interpretation of Findings

An interpretation of the findings, in comparison to the peer-reviewed literature described in Chapter 2, is presented in this section. This study's findings support the current research literature in several areas, including the importance of a supportive work environment with both peers and supervisors for CMs' ability to manage hearing trauma stories, the need for CMs to develop and utilize effective coping strategies, and the impact hearing trauma stories may have upon CMs. In the following sections, the main research question and two subresearch questions are described through several themes. The themes combine to provide a fuller description of CMs' experiences in hearing the trauma stories of trauma victims.

Research Question Themes

The literature identifies case load numbers, client demographics, and organizational supports as potential predictors for development of vicarious trauma within CMs (King, 2009). This was supported throughout the themes developed for this study based on how CMs described their experiences of hearing the trauma stories of trauma victims. Themes that emerged for the research question included the frequency of hearing trauma stories, how often this occurs, the circumstances under which hearing trauma stories happens, and that hearing client trauma stories is an expected part of the role of CMs. Additionally, the themes regarding the role of CMs included not being a therapist, feelings of not having or being able to do enough and learning that to accept you cannot fix the problem.

The role CMs have in relation to the case was also used to describe how they experience hearing clients' trauma stories. CMs identified that within the boundaries of their role they are not therapeutically responsible for the client being able to resolve the trauma. Yet due to their role in providing referrals and linkages, and in coordinating services for clients, they are often put into situations in which they hear their trauma stories. Additionally, CMs described clients as seeming to tell their stories simply because CMs are in the home where clients feel more comfortable and are therefore willing to open up about their trauma history.

Subresearch Question 1 Themes

The theme of personal history was described through CMs' ability to mask or hide their emotions. CMs also described the ability to not judge a victim or perpetrator by understanding their own personal prejudice. Within this description, the CMs explained the importance of understanding their personal experiences and building on past experiences to provide supports as part of knowing their own personal history. CMs also identified the impact of hearing clients' trauma stories from the point of view of those with a personal trauma history. Additionally, CMs identified their years of service as a difference in the way they experience clients' trauma stories such as the ability to remain professional and distanced while hearing the story.

Within the literature, personal trauma history and years of experience were identified as risk factors for the developing of vicarious trauma (Dekel, Hantman, Ginzburg, & Solomon, 2007; Iqbal, 201; Jordan, 2010), which were supported by the findings of this study. Further, relationship conflicts, stress-related illnesses, chemical

abuse, unprofessional behaviors, job dissatisfaction, and ethical violations are among the potential consequences identified by the American Psychological Association as occupational hazards ("Professional Health and Well-Being for Psychologists," n.d.). But in this study, the only occupational hazard identified by one CM was boundary issues. Seven out of eight CMs identified an intentional, conscious effort to remain professional. Although CMs did note feeling as though they did not do enough to assist in elevating clients' distress from their trauma, no participants expressed feelings of job dissatisfaction, stress-related illness, or chemical dependency, beyond smoking or an occasional glass of wine.

Subresearch Question 2 Themes

Subresearch Question 2 was described through the themes of self-care, supportive work environment, learning to separate work from personal life, and understanding the need to do things for yourself. Components of a supportive work environment include a strong sense of teamwork, sharing space both physically and emotionally, supportive supervisors, and supportive agency administrators.

Contributing factors for higher levels of job-related stress and professional satisfaction and job burnout for CMs are related to organizational supports and relationship problems with supervisors (Gellis & Kim, 2013; Kraus & Stein, 2013). The descriptions provided by CMs interviewed in this study revealed a supportive work environment as a factor in being able to cope with work related stresses. CMs identified agencies as seeming to either not understand or care about their experiences, even when the agency is based in a trauma-informed care model. However, closeness with

coworkers, both emotional and physical, when offices are nearby or shared provides a team atmosphere and supports in areas where agency support is lacking. Thus, the area of agency support as related to CMs' ability to cope and job satisfaction are supported by the current research.

Coping strategies identified by CMs as occurring outside the work environment, such as spending time with family and friends, gardening, hiking, going to the gym, and other recreational activities, are supported by the research literature. Professionals who have close personal relationships may more effectively prevent disruptions to schemas which can lead to vicarious trauma (Michalopoulous & Aparicio, 2012). CMs also described inappropriate coping strategies, such as avoidance and other isolating behaviors. These inappropriate coping strategies, as identified by Jordan (2010), may result in disruptions to schemas, which can contribute to development of vicarious trauma.

