“THIS IS NOT JUST A JOB”: TENSIONS IN ADDRESSING TRAUMA IN THE NEO-LIBERAL CONTEXT

“THIS IS NOT JUST A JOB”: TENSIONS IN ADDRESSING TRAUMA IN THE NEO-LIBERAL CONTEXT.

By VANESSA KATHERINE HEANEY

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AUTHOR: Vanessa Katherine Heaney, B.S.W. (Ryerson University)

SUPERVIOR: Dr. Mirna Carranza

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**Abstract**

Front-line service-providers are finding it challenging to address trauma-related issues within the confines of a shrinking neo-liberal environment. With larger case loads and increased focus on time and efficiency measures, front-line staff have less time available to address the more ambiguous aspects of practice, including trauma. To explore the challenges front-line staff face, a small qualitative study was conducted in which five service-providers took part.

The study findings revealed that in working environments that have adopted managerial practices, the implications of 'quantity over quality' are experienced as frustrating and have various implications for the ways in which trauma is addressed. Participants in this study, expressed a deep investment in their working roles which generally has positive implications for service-users, however, the compounding results of a deep personal investment and a prescriptive case-management role may intensify the experience of working with trauma. Finally, while service-providers believe that trauma is something all service-users live with, there is a sense that the issue remains under-recognized in the mental health agency setting. This study suggests that increased trauma-focused education is essential for front-line workers, as is trauma-informed models of practice in the agency. Furthermore, there is a greater need for trauma advocacy and awareness as the issues remains stigmatized, even within the mental healthcare system.

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**Chapter 1. Introduction**

The goal of the study reported here was to gain an understanding about front-line service-providers' perceptions of 'trauma' as it relates to service users. These service-providers work primarily with mental health consumer survivors, who have experienced homelessness. The term mental health consumer survivor was developed by the 'psychiatric' community in an attempt to rename oppressive medical discourse in the late 1980s. The term is an expression of 'consuming' the system (meaning the dominant and often oppressive medical institutions), and 'surviving' the experience. Mental health consumer survivors are typically faced with various forms of oppression including homelessness, marginalization, reduced access to healthcare, struggles with the use of substances and overall stigmatization that compromises their access to the mechanisms of everyday life. The participants in this study, front-line service-providers, deliver a high level of support to service-users, as they engage in case-management on a downtown Toronto, Ontario, Assertive Community Treatment Team (ACT Team). Five participants shared their thoughts, feelings and perceptions of 'trauma', as it relates to service users, contextualized within current neo-liberal framework. The findings revealed that service-providers are deeply invested in the services they provide and part of that investment is emotional. While trauma is something that they believe every service user carries, they found that for various reasons it is not always at the forefront of their service provision. Ultimately, the participants expressed the challenges associated in addressing more ambiguous issues associated with trauma, within the confines of a new-managerial social service system.

My interest in this topic developed out of my own experiences providing front-line service in the mental health agency setting. My experience had primarily been with mental health consumer survivors and people who experienced homelessness. The majority of my practice has been in the downtown Toronto area. Moving from the West-end to the East-end, I began to learn more about the people I was working with and their challenges as they shared with me. Most of these individuals had endured hard lives. This was in part due to mental health status, homelessness, marginalization and stigmatization that are so prevalent among this population. As I developed relationships with service-users it became strikingly apparent that virtually all service-users among this population, had at least one significant traumatic experience. It is my position that trauma is subjective, meaning that the experiences are not objectified or hierarchical. Trauma is any experience that disrupts the regular functioning of an individual (Black et al., 2012). There seemed absolutely no doubt in my mind that the individuals whom I worked with had often overlapping, sequential and compounding experiences of trauma, however, I felt that the traumatic realities were not receiving the attention I believed was necessary.

Through a critical lens, I began to conceptualize neo-liberal influences on this issue. As neo-liberal policies continue to be entrenched into our practice, new managerialism and efficiency measures chip away at the more ambiguous aspects of our profession. One of the unintended consequences of the neo-liberal workplace is that service providers are often overwhelmed with larger case loads, less job security and increased part-time/contract work. Service providers are left with fewer working hours available to focus on the less quantifiable aspects of practice, the aspects that have been defined by service-providers as “good practice” (Aronson & Sammon,. 2000). Studies have shown that service providers are often so overworked that they are simply operating in “survival mode” just to maintain this degree of 'efficiency' (Henry et al., 2011). Working in survival mode can demand that service-providers focus their time and energy on 'tasks' sometime above more human considerations (Aronson & Sammon, 2000). A concept like 'trauma' then, may be susceptible in these pressured and resource-starved agencies (Aronson & Sammon, 2000). The literature would suggest that the concept of 'trauma', post-traumatic stress disorder (PTSD) or secondary trauma can go under-recognized (Mueser et al., 1998; Putts, 2014; Salyer et al., 2004), especially in the mental health sector (Henry et al., 2011; Putts, 2014). Trauma affects all people more often than is typically recognized, however, studies have shown that individuals who have a mental health diagnosis are at greater risk for developing various trauma-related issues (Cusack et al., 2006; Salyer et al., 2004). Some studies have suggested that the under-recognition of trauma can have negative impacts on both service-users and service-providers (Pence, 2011; Sprang et al., 2011). In mental health agency environments where service providers may already be inundated with significant organizational pressures, there is risk that the more nuanced symptoms of trauma may go under-recognized. The literature on this topic and my own personal experiences left me with the research question, what are front-line service-providers’ perceptions of trauma as it relates to service-users within the current neo-liberal context?

This study will highlight the perceptions of five female front-line service providers in the mental health agency setting. The women illuminate the various challenges in addressing trauma in the workplace within the confines of the neo-liberal system. They unveil the struggles and concerns about the under-recognition of trauma in the workplace and how this under-recognition can have negative implications for both service-users and providers. Lastly, the women share their hopes for the future of trauma in front-line practice, emphasizing the need for more education.

**Chapter 2. Critical Literature Review**

The goal of this literature review is to gain a greater understanding of various tensions in addressing trauma in the neo-liberal context. The literature presented here includes themes about, the current discourse surrounding the general conceptualizations of 'trauma' and its prevalence in our society; competing and complimentary frameworks on the structures; causes and mitigating factors of trauma; barriers to the recognition and treatment of trauma related issues, especially among the mental health service-user populations; trauma's impact on service providers and finally, this critical review will reflect upon the ways neo-liberal ideology and managerial practices impact service providers' ability to address the more ambiguous aspects of our profession, including trauma in the mental health agency setting.

**A General Perception of Trauma**

A considerable portion of the data on this topic has focused on the general prevalence of trauma in our society. There are several theories as to what factors mitigate or increase susceptibility to enduring the prolonged effects of trauma, including a psychiatric diagnosis of post-traumatic stress disorder (PTSD). While traumatic events are experienced by the general populations at a rate of 56 percent, significantly higher rates have been reported for people with a serious mental health diagnosis, 91-98 percent (Cusack et al., 2006). Further, the intensity, risk for re-occurrence and horrific nature of the traumatic event tends to be higher among individuals with a serious mental health diagnosis (Muienzen et al., 2010; Padgett et al., 2006). Exposure to trauma can often manifest as PTSD. In studies conducted with newly referred psychiatric outpatients, 82 percent were found to have been exposed to at least one lifetime traumatic event (Switzer et al., 1999). Further, 31 percent showed evidence of having post-traumatic stress symptoms at some point, even when PTSD was never given as the reason for referral (Switzer et al., 1999). Unfortunately, the onset of PTSD has been linked to increased instances of substance use, depression and anxiety (Cusack et al., 2006)

Other studies have shown that among individuals who have a mental health diagnosis, 29-43 percent met the criteria for a diagnosis of PTDS, however, PTDS is rarely diagnosed in this population (Salyer et al., 2004). One of the ways that this relationship has been examined is by reviewing clinicians' charts (Putts, 2014). In a study conducted with community mental health service-users, who were recorded as having at least one period of hospitalization, 28 percent of the group had a charted trauma history (Putts, 2014). After the service-users were assessed independently by the researchers of the study, it was found that there was an actual trauma rate of 87.2 percent (Putts, 2014). It ought to be noted that there may be limitations in Putts' (2014) research given that the chart reviews were conducted by the researchers of the study. There have been other studies conducted that support the previous findings that demonstrate actual rates of trauma and trauma history are often much higher than recorded in charts. Mueser et al. (1998) studied 275 individuals who had a diagnosis of schizophrenia or bipolar disorder. The findings showed that 98 percent of the service-users were exposed to at least one traumatic event (Mueser et al., 1998) and 43 percent of the individuals met the DSM-IV criteria for PTSD (Mueser et al., 1998). However, when the service-users' charts were reviewed, only 2 percent of the 275 individuals actually had this diagnosis recorded (Mueser et al., 1998). Similarly, a study conducted by Cusack et al (2006) recorded a 3 percent charting rate of PTSD. Upon review, researchers found that the rate of service users who met the criteria for PTSD were 30 percent of the sample, significantly higher than the charts would indicate (Cusack et al., 2006).

Creating an especially unique experience, the authors, Griffin et al (2011) highlighted the challenges presented in the co-occurrence of traumatic experience and a mental health diagnosis. Griffin et al. suggest, trauma-related symptoms and mental health overlap (Griffin et al., 2011). The same (or similar) symptoms can be the result of traumatic experiences or mental illness, stating that both a traumatized child and a child with bi-polar disorder could have difficulty in regulating their emotions. This may occur even though the child that has a diagnosis of bi-polar has never experienced a traumatic event and the child that has experienced trauma, does not truly qualify for a bi-polar diagnosis (Griffin et al., 2011). While these symptoms may not necessarily be indicative of the specific diagnosis, they are also not mutually exclusive, noting that a traumatic event can exacerbate a mental health diagnosis (Griffin et al., 2011). This has important implications for service provision as an individual may not have a 'true' mental illness, rather suffering from undiagnosed trauma (Griffin et al., 2011).

Other studies have expressed that it may also be beneficial to critically analyze the actual role that experiencing psychosis plays in creating traumatic experiences (Putts, 2014). The author suggests that subsequent to a forceful hospitalization for psychosis, a majority of service users met the standards for PTSD (Putts, 2014). Participants in this study suggested that their PTSD was in part due to the traumatic experience with psychosis, however, noted that the hospitalization and related experiences were even more traumatic than the psychosis itself (Putts, 2014).

**Structural Influences**

Some authors have established links to structural factors that can increase the risk of exposure to trauma. Poverty, housing access, employment, family dynamics, are all considered risk factors in increasing exposure to traumatic events (McLaughlin et al., 2013; Milan et al., 2013; Padgett et al., 2012). Relationships have been drawn between PTSD and poverty that occur before and following exposure to traumatic events. McLaughlin et al. (2013), has suggested that the increased instances of trauma among those who simultaneously experience poverty is associated with lower odds for recovery (McLaughlin et al., 2013). The authors, Switzer et al. (1999), studied the association between higher rates of exposure to trauma, and socio-demographic realities such as, sex, age, race/ethnicity, poverty, single-parent homes, etc. They found that they are also common characteristics among individuals living in urban disadvantaged communities. The study reports that populations are not only vulnerable to PTSD by virtue of high levels of trauma exposure but also encounter increased risk by virtue of their social location, which heightens susceptible to PTSD (Switzer et al., 1999). Specifically in adolescence, structural and environmental factors such as income, housing status and family composition may contribute to the likelihood of developing trauma-related issues following a traumatic exposure (Milan et al., 2013). As the effects of trauma can have a long reach into the lives of those it affects, individuals may face an increased risk of physical health consequences (Padgett et al., 2012) as a consequence of trauma and trauma-related issues.

The literature has emphasized the relevance of traumatic experiences that occur during youth (Feeny et al., 2004). Rates of trauma exposure in youth are high, with 25 percent of youth reporting a trauma experience of high-magnitude before the age of 16 (Feeny et al., 2004). However, for youths who have been hospitalized for a mental health issue, up to 93 percent of these adolescences have reported experiencing a traumatic event (Feeny et al., 2004). In recent years there has been an increased focus on the high rates of trauma exposure, especially in youths, among mental health professionals and researchers (Feeny et al., 2004). Compounding factors such as street involvement and/or homelessness and substances use combined with trauma exposure have negative effects on overall life expectancy (Padgett et al., 2012). PTSD may worsen an individual’s primary symptoms related to serious mental illness, this may result in decreased functioning and increased use of services (Sayler et al., 2004). Given this factor, trauma and PTSD could be important targets for intervention and improved service delivery (Sayler et al., 2004).

**Medical Discourses**

The bio-medical model is dominant in social work, especially in mental health. Medical methodologies have been prevalent in analyzing trauma and traumatic experiences. A large portion of the literature focuses on trauma and its direct effects on the brain. Greater attention has been given to data describing the physiological affects to the brain that are believed to be the result of traumatic experiences (Black et al., 2012; Bremner, 1999; Kendall-Tackett, 2000). The literature has documented the ways severe trauma can change brain functioning and create a state of chronic hyperarousal (Kendall-Tackett, 2000). Chronic hyperarousal refers to an abnormal state of arousal that often occurs following a traumatic or highly stressful experience (Kendall-Tackett, 2000). Typically, the stress response is adaptive, meaning that it is designed to mitigate extreme circumstances and to preserve brain functioning (Kendall-Tackett, 2000). Problems arise when the stress response is either overwhelmed by an extreme isolated occurrence causing the brain system to flood with stress hormones, or in the case of a chronic stressor, where the appropriate acute response is becoming more frequent, producing increased and overwhelming levels of stress hormones such as norepinephrine and cortisol (Bremner, 1999; Kendall-Tackett, 2000). Neuro-imaging studies have shown areas of the brain that may be altered by psychological trauma, however, this research needs further supports (Flouri, 2005). Hyperarousal is thought to leave trauma survivors more vulnerable to continued life stressors through a process known as 'sensitization' (Kendall-Tackett, 2000). The brain's sensitivity to past traumatic experiences can cause the brain to overreact to less acute stresses (Kendall-Tackett, 2000). Focus has remained on areas of the brain such as the amygdala, which plays an important part in the regulation of emotions (Black et al., 2012). In addition, studies have been conducted on the influence traumatic experiences can have on regulating neuro-transmitters such as, serotonin and cortisol which benefit the regulation of emotional and stress responses (Black et al., 2012).

The nature of medical discourse has been challenges by authors, Poole et al. (2012). The authors describe a particular form of oppression known as Sanism. Sanism, is a term used to confront the highly medicalized model of mental health in the social service profession (Poole et al., 2012). This critical analysis of the issue concerns itself with the normalizing and often authoritative practices in mental health (Poole et al., 2012) that limit and potentially devalue the lived experiences of service-users.

Similar to Poole et al., (2012), other authors look to alternative approaches on the subject, focusing on a politicized understanding of trauma that seeks to explore the relational, social and political challenges that are related to the experience of trauma (Mckenzie-Mohr et al., 2012). The authors posits that the medicalization of trauma and PTSD have narrowed the parameters of the issue making it a highly individualized experience (Mckenzie-Mohr et al., 2012). Furthermore, this individual construction of trauma devalues the social and political roots of the problem (Burstow, 2005; Mckenzeie-Mohr et al., 2012). The authors argue that the PTSD diagnosis is grounded in a naive assumptions that the world is a generally safe and benign place and as such, an individual response to the unsafe world is understood as a maladaptive perception (Mckenzie-Mohr et al,. 2012). An individual who acts or holds the position that the world is unsafe is perceived as responding inappropriately and is subsequently labeled with a disorder (Burstow, 2005). Burstow (2005) contends that people who have been saved from the effects of trauma hold the illusion that there is safety, day to day and moment to moment, in the world. They do so by editing and ignoring facts of reality such as war, violence, racism, religious intolerance, sickness and death, etc. This conceptualization can create a hegemonic worldview that negates the unique and individual knowledge of trauma (Burstow, 2005; Mckenzie-Mohr et al., 2012). Individuals who have experienced trauma are less inclined to edit out these unsavory dimensions of reality (Burstow, 2005). Sapey (2013) expands on this notion and illustrates how social workers are in the unique position to participate in politicizing and deconstructing the hegemonic positioning of trauma and mental health in general. By respecting and valuing service users' experiences and perceptions present in mental health, social workers can ensure they avoid compounding experiences of trauma by recreating some of the traumatic structures that contributed to developing the issues to begin with (Sapey, 2013).

**Trauma-Informed Care**

Trauma-informed care, is a philosophy that has been designed to address social service agencies' systems and operations. It strives to ensure that staff have a comprehensive understanding of the impacts of trauma, that they are alert to trauma triggers, and the ways in which service delivery approaches may actually work to exacerbate the effects of trauma (Conviers-Burrow, 2013). Trauma-informed care, also informs the service delivery process. Organizational tasks are conducted with the understanding that certain processes can be triggers to past traumas (Pence, 2011). Proponents of the trauma-informed model have found that structural organizations such as psychiatric hospitals, residential foster care, etc., can in fact recreate the experiences that have proven to be traumatic for individuals to begin with. This can compromise service delivery, trauma recovery and the overall health of individual’s front-line service providers seek to support (Henry et al., 2011).

Trauma-informed models, seek to obtain and discuss facts, thoughts and experiences with trauma in a way that works to minimize the potential for system induced trauma (Pence, 2011). They enforce this model by avoiding triggering memories and actions/reactions that are known to be associated with past traumas (Pence, 2011). Trauma-informed care models requires that workers connect to service users in a manner that fosters engagement rather than building fear and distrust. Consciously opening up to service users in this respect, creates an environment that is conducive to strengths building, contributes to more efficient functioning and reveals a more realistic picture of the individuals past traumatic experiences (Pence, 2011). A study by Conviers-Burrows et al (2013), states that it is necessary that front-line staff are well-equipped to address and be prepared to respond to the myriad of challenges associated with reporting on issues in mental health and trauma. The authors call for the incorporation of trauma-informed systems to reduce the risk of misunderstanding trauma symptoms, leading to the under-recognition of trauma. The literature that I have been able to access has strongly supported the notion of implementing trauma-related education and trauma-informed systems in agencies as a way of reducing the negative effects of under-recognized trauma and issues of trauma more generally. The literature shows that while training and education are key components to this strategy, there is scant literature or education at the undergraduate and graduate level on this topic (Pence, 2011). While the notion of trauma-informed care is likely the only approach that has been applied to address the issue of under-recognized or under-treated trauma, it remains to be a singular approach to the problem.

**Neo-liberal Ideology and Trauma in the Mental Health Agency Setting**

The literature has shown that trauma is pervasive in our society. While this is generally agreed upon, the theoretical and ideological underpinnings are far more contentious. There is scant literature detailing the impact of neo-liberalism and managerialism on trauma in mental health specific agencies. The literature did reveal, however, shrinking services in favour of privileging easily quantified tasks and the impact related to service delivery. The resistance to adopting new frameworks such as trauma-informed care as it can be viewed as 'extra work' in an already inundated organizational structure (Henry et al., 2011). Front-line service providers noted that they were in 'survival mode' in their agencies and had little time or effort to enlist new forms to document trauma, or to implement trauma-informed care (Henry et al, 2011). Aronson and Sammon (2000), found that social workers in front-line practice have been particularly affected by neo-liberal policies such as new-managerialism (Aronson & Sammon, 2000). Between time constraints, tedious forms and documentation, practitioners felt like the 'best parts' of their practice or 'good practice' were being squeezed out (Aronson & Sammon, 2000) in favour of distilling practice into a series of quantifiable tasks.

Managerialism is not necessarily a definition of an agency's management. Managerialism or new-managerialism, is a reflection of dominant economic policies which give undue privilege to market forces (Rees, 1999). Managerialism understands society as an economic market rather than a community with common goals (Tsui & Cheung, 2004). The literature suggests that the economic policies were based on the influence of market forces and were justified and exalted by being defined as 'rational' (Rees, 1999) reinforcing neo-liberal ideology and supporting the status-quo. This process is widely regarded as being self-evident as it is believed that individuals and corporations are solely motivated by self-interests. Further, the framework is regarded as more profitable compared to those who maintain a collective understanding of society (Rees, 1999). This ideology, as it is owned and defined by the elite and dominant class, drives public policies (Rees, 1999). Ultimately, the economic policies engendered a new style of management. Under this new style, attention to financial accountability is exalted. Managers or workers who can demonstrate fiscal responsibility are rewarded and a manager's performance then, becomes based primarily on their ability to control money and resources (Rees, 1999). This results in management taking harsher and more austere measures to meet or exceed financial expectation, the race to the bottom includes cutting staff, limiting already starved resources and reducing employee job security and longevity (Aronson & Sammon, 2000). The cost of this economically driven method means that clients may be denied services, vulnerable individuals become the target of monitoring and surveillance as they are viewed as starving the resource pools, social rights of citizenship are replaced by ones of economic worthiness. Individuals who can pay for services are rewarded and those that cannot are punished (Rees, 1999).