CMs identified the impact of hearing clients' trauma stories on those CMs with a personal trauma history. CMs also identified their years of service as a difference in the way they experience clients' trauma stories, in their ability to remain professional and distanced from hearing the story. Within the research literature, personal trauma history and years of experience were identified as risk factors for the development of vicarious trauma (Dekel, Hantman, Ginzburg, & Solomon, 2007; Iqbal, 201; Jordan, 2010). The risk factors identified within the research literature were supported by the findings of this study.

Relationship conflicts, stress-related illnesses, chemical abuse, unprofessional behaviors, job dissatisfaction, and ethical violations were among the potential consequences identified by the American Psychological Association as occupational hazards ("Professional Health and Well-Being for Psychologists," n.d.). In this study the only occupational hazard identified (by one CM) was boundary issues. Seven out of eight CMs identified an intentional, conscious effort to remain professional. While CMs did note feeling they did not do enough to assist in elevating client's distress from their trauma, no participants stated feelings of job dissatisfaction, stress-related illness, or chemical dependency, beyond smoking or an occasional glass of wine.

Conceptual Framework

This study was conducted through the conceptual framework CSDT. According to CSDT, individuals develop schemas which frame their assumptions, beliefs about themselves and others, and expectations of the world, which continually grow and evolve over time (Branson et al., 2014). These schemas may become disrupted with new information which is contrary to established beliefs, and which cannot be assimilated into the already existing schemas (Wang et al., 2014). Through the integration of new and contrary information, changes to the original schema may occur.

The role of CMs, as described by participant's, identified CMs as not being therapists, yet stated that, due to their role, they are often exposed to hearing client trauma stories. The circumstances in which these trauma stories were told to and heard by the CMs are not therapeutic, but rather, a retelling of the story for support, a venting on

the part of the victim, or family, or recounted to explain current behaviors. As a result, there is no venue for CMs to manage the experience of hearing clients' trauma stories.

CMs described an intentional mind-set for disengaging from hearing these stories, to limit the personal impact upon CMs. CMs further described the ability to utilize past experiences as integral to provide assistance while listening to clients' trauma stories in the present. In this manner, CMs were able to take information learned from past experiences with former clients and other applicable situations, in order to assist current clients who may be experiencing similar trauma.

The interpretation for CSDT in relation to CMs hearing trauma stories would be supported, in that CMs do note changes occurring throughout their experiences of hearing client trauma stories.

CM6: "For good or for bad, hearing these stories does change you."

However, CMs further description of post-traumatic growth and vicarious resiliency in being able to use experiences to help others may not be supported by CSDT. As opposed to allowing negative changes to schemas which result in vicarious trauma occurring, professionals may gain positive life views from their work, which may result in a deeper appreciation of life and stronger feelings of professional and personal worth (Chopko & Swartz, 2009).

Limitation of the Study

Limitations of a study may be imposed by the location in which the study unfolds, or the population under investigation, and how these aspects may pose limits on the researcher's ability to make broad generalizations (Marshall & Rossman, 2016).

Additionally, limitations may be present during interviews, due to reasons relating to anxiety, politics, personal bias, or lack of awareness, as interviews may be affected by the emotions of the participants (Patton, 2002). During data analysis, limitations for developing themes are dependent on (a) the ability of participants to fully disclose their experiences when sharing information relevant to the phenomenon, (b) the interviewer's insufficient knowledge of appropriate questioning, and (c) the interviewer's inadequate interpretation of the interviewee's responses (Marshall & Rossman, 2016).

To minimize potential limitations, interviews were conducted using open-ended, semi-structured interview questions. An interview guide was utilized to provide guidance and to ensure that questions were asked in an order which would lend to credibility. During the interviews, all participants were asked the same questions in the same order. During interviews, participants were open and honest in providing responses. Participants noted that providing answers may prove beneficial for future workers within the CMs field, and within their agencies. Limitations to providing broad generalizations for the experiences CMs describe to those in similar fields do exist, as CMs describe theirs as a unique position for hearing client trauma stories, which may not be experienced similarly by those working in other, related professions.

Recommendations

The limitations of the study may be found in transferability. A recommendation I, as the researcher, can make is of future studies of professions where individuals may hear trauma stories from trauma victims. The broader population for individuals who may work with trauma victims, and as a result may be exposed to hearing their trauma stories

from trauma victims, has yet to be explored. Individuals working through Family Court, Direct Care Aides in Residential Treatment Facilities, or juvenile detention centers and runaway shelters may also benefit but have yet to be explored within the current research literature and through this study.

Additionally, quantitative methodologies may be used to understand the number of CMs who experience vicarious trauma symptoms. Information from a study of this nature may provide statistical relevance, in support of changes to the system in which CMs currently work i.e., reductions in case load numbers. Future studies within the vicarious trauma literature may benefit from developing a broader view for who may be impacted by vicarious trauma and factors which may be used to mitigate the impact from hearing trauma stories from other individuals. An additional recommendation would be for the exploration of vicarious resiliency and post-traumatic growth within this same CMs population.

Implications

The current definition of vicarious trauma is narrowly focused on therapists as the trauma worker. The potential impact from this study for positive social change is in a broader definition of vicarious trauma which may allow for further theorizing of vicarious trauma, furthering research to include CMs, the potential to impact policy makers, and assist CMs in understanding the impact of hearing trauma stories of clients. This study may be used in the development of trainings for agencies and supervisors to both understand the impact of hearing client trauma stories on CMs as well as destigmatize vicarious trauma. CMs may also benefit from learning to manage their lives,

both professionally and personally. CMs understanding the ways in which hearing client trauma stories impacts their own experiences may assist in mitigating the negative impact. Finally, the move towards post-traumatic growth and vicarious resiliency may also prove beneficial for positive social change. Agencies and CMs may benefit from learning how to develop post-traumatic growth and vicarious resiliency as an important step towards eliminating the effects of vicarious trauma.

Conclusion

The purpose of this study was to explore the lived experiences of CMs who have worked with trauma victims. This study found CMs are impacted from hearing client trauma stories, personally and professionally. The identified themes describe the frequency of how often CMs hear client trauma stories and the role CMs have in relation to clients while providing supports relevant to client trauma. CMs are also impacted by their personal history and how they manage hearing client trauma stories, including becoming desensitized to hearing the trauma story. The theme of supportive work environment may provide the greatest understanding for the ability of CMs to develop coping strategies, both personal and professional, which allow them to manage hearing client trauma stories.

CMs interviewed for this study reported never thinking about how they are impacted, because they had not been asked before. Despite this lack of awareness of the symptoms of vicarious trauma, CMs have developed strong coping strategies which assist them in managing their experiences from hearing client trauma stories. Through this description of hearing client trauma stories, CMs identified a natural ability to develop

vicarious resiliency and post-traumatic growth as a natural barrier to vicarious trauma symptoms. Gaining a greater understanding of the ways in which CMs coping strategies develop towards post-traumatic growth and vicarious resiliency may be integral in the development of trainings for CMs. supervisors, and agencies as a move past vicarious trauma.

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Appendix : Interview Guide Worksheet

Date of Interview:
Time of Interview:
Location of Interview:
Interviewer:
Interviewee:

Provide a brief introduction of myself as the researcher, including contact information, and school information. Review consents, reminding participants the study is voluntary, their participation will remain confidential, and they may ask to end the interview at any time. Inform participants I will be taking field notes of responses. Ask permission to audio record their responses. Remind them of the second interview.

1. Please describe how you feel or have felt when clients have told their trauma stories to you.
2. Can you please describe the frequency and circumstances for clients telling their trauma story to you?
3. How often do you hear the same story from the same client?
4. Please describe how you feel/felt when you hear colleagues retell trauma stories from their clients?
5. Is it a common occurrence to hear colleagues retell their clients' trauma stories?
6. How does hearing these trauma stories impact your professional life?
   a). With your supervisor?
   b.) With your co-workers?
   c.) With your colleagues?
   d.) With your employer?
7. How does hearing these trauma stories impact your personal life?
   a.) With significant other?
   b.) With family and friends?
   c.) Alone time?
8. What supports or coping strategies do you use at work, in hearing trauma stories of clients?
9. What supports or coping strategies do you use at home?