Rees (1999) notes that staff who are morally or emotionally against the imperatives of managerialism are at a loss. The study has shown that non-compliant staff experienced low morale and stress-related illnesses in already emotionally challenging environments (Rees, 1999). Professional autonomy is not respected in neo-liberal agencies (Tsui & Cheung, 2004). The reflection of neo-liberal ideology in social service agencies may be particularly problematic due to the conflicting nature of interests. For many individuals, working in public services is “more than just a job” (Miller & Hoggett, 2006). Social workers have a strong emotional commitment towards the people with whom they work (Miller & Hoggett, 2006). As a result of their often strong emotional connection, front-line staff have indeed declined or strategically avoided managerial careers (Miller & Hoggett, 2006) in an effort to remain close to the individuals with whom they work. Alongside increasing managerialism within the practice, social workers are experiencing increased managerialism in mental health and clinical work (Thompson, 2004). The social worker role in mental health has been subordinated (Nathan & Webber, 2010). This has created tensions within practice, social workers have reported feeling under-valued and the work that they perform, misunderstood (Nathan & Webber, 2010; Thompson, 2004). Through this model, social work's role can become reduced or even undermined. Nathan and Webber (2010) noted in their study focusing on institutional hypocrisy, that social workers in mental health hospitals were expressing their frustration competing against bio-medical discourse. Social workers, who as part of their professional scope establish relationships with service-users and illuminate service users' needs, felt that their holistic views of the presenting issues were undermined. They found that their professional roles were undermined by medical professionals. Perhaps most concerning was the lack of discussion and debate on these issues, psychiatrists decisions trumped social workers professional autonomy (Nathan & Webber, 2010).

A majority of mental health initiatives are heavily driven by government policies and initiatives. Often calculated government policies that are intended to improve the quality of service for service-users can be 'hijacked' by institutional precepts which leave the needs and safety of service-users subservient to the organization (Nathan & Webber, 2010; Thompson, 2004). There remains and may always be a divide between governmental policies and the working class whose job it is to translate the policies into working actions (Nathan & Webber, 2010). The creation and provision of service-user led initiative are confronted by dominant ideological concerns such as public safety and shrinking services (Nathan & Webber, 2010). Furthermore, a report by Thompson (2004), expresses the relationship between individual and institutional ethics. The author notes that while the two competing value systems may share a common moral, that the two ethical interpretations are fundamentally different (Thompson, 2004). Individual ethics refers to the interpersonal relations that aim to address people on a moral level. Institutional ethics have developed out of a perceived need to set standards among individuals who may never meet, seeking to increase the potential of improved general relations by making the leaders of these institutions more accountable (Thompson, 2004). Professional ethics shift from collective-morality with a focus on community benefits to personal-competence and individual benefits (Tsui & Cheung, 2004). Authors Tsui & Cheung (2004), express that this moral ambiguity has created spaces for dominant systems to infiltrate the everyday working environment so that new managerial policies appear to be 'business as usual'. Efficiency replaces effectiveness as the primary yardstick for performance (Tsui & Cheung, 2004). Looking at the impact these systems have on front-line service delivery, reveal challenges in meaningfully addressing hard to quantify issues such as trauma, potentially engendering negative implications for service users and service-providers.

**Under-Recognized Trauma**

The reasons that under-reporting and/or under-diagnosing exists among this population are unknown, however, it has been reported that under-diagnosing can negatively affect service users as well as service providers (Salyer et al., 2004). The under-recognition and diagnosis of trauma among this population can negatively impact service users in multiple ways, one of which may be that service users feel dehumanized as they struggle to re-tell or initiate conversations regarding this painful traumatic history (Putts, 2014).

The literature suggests that there are a set of barriers to addressing trauma in the workplace.

Researchers in the United States, conducted a state-wide survey of clinicians who served individuals with severe mental illness in community support programs. Their intentions were to identify barriers to the diagnosis and treatment of trauma-related issues (Salyer et al., 2004). This research study found that most of the clinicians surveyed did not feel competent to effectively treat trauma-related problems (Salyer et al., 2004). While the study found that 98 percent of their clients with a diagnosis of serious mental illness had at least one type of exposure to a traumatic event (Salyer et al., 2004).

Some of the perceived barriers to recognizing and diagnosing trauma among this population are, service providers may lack specific trauma-informed knowledge, they may feel personally uncomfortable discussing traumatic events, or as the author notes, PTSD may seem superfluous amid a range of other serious and pressing mental health issues (Sayler et al., 2004). In addition, research has shown that service providers may be unwilling to discuss the issues, some workers noted that trauma was not as serious an issue as some of the other problems they were addressing (Sayler et al., 2004) among individuals with serious mental health. Other study participants worried that raising issues of trauma would “make situations worse” or bring service users into crisis (Sayler et al., 2004). The majority of service providers surveyed in this study, however, reported that their agencies did not provide sufficient training opportunities on trauma or PTSD (Sayler et al., 2004).

Many of the same sentiments were shared in reviewing the literature on the under-recognition of trauma, Other studies noted barriers that included, front-line workers' personal stress levels, physical fatigue from the physical aspects of front-line work, stress associated with meeting organizational criteria and requirements. Trauma and crisis situations even among front-line service providers, seem to elicit an emotional response, this study reported that some workers may feel that their skills are inadequate to handle such emotions, they may be fearful of “opening a can of worms” or inducing a crisis response (Conviers-Burrow et al., 2013).

The magnitude of issues that are associated and often present among individuals with a serious mental health diagnosis may be a barrier to recognizing and addressing trauma related issues. Mental health consumer survivors often experience a number of complicating factors associated with their diagnosis. In severe cases of mental health, distressing symptoms such as hallucinations, delusions, disorganized thoughts and behaviours, have a direct impact on the individuals lives (Putts, 2014). Diagnoses that often include these symptoms are generally termed in the mainstream as 'psychotic' symptoms. 'Psychotic disorders' include diagnoses such as schizophrenia, bipolar disorder, schizoaffective disorder and major depression (Putts, 2014). Many front-line service providers in the mental health agency setting are confronted with these issues on a daily basis. Given the intensity and significance of these issues, service providers may tend to concentrate their limited time and effort on the more predominantly displayed psychiatric symptoms (Putts, 2014). The author imparts the imperative to examine the relationship between traumatic events and instances of psychosis to better understand under-recognized PTSD among mental health consumer survivors (Putts, 2014).

The author identifies the first step in this process as creating an awareness of overlap between traumatic events and mental health issues (Putts, 2014). This author articulates that among individuals who experienced their first episode of psychosis, 29 percent were victims of sexual assault and 45 percent were victims of physical assault (Putts, 2014). In addition, childhood abuse was experienced by the majority of individuals who experienced either short term or long term psychosis (Putts, 2014). More than half of participants in this study, hospitalized for the first time with a diagnosis of psychosis, reported childhood sexual and/or physical abuse (Putts, 2014). This finding shows that even for individuals who had only endured a single hospitalization due to psychosis, there is reason to consider the impact and relationship to trauma (Putts, 2014). The conclusions of this study show that for individuals who have experienced multiple instances of psychosis, the rates of exposure to trauma are magnified (Putts, 2014). Despite the above reports, there remains evidences to suggest that this relationship is not well recognized by clinicians (Putts, 2014).

Epistemology, personal values, skills and knowledge may shape the kind of service front-line workers provide (Weine et al., 2001) For example, a social worker educated in positivist methodologies may be more inclined towards medical discourse. A social worker who has had experience as a service user may have a special perspective on service user advocacy issues. A study conducted by Weine et al. (2001), looked at service-providers' attitudes and knowledge towards trauma and PTSD among the refugee population in Chicago, USA. The study found that service-providers trained in mental health with a presumably sophisticated knowledge of trauma and PTSD, did not always link trauma or trauma-related issues to the requirement for treatment (Weine et al., 2001). The study found that the rate at which service providers recommend treatment vary depending on the service providers' presumed knowledge or training in mental health. However, when service-providers did recommend treatments they were not presenting a rationale that reflected a perception of a diagnosis of PTSD. Similarly to Putts' (2014), study regarding the relationship found on under-recognized trauma, suggested that the connection between the knowledge of PTSD and providers' attitude towards treatment may not be as strong as one may assume (Weine et al., 2001). The study also noted that education, assessments and interventions are not consistent with the study's participants' perception that PTSD is a highly prevalent issue in the refugee population (Weine et al., 2001). In other words, they found that mental health service providers' knowledge of PTSD was high, however, they found that this knowledge was being under-utilized as an explanation for treatment (Weine et al., 2001).

**Trauma's Impact on Service Providers**

Trauma as it relates to service-users may also have negative impacts on service-providers. Secondary Traumatic Stress (STS), refers to the presence or re-experiencing symptoms of trauma after indirect exposure to traumatic events (Sprang et al., 2011).The failure to address secondary traumatic stress may lead to greater instances of burnout among service providers. STS may have an influence on decision making and treatment in relation to service-users (Pence, 2011). Predictions for service providers experiencing STS suggest that professionals who are constantly exposed to trauma-related work can develop varying degrees of psychological distress often referred to as STS, burnout or compassion fatigue as a natural consequence of their work (Sprang et al., 2011). The author notes that as gathering and interpreting personal stories, facts and experiences is essential to the work of a front-line service provider, that an investigation that is not well trauma-informed, may unwittingly have consequences and possibly exacerbate trauma (Pence, 2011). Organizational interventions to prevent STS had a high rate of success and supervisory roles played a part in the successful promoting and entrenching of such initiatives (Sprang et al., 2011).

While under recognized STS may lead to increased burnout among staff, perhaps more concerning, workers who are experiencing STS may have compromised abilities in making critical case decisions (Pence, 2011). Participants in a study reported being affected by STS in their overall loss of perspective, which had significant impacts on their ability to assess risks and safety (Pence, 2011). Further consequences included decreased motivation at work, increased absenteeism and attrition (Pence, 2011).

Similarly, Wies and Coy (2013), report that the experience of secondary trauma may be understood as a mental conceptualization of the world around through the lens of repeat exposure to individuals who have experienced trauma (Wies & Coy, 2013). The symptoms of STS have been found to be similar to the symptoms associated with PTSD (Wies & Coy, 2013). The symptoms can be so similar that the main difference is only that the experience of trauma is not first-hand (Wies & Coy, 2013). Vicarious or secondary trauma have been well-documented among individuals providing direct care including front-line service-providers working in emergency rooms, in psychiatric care, end-of-life care, gender-based violence, etc. These service positions are often located in environments where low-pay, long-hours and exposure to violence and disease can increase the risk of suffering from symptoms associated with secondary trauma (Wies & Coy, 2013). The author suggest that this may simply be a consequence of being deeply committed to working responsibilities (Wies & Coy, 2013)

To conclude, the majority of research on trauma and the ways it influences practice is focused in the child-welfare sector and research has been primarily conducted in the United States. The literature has focused on medical conceptualizations of trauma and treatment, looking towards mitigating factors such as PTSD, this literature review highlighted a disproportionate amount of positivist research as alternative perspectives on the topic were scares. Gaps in this literature review pertain to the absence of the service-users voice. The voices of mental health consumer survivors are rarely privileged in academic pursuits which negates key areas of research on this topic. Furthermore, there were shortcomings in terms of the neo-liberal influence on the mental health agency setting specifically, however, I felt that the neo-liberal themes that occur in other agencies settings were transferable to the mental health setting.

My research question seeks to gain a greater understanding of front-line service providers’ perceptions of trauma within the neo-liberal context. This study was conducted in a mental health agency setting in Toronto, Ontario. There are concepts and issues that are undoubtedly unique to the mental health agency setting, given the connection between trauma and mental health diagnoses. Further, providing a Canadian context will work to diversify the range of data on this topic. My research contributes a unique dimension to the established literature on this topic as it uses qualitative methodologies and privileges the voice of the service-provider. It is my hope that this research will serve to address some of the gaps that have been illuminated in this literature review.

**Chapter 3. Methods**

My practice and research interests are a reflection of my lived experiences. Growing up, mental health was a part of life. My familial experiences fostered a deep sense of compassion and understanding of the issues. It also established a recognition of the structural and systemic factors that impact the experiences associated with mental health and addictions. Beyond my own micro understanding, I became sensitive to other injustices and inequalities in society and knew that there had to be better solutions than the current efforts. These experiences brought me to social work and more specifically, my interest in mental health.

My interest in front-line service-providers' perceptions of trauma as it relates to service-users came from feeling uneasy in my own practice. As I moved across agencies and worked in different capacities, I began to encounter a common thread among the service-users in this population. The stories of trauma were pervasive. They came out organically and often unexpectedly. For instance, once I was walking with a service-user to a meeting together, when suddenly the service-user pointed across the street to a low-rise building, and informed me that they had been held captive and horrifically abused for years. Another time, while conducting an art class, a service user lifted their shirt to show me the location where the service-user's father had struck the young individual with a screw driver. More and more, I was informed about these traumatic histories, not all as alarming as the above examples, often times, the service users expressed the relentless and lingering experience of trauma that were an unfortunate part of their life's trajectory.

As I became more attuned to what I perceived as underlying traumatic histories, I was puzzled by the lack of attention or treatment the issue was receiving in my working experience. I began to think that something was missing. Critically reflecting on my own experiences, I wondered if the neo-liberal policies and procedures I had been learning about were impacting this issue. It was my intuition that trauma was under-recognized in the community mental health setting and I wondered if neo-liberal policies and practices such as new managerialism were impacting service-providers' ability to attend to these issues or address trauma in the agency setting. These thoughts engendered more questions than answers. Ultimately, the search to learn more about trauma in the neo-liberal context, brought me to this research topic.

**Epistemological Underpinnings**

Ahead of describing my theoretical frameworks that will be the guide and justification for knowledge in this study, I would like to preface the core themes by expressing my deeply held epistemological understanding that the construction of our worldviews are in a constant state of evolution. For me, remaining open to the fluidity of practice allows for the recognition that each new life experience has the potential to alter my frames of reference. Critical reflexivity, is how I choose to understand this constant change as I believe it has the power to engender positive change not only in my practice and research but in social work as a profession. Critical reflection is an essential element of practice framework, as it is the avenue to transformation within practice (Fook & Askeland, 2007). Reflection is a subjective activity as we can only interpret the world through our own lenses which have been constructed by our unique life experiences. I believe the commitment to reflexivity that involves one's 'whole self' is a relationship between the practitioner, service user, culture and society. Therefore, our processes ought to go beyond the reflection of individual circumstances and towards the questioning of unanswered cultural norms (Fook & Askeland, 2007). This means that despite the current application of any given framework, that the worker is foremost committed to the maintenance of an ethical relationship through critical reflexivity. There is no one theory that is a panacea for social change, nor will there ever be given the nature of our human practice. We work within the uniqueness of humanity, every situation is inclined towards an ever-changing social world. Without critical reflexivity, we risk social-justice oriented practice falling victim to the status-quo. For these reasons, I find it necessary to first locate my theoretical frameworks within this notion of critical reflexivity, the conceptualization that despite our use of theoretical knowledge we are primarily in a state of constant growth and change, to deny this factor would be to accept the possibility of even the most progressive frameworks becoming co-opted by dominant systems. As social justice oriented social workers, it is our duty to search out, recognize and address all instances of discomfort, challenge and contradictions to ensure we are always striving to deconstruct places of elite privilege in favour of creating spaces for the generation of new knowledge that's foremost principle is to serve those it directly effects.

With that, I have found that feminist methodology, specifically socialist feminism provides a solid base in terms of increasing our knowledge of oppressive structures, addressing power relationships and combining the knowledge of both the researcher and the participant (Becker et al., 2012). As a feminist researcher, I subscribe to the notion that every researcher holds a unique perspective and will ask questions and raise issues based on their own epistemological position (Hesse-Biber, 2007). Feminist research approaches have created space to address both the process and the outcomes of this research study and focus on the synergistic linkages between epistemology, methodology, and personal values that inform the collection and analysis of 'data' (Hesse-Biber, 2007). Similarly to critical reflection, feminist methodology can be related to the open acknowledgment of subjectivity, the notion that no research can be completely value-free (Beacker et al, 2012) as human research involves the connection between both personal and professional life (Neuman, 1997).

The purpose of this study is to gain insights on the subjective experiences of service-providers in a general sense. As my research progressed and I began my data collection, an interesting relationship to feminism developed. Although I recruited openly to both women and men, my sample is entirely female. This added an interesting dynamic to my research analysis that I had not anticipated. Given this development, socialist feminism, a sector under the feminist umbrella, is most fitting. The key difference with this model of feminism is the conceptualization that the fight to deconstruct male dominance is a key to social justice, however, it is not viewed as the only or primary contradiction, it is perceived, rather, as among many oppressive structures that limit woman’s access to social justice (Kennedy, 2008). Feminism does not necessarily exclude men and male issues from its research, in fact feminist research may even be conducted by men (Becker et al., 2013) and men may also be feminist research participants (Correia & Bannon, 2006). I am interested in the various intersections in which women and men encounter oppression. Some proponents of socialist feminism focus on the impact of hegemonic masculinity as an important gender issue (Corriea & Bannon, 2006) in that masculine identity is based on polarizing stereotypes of how men and women ought to behave (Correia & Bannon, 2006). This intrinsically links women’s issues with men’s issues and as such make both genders vital consideration within feminist research.

As I am primarily concerned with the ways in which everyday oppressions affect peoples' lives, anti-oppressive research has influenced this research design and analysis. Anti-oppressive research methodology recognizes that all knowledge is created through the various interactions between people (Potts & Brown, 2005). Similarly to feminist methodologies, anti-oppressive research seeks meaning above 'truth'. An important consideration for both feminist and anti-oppressive researchers is the question, who does the research serve? (Fook, 2003). This was a particularly important consideration in terms of this research project as I am interested in privileging the voices of those who have been typically excluded from research, however, in this design I have chosen to analyze the perceptions of service-providers instead of service-users. This remained a tension throughout this research project. As my questions will ask service-providers about their thoughts and opinions as it relates to service-users. I rely on the interpretation of service-providers rather than privileging the voice of the service-user which was a decision made primarily in the interest of time and in consideration of the scope of this Master level thesis. This is a tension in this design that I continue to grapple with, and will remain cognizant of, returning to it throughout this analysis.

**Research Design**

My goal is to learn more about the meanings front-line workers attribute to trauma in the mental health agency setting thus, my research question is, what are front-line service providers’ perceptions of trauma within the neo-liberal context? A qualitative research design was chosen because qualitative research privileges the participants' voice, minimizes power relationships and seeks to understand the context of the issues (Carter & Little, 2007). Qualitative research involves a naturalistic approach that studies various topics in a natural atmosphere with the intention to make sense of or interpret the phenomenon in terms of the meanings that people ascribe to them (Cresswell, 2007). As I am primarily interested in the subjective experiences of trauma as perceived by front-line service-providers, qualitative methodologies allowed for a thorough analysis of the meaning individuals or groups ascribe to human challenges (Cresswell, 2007), specifically tensions in addressing trauma within a neo-liberal atmosphere. Utilizing qualitative methodologies aided in constructing a style of data analysis that is conducive to establishing patterns or themes (Cresswell, 2007) that derive from a reciprocal relationship with study participants. It was imperative in the study to highlight the participant’s voice, which required critical reflexivity on my part (Cresswell, 2007). Finally, qualitative research serves my research purpose by creating opportunities to develop complex interpretation while supporting a call towards action (Cresswell, 2007).

**Insider vs Outsiders.** This agency held meaning for me as I completed my undergraduate practicum at this location and was moved and inspired by the dedication and service that the front-line workers provided. No other agency felt more appropriate for this research project. Anti-oppressive research methodology analyses the insider/outsider relationship present in research. Anti-oppressive methodology would understand the relationship along a continuum where a researcher would locate themselves somewhere along the middle of that continuum (Potts & Brown, 2005). As the relationships we hold are fluid and socially constructed, it is difficult to define oneself as an absolute insider or outsider. In different ways and to different people we may be and insider, an outsider or a combination. Despite this ambiguous analysis, the anti-oppressive researcher maintains that it is necessary to continue to question and critically reflect upon this relationship.

***Insider vs Outsider’s Dynamics.***  I am an insider in that, I performed as a case manager on the ACT Team. An insider often begins the research process with a deeper understanding of the group dynamics, history, politics and power relations (Staples, 2000). This was certainly true in my experience as part of what informed my research topic was an understanding of the ACT Team’s unique dynamic and power relations. Being privileged to this information may make an accurate power analysis more feasible (Staples, 2000). My insider knowledge afforded me a certain privilege when constructing the research question and the interview questions. I was aware of the political dynamic and the changing agency culture with the agency’s pending transition to government funding. During the time of my undergraduate placement at the agency, I could sense conflicts developing over what the changes would mean for the service providers’ practice and how it may impact service-users. To my knowledge, the impacts on addressing trauma were never raised as an issue, however, I used my insider perspective and experience working with this population to develop research questions that related to this concept. Further, my insider knowledge of the agency and the study participants contributed to the construction of this study’s analysis. In conjunction with the interview data and the current literature on the topic, my insider experience aided in informing and developing some of the conclusions along with raising further questions.

While I identify as an insider and undoubtedly benefitted from this relationship, I recognize my outsider relations which include, being a student and a researcher and also having been disengaged from the agency for approximately one year prior to initiating the recruitment process. As an outsider, I am in a position to re-establish relationships and engage in the process of attempting to understand the social phenomenon (Staples, 2000). On a continuum, I felt myself navigating between the two roles, at times during the research process I felt like an insider, sharing in experiences and easily empathizing with the participant’s concerns. Simultaneously, re-entering the agency environment, I was acutely aware of my outsider role as numerous changes had occurred since my time there and I felt a divide given the power dynamics associated with my previous student role vs, my current researcher role.

**Recruitment Process**

As noted above, from the conception of this research project, it was evident to me that I would recruit from a former agency. I reached out to potential participants via email (Please see Appendix A). I requested that the ACT Team's administrative assistant distribute the recruitment emails which briefly outlined the research project and what would be involved in participating. I also posted recruitment posters (Please see Appendix B) throughout the office and at the request of the team members, handed posters out individually. Additionally, I made a brief announcement regarding my research topic and request for participants during the team's morning meeting. For me, this was my most effective recruitment method as it allowed for me to reconnect with the team, speak with them informally and answer any questions they had. After, I conducted the first two interview, I learned from the participants that they were encouraged to participate based on the positive experiences of others. This was a pleasant surprise and improved my recruitment process.

**Description of Participants**

Five participants were recruited from a downtown Toronto, Ontario ACT Team. All staff members on this ACT Team were recruited including front-line professionals such as social workers, peer workers, nurses, psychiatrists, medical doctors and the team's manager. All of the front-line professionals are termed 'case managers' save for the medical doctors and the manager. This group is diverse and includes women, men, a range of ages, ethnic and cultural backgrounds and educational backgrounds. The participants were entirely female which allowed for a deeper feminist analysis and fluidity throughout this feminist-based research project. The women range in age from late 20s to late 60s. They come from different racial and cultural backgrounds, diverse educational disciplines, and they all have extensive experience in front-line service provision.

**Data Collection: Semi-Structured Interviews**

Semi-structured interviews were used as the primary source of data collection. The goal was to achieve a form of conversation that would encompass a wide range of information (Uttarkar, 2010) pertaining to the research topic. Semi-structured interviews are a common data collection method used in feminist research. Semi-structured interviews allow for free flowing interactions (Uttarkar, 2010) that foster the kind of personal relationships I wished to established with the participants. The interview questions were designed to have a degree of focus in terms of the research topic, however, they were intentionally open-ended so that the participant could lead the discussion (Please see Appendix D). I also believe that this open-ended style question not only produces richer data, but increases the likelihood of participant receiving some sort of satisfaction from the research process, as feminist research would suggest that this method elicits information quality that is superior (Uttarkar, 2010). Taking these steps to improve the research experiences for both the researcher and the participant, it may be that the hierarchy between the researcher and interviewee may be minimized but never completely obliterated (Uttarkar, 2010). Consent was obtained orally and in written format as participants were presented with the consent form prior to conducting the interview and then again at the time of the interview, the participants and myself read through the consent form, followed by written consent. I purposefully left the time and location of the interviews up to the participants, I wanted the interactions to be as comfortable as possible. Some of the women chose to meet outside the office, at coffee shops and other women opted to meet at the agency location in secluded spaces such as a private interview room. I opted to conduct one forty-five to sixty minute semi-structured interview with participants. My hope was that, in a relaxed environment chosen by the participant, the semi structured interviews would provide enough guidance to nurture discussion but be open-ended in design so that the participants could truly delve deeper into the themes and issues surrounding trauma that were meaningful to them. Feminist research practice tends to be process oriented (Neuman, 1997), this factor has guided the construction and the delivery of the interview questions as it was my primary goal to not only collect 'data' for my project but to ensure that the service providers felt that their relationship with me and the experience of the interview was part of the overall process. I do not experience my role in the research process as detached or objective, I endeavour to interact and collaborate with participants (Neuman, 1997).

**Interview Process**

The interviews were audio recorded so I could be completely immersed in the discussion. I had originally planned to take written notes, however, the conversations that came out of the interviews were so engrossing that writing notes never came to mind. To contextualize the interview questions regarding trauma, I first attempted to gain a deeper sense of how service-providers perceived themselves in relation to service-users, how they viewed their roles in the agency and how they understand and qualified the work that they do. When asked about their roles at the agency, it was made clear that front-line service-providers are deeply dedicated to their service provision. The dialogue surrounding this point was indirect, however, demonstrated both a professional investment as well as an emotional investment in their work. “We help them with their [service users'] ups and downs and even if they fall apart, we pick them back up and build them strengths.” Theoretically, this discourse reflects a strengths-based perspective with an emphasis on empowerment. It may also reflect a particularly feminist approach to service provision, where service-providers are emotionally attuned to the people with whom they work (Neuman, 1997).

I believe this provided an opportunity to give voice to women, complementing the subjective experience of females (Neuman, 1997). The field of mental health is predominantly informed through positivist methodology that has been described as reflecting objective task-oriented practice (Neuman, 1997), relying on its own domination to perpetuate its control. Embracing a feminist perspective and drawing forward the voices of women works to challenge these perspectives and focus on more human consideration within the practice. Women tend to emphasize the subjective and empathetic process-oriented aspects of practice (Neuman, 1997), this was my experience throughout the interview process. Interviews were fluid and conversational. They allowed for honest and open discussions that required a great deal of courage and openness on behalf of the participants. The participants informed me that they enjoyed the process and were excited to see what change may come from sharing their personal stories. This positively impacted my research and findings and created an environment for what I believe to be a genuine reflection of front-line service providers in the mental health agency setting.

**Making Meaning**

The 'data' analysis is more akin to the anti-oppressive research concept of 'making meaning' which views the role of 'analysis' as an ongoing research process, so that analysis happens in the interpretations, reflections and construction of meaning (Potts & Brown, 2007). The process of meaning making involves constantly searching out and addressing places of power and privileged and deconstructing those issues (Potts & Brown, 2007) while seeking to combine the knowledge of both the researcher and the participant (Becker et al., 2012). Meaning will be made by analyzing various points and intersections of oppression including gendered issues, using a critical lens and a politicized view to draw out the experiences and thoughts that the participants use to make meaning in their lives (Potts & Brown, 2007). By focusing on these elements, we can become increasingly aware of the histories, contexts and social dynamics, discovering new opportunities for critical reflection and social action (Potts & Brown, 2007). Therefore, meaning making began at the start of the research process, my experience as an insider in this population allowed me to begin critically thinking about the various political and power dynamics evident in the mental health agency setting.

During the interview process, I conscientiously listened to the women share their stories, listening for tensions, points of conflict and similarities among the participants. Following each interview I made written notes of the emotional gestures and points where the participants expressed discomfort with either the questions or their own feelings. I used these notes to help discern commonalities during the transcription process. I transcribed the interviews myself which allowed for an intimate relationship with the data and fostered a deeper understanding of the issue.

The coding process involved repeatedly reading through the transcriptions, highlighting commonalities within an interview, and locating similar quotes, stories and feelings among all five interviews. On a separate document, I began to write concepts in relation to the data. As I continued, a more refined collection of categories and sub-categories were created. This allowed me to arrive to the themes presented in the finding chapter.

As this study sought to understand more about front-line service-providers’ perceptions of trauma, I attempted to remain authentic to the participants’ voice whenever possible, privileging the participants’ perceptions. This allowed me to conceptualize the meaning that the participants ascribed to trauma in the mental health agency setting.

**Chapter 4. Findings**

The way new-managerialism integrates itself into the dominant social services is similar to the ways in which it has become ubiquitous in our society. It continues to chip away at the more ambiguous aspects of our practice to co-opted larger spaces reserved for time and efficiency measures. This process is intended to improve the way agencies operate, however, there are several unintended consequences. In this chapter, five women express their frustrations, concerns, perceptions and stories on the topic of trauma in the mental health agency setting. The women address issues surrounding the structural implications of the agency model and share stories about meeting the agency's efficiency guidelines while maintaining authenticity in their practice. Deep personal and emotional investment in their front-line service was expressed. This raised questions regarding the overall intensity and stress of the work. The notion of under-recognized trauma was reinforced through the stories and experiences shared by the women, outlining some of the negative implications that the under-recognition of trauma can have on both service-users' and service-providers' overall wellness.

**Quantity over Quality**

Virtually all the participants noted a change in the agency culture from pre-government funding to post-government funding. The ACT Team was originally classified as a 'project' and received time-limited funding by the Mental Health Commission of Canada, after the ACT Team's research results demonstrated the success of the project, it received long-term funding by the Central Local Health Integration Network (LHIN). Like most government funded agencies, with the promise of perennial funding came new productivity and efficiency measures. “The Central Local Health Integration Network (LHIN) looks at our 'contacts' for funding. The project just gave us some money, we dealt with that but now we are responsible to the government funders.” The onset of this new funding has also translated to increased documentation. From my own experience, service-providers spend equal if not more time completing documentation as on their visits or meetings with service-users. “The structure is slightly different now, it now incorporates this OCAN where you need to fill out all these questionnaires and capture the details of the clients and their goals and so on.” The women related organizational pressures to the type of care that service-providers can be expected to perform.

People need to be very responsible around charting and documenting not just their scheduled visits but the unscheduled visits. We weren't being so meticulous and picky about every little thing, now, if you run into someone on the street and you have a quote “visit” as long as it’s at least 10 minutes that counts as a contact and needs to be documented.

Quantity over quality or the introduction of new quantitative efficiency measures was a dominant theme throughout the interviews. The women voiced concerns regarding this changing culture and the ramifications on their personal wellness and ability to provide services in a way that is meaningful to them.

Like you can make maybe five phone calls out to resources about the client or speak to their doctors and that is not a contact. So in essence it doesn't really account for a lot of our time. We see three or four clients in a day which is only four contacts but only if we actually speak to the client or their family members, then it’s not a contact. So it can be very frustrating because it doesn't – I'd say the majority of our work with clients is not face-to-face, it’s doing all the work setting up, finding out resources for clients setting up appointments, that's where we are all feeling the pressure.

'Contacts' and 'benchmarks' are new qualifying components and conditions of the agency's government funding that every participant raised as an issue. The new 'contact', as one participant described, refers to “a face-to-face or telephone interaction with a client.” The rules around what may be deemed a 'contact' are stringent,

The funders are very strict about these contacts you can't even-in the past anytime we were talking to a doctor (on behalf of a client) we would use that as a contact but I think they got hip to that.

In addition to the challenges of meeting the monthly benchmarks, the policy itself is dependent upon an agency operating in top working order, therefore, if the agency is short-staffed or if there is some other operational challenge the numbers are affected.

We're supposed to have a certain number of contacts with clients per month, and we were running a little short because of a leave of absence, so our numbers were short approaching the deadline, so we were short to meet our quarterly deadline benchmark, but we ended up meeting the benchmark so that is good.

Added pressures were mounting with a team member away on a leave of absence. The increased workplace pressures can also lead to conflicts, placing additional stress on service-providers’ wellness. The women expressed that the increased pressure associated with making 'contacts' were contributing to tensions and conflicts amidst the team. Making daily contacts is formulated as a 'goal' for front-line staff. Value is ascribed to an individual's ability to perform under these guidelines. Front-line staff are finding themselves in disputes over their daily visits to ensure that they have taken on sufficient “clients” for the day.

That's where we are all feeling the pressure, when it [benchmarks] was first instituted some people were taking it like, you took my client and you took my client, that was a big stressor. It’s very frustrating but I'm doing my own thing-I write down my contacts when I do them and when everybody else is having their issues, I try to stay away, because it makes me extremely anxious.

One participant noted, “Everyone is very aware of the pressure to make their 'contacts' now to the point where they are fighting over them in morning meeting, it can cause conflict, right?” Aside from “causing conflict”, a preoccupation with meeting benchmarks may take attention away from the actual work with service-users. One participant explained how meeting the requirements for the government mandated benchmarks can be difficult when staff are unable to locate service-users. When attempting to locate a service-user in the community for a scheduled meeting, it is not uncommon to have service-users who are 'not found', this simply means that a worker had attempted a visit with an individual and they were either not at home or not at the agreed upon meeting location. It can, however, become problematic when an individual is continually 'not found' as it raises concern about the individual's safety and well-being.

When clients are not found that becomes like a minus contact because that doesn't count, so if you've been given five clients for the day and four out of five were not found, you need to start making calls and finding other ways to make your 'contacts'.

Service-providers often make up shortcoming in the services by working extra hours, working through breaks or lunches or taking work home with them, all of which adds to the service-providers' stress.

Oh you only have three visits? We need you to do at least 4 visits. So then I do and I only have X amount of hours a day, I'm not going to be able to pick up four visit, but then I do anyways and that person who needs the extra time gets compromised somehow.

Like in many new managerial agencies, the quality of service can be compromised for the necessity to perform, make deadlines, and be efficient. “It becomes about number of visits rather than necessarily the length or quality of the visit.”

Not all participants noted the negative impacts of the changing agency culture. As one participant noted a positive perspective. “It also affects me positively because now I have a full time job!” Further, the changes in funding for housing has been good for service-users as it means they can keep their housing, however, with long-term funding came cost containment measures that eliminated some of the 'non-essential' services.

When it came to rent, the research project was paying the full amount of rent on top of other expensive like, basic telephone line, insurance, a lot of things were covered by the project. So when the LHIN started funding the Team, a lot of things needed to be cut. We don't have that luxury you know... “Luxury” that we used to have for the clients they have to pay their own insurance now, ODSP has to pay the maximum 30 percent to their rent. So a lot of things like that changed and you know it affected the clients, at the beginning they weren’t happy but now they're getting used to it.

Participants reported feeling 'helpless' when they felt their work was restricted by governmental policies.

I feel that the quality of care, not that it has shifted, but because we have to get the benchmarks and I feel I can't necessarily always spend that quality time I need to with clients, I feel it affects a bit of the care that is being provided.

Other concerns were raised about the dominance of the medical model in mental-health agencies. Participants felt frustrated over the confines of their working practice and felt that the “root” causes were being overlooked.

A lot of health reporters including myself, we are looking at it from a very medical model...and it’s like you can't always look at it from that lens-it doesn't get to the root of why or what’s happening underneath. When you look at-it’s almost a paradigm the person is using-oh, it’s hereditary-but maybe they are dealing with trauma, so instead of dealing with the actual symptoms what about treating the trauma and then there may not be a need for the drug use?

Another front-line service-provider noted,

Right now we are just addressing the cover of the problem, right? Oh you have this kind of mental health here's your medication here’s your injection. Oh you have addictions? If you go to the detox this won’t happen. The main core problem is the trauma.

'Quantity over quality', has become omnipresent anti-managerialist jargon, however, it is essential to ensure that this very real consequence of neo-liberalism in social services does not become so ubiquitous in the discourse that it invalidates appropriate critiques. The participants emphasized that the structure of their organization involved a long-chain of command. The majority of the women expressed their accountability to management. Some participants felt obligated to their manager, but also to physicians, psychiatrist as well as program directors and government funders.

There are many tiers of the government and outside resources that we are accountable to...so our manager is responsible to their manager so in a small way we are also accountable to their manager as our actions and the work we do will affect my managers' performance.

It is not my impression that the participants as a whole do not feel accountable towards service-users, I believe that the commitment and dedication to the work cements this fact, however, it seems that the discourse would dictate a foremost loyalty to the authority of command. It is essential to deconstruct this issue because like neo-liberalism, the ideology makes slow and subtle changes to our practice in ways that are difficult to discern. As the study participants continued to raise the conflicts of working within the policies and procedures of new-managerism, I wondered how this model may affect the service providers' ability to attend to the more nuanced aspects of practice.

**“This is Not Just a Job”.** The women described a sense of sharing in the happiness of service-users' successes, feeling proud when service-users achieved their goals, but also, sharing in the disappointments or loss. Participants expressed that these aspects of work make front-line service delivery more than “just a job” that there was an emotional component that satisfied a sense of “joy”. Furthermore, the women expressed that at times, some of the emotions associated with trauma can 'rub off' or ‘transfer over’ onto the service-providers, which may pose challenges in service delivery. In my working experience, part of the joy of front-line work is witnessing the successes of individuals you have worked with and hoped for. Part of that happiness however, is intertwined with sadness when a service-user experiences a loss. Working closely with individuals especially on 'goal' related work, such as, receiving education, reuniting with family, starting a job, the investment of the service-provider moves beyond simply providing resources. In some ways, a service-provider’s own goals as a worker are tied to the service-user’s goals. They have established their desire to further their education, the worker is naturally hopeful that they will achieve this goal, engendering an investment in that individual.

When one of our clients first came to the team, they were living on the streets, addicted to drugs and when she got on the team, she worked very hard, we got her an apartment and she stopped doing drugs, she was taking a training course and we were considering 'graduating' her from the program. Then she had a relapse, was doing very poorly, we found out that she had been assaulted in the classroom. It was a trauma that made her relapse. So when we found out, we started talking to her almost every day, we spent a lot of time checking in with her and for that first two weeks I talked to her every day.

A study participant expressed the emotions involved in being witness to dreams not coming true or simply the emotions attached to loss.

So the guy [client] wanted to go to college and he had been working towards it for months. He wasn't doing well, so the worker went to do a visit at the service-users' apartment. The worker found the client dead in the home with the client's acceptance letter in his hand, it was very traumatic.

The emotional and personal investment was especially evident when a tragedy would occur or with regards to the death of a service-user. A study participant discussed their personal investment and the emotional consequences that can be attributed to this level of care.

I think our first client that passed away was significantly traumatic for the workers, so the client was our age, he wasn't doing very well and we couldn't get a hold of him. Finally, I said to my colleague, I think he needs you to go and check on him but don't go by yourself, he goes, no no I’ll go by myself and I'm like don't go by yourself! He walked in and the person was collapsed dead, he was dead for a couple days or weeks. The worker remembers the smell to this day.

Naturally, death is a difficult but expected aspect of front-line practice, especially among vulnerable populations. In this scenario, the death of a service-user is traumatic, however, the experience is complicated when hope and expectations have been affixed to the working role. It can be difficult to regulate emotional involvement. Is it possible to genuinely care for a service-user in their successes, but then remain stoic and objective when perhaps more uncomfortable or gritty emotions arise? Emotions such as, shock, fear, disappointment, anger and anxiety that may be associated with the death of a service-user.

You're too involved, step back and let someone else do it, and it’s like no! I just want the person to die with dignity and I don't want them to be- a lot of people are like, “let the city of Toronto take care of it” and it’s like no. This is our client the City is going to put her in some cardboard box and ship her to one of the cemeteries and I’m not comfortable with that.

A study participant explained how her emotional investment is part of her own recovery, finding satisfaction in being able to be a “peer” or a “role model” to other service-users after experiencing her own struggles.

I think part of it comes from the type of person you are and the life experiences you've had. If you've always lived a quiet life with no struggles, had a great family relationship and you know, was the top cheer-leader, haven't had a lot of stressors in your life, you have a different view. But when you come from having experienced difficult situations you have learned how to deal with that and can empathize with clients a little more.

One of our clients says that she considers me, one of her- I give her hope because I show that there is a light at the end of the tunnel and that she can come out on top, if I did, then she can. A role model, I'm a strong role model.

Despite noting the risks involved, the women value a professional and emotional investment in the work and believed it to be a positive characteristic that is respected and a marker of a 'good worker'. A study participant expresses, “Some people are very emotional and in tune and for other people it’s just a job, they do what they need to and then they leave.” This sentiment was also associated with a personal pride in the work that they conduct. When asked about their roles at their current agency, the responses were detailed with enthusiasm and encapsulated a sense of pride in the work that they do. One women, expressed a common feeling among front-line workers, “this is not just a job, I don't know I just-I get pleasure from you know, providing that support to the people who need that support.” Working on goals with clients was raised as one of the primary duties. Another participant noted,

It’s our job to work with the clients to help them get their goals that they've made...somehow I have this- [service-users] tend to tell me things probably because I'm more like a mother to many of them.

While a strong and authentic investment in work arguably results in the best service delivery for clients, the notion of empowerment can be problematic as being given power may not always be experienced as empowering (Fook, 2012). For example, I recall a practice incident where I was asked to encourage a service-user to start a bank account. It was assumed that creating the account would be an empowering experience for the individual. The service-user was not ready to take this step and instead internalized the experience as shameful and disruptive to her wellness.

One of the participants enthusiastically listed the many tasks that are involved in everyday case-management service delivery “So I manage about 12 clients on the team, we work with clients on any plan they have; budgeting, employment, volunteer work, assisting in all aspects of living, court, doctor's appointments, ODSP, yeah it’s a lot of work.” Outside of the pride that the participants showed for the work they do, they expressed a sense of loyalty towards the organization. “Anything we do outside or inside the office will reflect on the agency as a whole. Showing a good professional role with outside resources also reflects on us and reflects on the organization. It helps give them a good reputation.”

Tensions emerged between emotional and professional obligations towards service-users and a workers' loyalty towards the agency or organization. On one hand, the women were clear in expressing their emotional and professional commitment towards their work. On the other, many of the women also noted their loyalty to the authority of command in terms of the organizational structures. This illuminated issues surrounding the women’s perceived ability to dedicate time to the more nuanced aspects of service including their own emotional wellness.

**Paternal Discourses and Case Management.** A somewhat paternal conception of service provision emerged from the interviews,

Even if they fall, we pick them back up, we help them understand what is going on with them and monitor their well-being...any problems that arise we keep them on board and if they fall, we pick them back up.

With only the most genuine intentions, the notion of 'own good' may satisfies a worker’s sense of what is best for the service-user. I would suggest, the nature of 'case-management' may induce a sense and a culture of paternalism in service provision. As each participant described their perceptions of who they felt accountable to. The majority described the latter of organizational accountability, including management, directors and the government. Fewer reported feeling accountable to service-users.

I feel most accountable to our manager, because she is the manager of the program so even though I know there are executive directors I don't really feel so accountable to them.

This suggests that the structure of case-management, rather than service-providers’ practices frameworks, may engender a sense of responsibility towards the agency and the system, but that the nature of social work and the emotional investment together may create a culture that is perhaps more paternal than it would be otherwise. The language of case-management and the structure of the organization draws service providers to conceptualize themselves among the business-like structure which they are a part of.

The thoughts and feelings that were shared, lead me to begin thinking about what connections or risks may be involved in being deeply committed to one’s work? Is this a natural consequence of the profession and/or is it a marker of 'good social work'? What are the implications in terms of trauma and wellness or feelings of frustration when neo-liberal ideology limit one’s ability to provide their desired service?

When you are working on the team there has to be this level of professionalism you almost have to show people that you've got it together, you gotta keep it together and when you do bring it up, you gotta be careful how much you bring it up because then you're not coping and unprofessional.

A personal investment in the work is certainly a quality held by front-line workers, however, the nature of 'case-management' may prescribe a step beyond investment with the potential to become paternalistic.

**Invisible Service User Trauma**

A common theme raised by participants, related to the increased organizational pressures that had negative effects on the quality of service that workers would like to provide, emphasizing the theme 'quantity over quality'. The women expressed that for various reasons including structural and systemic issues, such as, lack of education, lack of training, divisiveness on the topic and new-managerial practices, that trauma and/or other more subtle symptomology may be under-recognized in the mental health agency setting.

**“All Our Clients Have Trauma”.**  The general narrative surrounding the notion of trauma is that it is a subjective experience. Meaning, each individual experiences trauma differently and are subsequently affected in different ways. A study participant noted trauma's long-reach into the lives of those it affects describing it as, “an event that has happened to a client that has created great long-term discomfort and grief”. Another participant emphasized the long term impact and trauma's severe and relentless nature, “certain experiences, images and feelings that just sort of follow them throughout their life.” Conceptions of trauma are based on the uniqueness of the individual. “It’s not just my interpretation but it’s also the clients' interpretation you can have something very small, an incident and that client has reacted.” The definitions underscored the intensity of traumatic experiences as well as the debilitating effects that those experiences can have. The following are four different yet complimentary definitions of trauma.

Having gone through some experience that was basically emotionally scarring could be physically scarring as well but it is the emotional aftermath that we are hearing so much about these days. Like people who have gone through war but also people who are immigrants but we are also hearing about it through our clients a lot of women have trauma, whether it’s having their children taken away or physical or emotional abuse.

My definition of trauma is someone who has experienced something that has affected them on a level where they are unable to cope and it has affected their ability in terms of quality of life and there's some form of dis-regulation, that how I see it a form of dis-regulation where they have difficulty returning back to whatever normal state that they had.

Somebody that experiences some kind of emotional physical mental or verbal, I don't want to use the word abuse but some kind of experience in their lives that has not been able to sort of go away, so it sort of follows them throughout their lives.

It is an event that has happened to a client that has created great long-term discomfort and grief. Whether it is physical abuse or emotional abuse or verbal abuse, whether its having witnessed a trauma such as clients who are coming from war-torn countries.

Interestingly, when asked about the prevalence of trauma, every women in this study, felt that trauma was something that all their service-users live with. This was an especially poignant element of the interviews, as despite reporting varying comfort levels or perceived knowledge of trauma, they were able to recognize trauma in every service-user.

**Under-Recognized Trauma.** There was a general sense that trauma in the agency setting is something that is under-recognized in terms of service-users' overall wellness and service-providers' overall wellness.

I think that perhaps a lot of staff are in the same situation like me they don't have the education or knowledge base to work with clients and I feel like the trauma side kinda gets over looked we are so focused on housing and the medication and the other stuff that the trauma gets over looked.

Font-line staff are so preoccupied with tasks that are undeniably essential such as housing and medication, that trauma would may be neglected “we wouldn't bring something [trauma] like that up unless it was brought up to us.” The dominant model in mental healthcare is the medical model, this lens impacts the way various issues are viewed and treated.

We are looking at it from a very medical model the medical lens, OK what symptoms do they have are they taking their medication? And it’s like you can't necessarily always look at it from that lens because if we are looking at it from that lens then we treat it from that lens, it doesn’t get to the root of why or what’s happening underneath.

The lack of attention and in some ways the avoidance of the issue, may cause negative effects for service-providers. They feel isolated and at times helpless when faced with trauma in the agency setting. In addition, the nature of the practice means that front-line staff are constantly exposed to stories and shared experiences of trauma. “I think a lot of people aren't comfortable talking about trauma because it can certainly can bring out feelings in both of us, feelings in the client and we as front-line workers can be greatly affected by vicarious trauma.”

Echoing some of the earlier sentiments, when participants felt that trauma was recognized, they felt that the issue was not given its due attention or action. “When we do recognize it, it’s like hey he is a child solider and then we are moving on about how we are going to get him housing and I'm like whoa, do you know what child soldiers go through?”

The compounding effects of trauma and mental health were raised as one of the reasons trauma may be under-recognized.

Yeah it’s under-recognized and it’s under-supported. Like I said earlier, when we look at a person we look at what's happening right now. Yeah this is happening, you are using crack and crack is negatively affecting your housing, your health. Let’s deal with the crack and deal with the situation but we don't really deal with what has happened, in the past. You know as a worker we fail to understand that you need to recognize the base of the problem.

It was expressed that as front-line staff, you often have a long working relationship with service-users, “and tend to forget what happened in the past” because of the overwhelming nature of the current crises. The participants noted feeling “frustrated”, “helpless”, and “inadequate” because as one front-line staff noted “I’m only dealing with the cover of the problem, but the real issue is not address. It gets frustrating for me too, I feel like I’m not doing my job.” This can negatively affect the service-providers' overall wellness,

It does affect workers you can feel it changing you-your mood it changed. I was burned out like a few months ago to the point where I'm like snapping on everybody which is not the right thing, then I realized I got burned out.

One woman expressed the frustration felt when the emotional needs associated with service-user trauma are under-recognized in the workplace

It was like so and so passed away and we need to debrief and it’s so superficial. I just want to decompose right now. I just wanna sit down and weep and I can't so I have to find a way to weep somewhere else. And they're starting the meeting OK we have check-in we have about 5 to 10 minutes and I’m like I need five to ten hours to cry, cry about the situation, cry about the family, everybody's like move on with your life and I'm like I haven't moved on!

One participant, described the difficult emotions involved in bearing witness to someone’s trauma and feelings helpless in addressing it.

One of the clients was telling me she was raped by her father at 13 and she got pregnant, then she was raped by her brother, and got pregnant by him and so on she says she has 5 kids from 5 different family members...I almost threw up. I was in a taxi with her and I almost threw up. And you know, I was avoiding it I didn’t have the training.

Someone comes to me and says, I was raped by my father when I was 16 and I have a daughter from him, OK what am I going to do with that info? Ya I will go ahead and document it, but what is that going to do for the client? Where am I going to refer this client to? What kind of counseling does this client need? So not having those resources feels tough.

I know when one of my client's went through some kind of trauma and they are self-medicating. Their mental status is being affected and I'm only dealing with the cover of the problem, but the real issue is not bring addressed. It gets frustrating for me too, I feel like I'm not doing my job I feel like I'm trying all these things and nothing is changing, so it can get frustrating. Ya, it does affect- I worry the fact that are not many service out there and they cost a lot of money to access them.

Overall, the women were unanimous in stating that more education on the subject would increase their confidence addressing trauma as it is a reality of front-line service. Trauma-education would also decrease stress, providing the tools necessary to provide the kind of service that instills confidence in the workers and is a genuine reflection of their desired practice,

We have had someone come in to talk to us about trauma. It’s just this woman for like half the day to talk to us about trauma and I found it so interesting. So if there was more training, I think I would feel better equipped for sure.

Another participant explains,

But if I had the training to deal with it then probably it would be easier for me to work with clients because right now we are just addressing the cover of the problem right? Oh you have this kind of mental health here's your medication, her is your injection. The main core problem is the trauma.

The women expressed the frustration in recognizing trauma in their everyday work and feeling unprepared to address it.

**Trauma, an Agency Priority?** Participants were asked about a time when trauma was raised or made a priority in the agency setting. Overall, the participants noted that it generally requires a catastrophic event such as death, assault or becoming severely “unwell” for the issue to be raised. A study participant described a service-user’s death as a trauma that affects the well-being of service-providers. One of the women shared a story that transpired with a colleague, and a former front-line service-provider. The front-line worker found a service-user dead in their home. In confidence the former worker told the participant that he just could not overcome the event and left the position shortly after the incident. “It was very traumatic. I think the organization could do a better job working with front-line workers because there's a high turnover rate on ACT Teams and this person quit shortly after.”

In another experience, the front-line staff had been working closely with a service-user who suffered a relapse and became 'unwell' after a particularly long period of wellness. The workers learned that the service-user had been sexually assaulted. “It was a trauma so we increased our visits and constantly saw her, talking to her almost every day.” The feeling was that something had to occur for the issue of trauma to be raised, as opposed to being treated as an aspect of a person's overall wellness. “I think indirectly trauma comes up often”. Trauma was discussed by the Team if it was something that the service-users would readily talk about. If service-users are vocal about their past, then the case-managers would draw links between past traumas and current issues. “We talk about it in morning meeting we will talk about their trauma and like why they are doing this? Well because of the trauma, the stuff they have experienced.” Conversely, the following study participant’s experience highlighted the challenge of accessing service-users' histories.

The thing is, due to a client's history of having trauma because they are not forthcoming with the information you might find out about it later on so when we get a new client we don't necessarily always talk about trauma because we just don't know.

One particularly distressing story outlined the frustration and exasperation when trauma is under-recognized.

Like my client that passed away, I wasn't allowed to bring up her daughter, she said never ever bring up her name. She did not receive any treatment for trauma, it’s unfortunate that we were not able to talk about her trauma because it maybe would have helped her open up and maybe she would not have overdosed.

The notion of trauma was discussed in the context of acute and immediate detriment to an individual rather than as an ongoing piece of a person’s wellness. When trauma was raised as an issue, some participants, felt that the efforts to deal with the issues were 'superficial'.

I think the agency could do a better job working with front line workers because there's a high-turnover rate on ACT Teams and this person quit shortly after [finding a service-users dead in their home], it’s hard to say why he quit and he won't talk about it.

I feel like I’ve been affected with it a lot, I'm like OK, we did Friday check-in, OK, how are you coping? And that was it. So that day I didn't feel like talking so does that mean that there's nothing? Maybe it’s not the responsibility of the agency, for myself I feel like now I need to go out and get support in order for me to continue.

Feeling emotionally isolated can contribute to a service-providers' stress and limit their emotional range to address more challenging topics such as trauma.

**Tensions in Addressing Trauma.** The varying comfort levels in addressing trauma suggests several possible explanations, including a person's professional confidence, belief in their ability to address the issue and the appropriateness of addressing such a sensitive topic. Tensions were visible. Some of the participants noted feeling confident in their ability to discuss traumatic histories or traumatic events with service-users while others demonstrated some apprehension in tackling the issue. “I personally feel very comfortable working with clients (on trauma) because I somehow have this, they tend to tell me things probably because I’m more like a mother to them.” Experience in the field and personal experience with trauma were also reported as factors that improve comfort when discussing trauma. “I think I’ve also developed over time, I think (trauma) it’s something you can certainly learn in training, but learning and doing something are two different things.” Age was also acknowledged as an element that increases confidence in dealing with trauma-related issues. “I've become wiser and just through all life occurrences that have happened and being calmer as you get older.” In addition, a politicized notion of trauma was raised with the idea that a person who has suffered personally, may have greater access to empathetic emotions that make addressing trauma more feasible.

I think part of it is the kind of person you are and experiences you've had. If you've always lived a quiet life with no struggles, haven’t had a lot of stresses in your life, you have a different view, but when you come from having experienced difficult situations you have learned how to deal with that and can empathizes with the clients a little more.

Some of the factors that contributed to service-providers feeling uncomfortable addressing trauma are, lack of education, lack of experience with the issue and the perception that front-line staff or rather non-medical staff are not qualified to address trauma.

It’s a very touchy subject, I’ve never experienced nothing like that before, I mean I have experience in mental health but like I said in trauma, that's something to be honest I really don't have a lot of experience in.

One participant expressed their apprehension to addressing trauma as a non-medical staff on an ACT Team,

We've had some trauma training and we were basically told don't do it- we are not skilled to do the trauma treatment ourselves, it would be something that would be done through a psychiatrist or through a therapist who is trained to do that.

Naturally, after being warned off approaching traumatic situations a worker would be disinclined to address the issue. In a few of the interviews, women discussed what they would do if a service-user did approach them and began discussing trauma. They talked about using active listening skills, validation and providing support to their service-users. One woman was informed by another professional that it is,

better not to raise that [trauma] because unless I’m prepared to deal with what comes out of it you can actually make things worse. It is better to just help them with the day to day and support them but not to delve into that [trauma] because that actually would be a bad thing for them.

It is difficult to discern whether this attitude towards trauma-related issues was representative of the overall feelings, certainly some front-line staff expressed a comfort in dealing with trauma while others expressed a discomfort or at least an apprehension towards the topic.

Personally, I still would like a lot of training around trauma because trauma is the source for most of the problems that they [service-users] have, addictions, mental health, most of the time trauma is the source so unpacking the trauma is very easy. To do that, you build a good rapport with clients you get to talk them, they get to talk to you, they know and like you so they open up. Dealing with that trauma and handling after its unpacked needs a lot of work, a lot of emotions, a lot of time, a lot of experience and a lot of training. My training is not strong in that area, so I personally don't feel comfortable unpacking any kind of trauma.

There were conflicting ideas about how forthcoming service-users are when deciding whether or not to share traumatic histories. Some participants felt that trauma was something service-users would bring up often and others felt that it was not.

I don't know how much I could offer somebody you know who needs a lot of that emotional support but my experience I guess with clients is just sort of letting them talk it out, sitting here and just listening. I don't think anybody really wants you to offer your opinions there is nothing you can really do, you kind of just want to validate what they are saying, sometimes they just want an ear to let it out. It’s something that people don't really talk about a lot.

Another participant shared a similar view,

Generally, clients don't want to sit and talk to you about the things that happened in the past, it’s unusual for someone to do that. I would have to be delving in order to get to it, which if anything I find that to be inappropriate and intrusive. So I'm sort of just crossing a boundary that I shouldn't cross, for what purpose?

As many of the participants are known to me, I am aware that they have a level of education that would suggest a certain aptitude towards handling crises and I believe that front-line staff handle crisis often. However, when asked about trauma specifically, it seemed that the fear of a crises erupting was enough to deter some workers from addressing the issue altogether.

This conclusion points to several themes. The first being an emotional investment combined with the case-management model may create an environment that is more paternalistic than would otherwise be and that this may have implications for service-providers' perceptions of trauma.

The second theme emphasized the paradox apparent between a perception that all service-users carry trauma and a belief that trauma is under-recognized in the mental health agency setting. Finally, the apprehension and discomfort in addressing trauma, points to questions around the greater discourse surrounding trauma and stigmatization.

**Chapter 5. Discussion**

This study presented the thoughts, feelings and perceptions of five female front-line service providers in the mental health agency setting. The findings revealed the negative impact new managerialism can have on service provision, focusing on the ways it limits the quality of service. It raised questions over service providers' personal investment, the perceived ability to allocate time and resources to addressing the experience of trauma in the mental-health agency setting. Finally, the women in this study expressed their feelings and concerns regarding the under-recognition of trauma in the agency setting. This chapter will critically analyze the various themes that emerged throughout the interviews, drawing some conclusions and raising further questions.

Neo-liberal ideology impinges upon the financial fears of society. When capital appears to be restricted, rational and economic policies prevail. Much like this ideology, managerialism is accepted as self-evident and rational as individuals under this model are motivated by self- interest and profits, a sort of solution to fiscal irresponsibility that is viewed as superior to collective wellness (Rees, 1999). The intensification of efficiency measures (Aronson & Sammon, 2000) means that front-line service-providers may spend less time face to face and one on one with service-users. The participants in this study discussed their frustrations with this consequence. They felt the full scope of their work was not acknowledged, while feeling pressured to attain a level of efficiency that was not a comprehensive measures of their work. “Like you can make maybe five phone calls out to resources about the client or speak to their doctors and that is not a contact. So in essence it doesn't really account for a lot of our time.” quantitative measures can weaken social work's professional role leaving front-line staff feeling devalued.

In many ways new-managerialism's rational, objective and systematic qualities are incompatible with the unique, complex and fluid nature of social work practice. Unlike capital-driven services, social services are based on relationships (Aronson & Sammon, 2000), when service-providers feel restricted with insufficient time to address a service-users' needs in a meaningful way (Aronson & Sammon, 2000) the front-line staff feel 'helpless', 'frustrated' and “like [they're] not doing their job. One of the women noted the tensions in practice with competing agency requirements and service-user needs, “That person who needs the extra time gets compromised somehow.” Another woman noted that “it becomes about number of visits rather than necessarily the length or quality of the visit.”

The majority of participants described their current work duties under the title, case-management. The case-management model is commonly used in mental health agencies (Stanhope et al., 2012). Aside from mentioning some of the formalities of their working roles, the most prominent commonality among the study participants was an emotional and professional investment in the work that they perform. The front-line staff constructed a discourse that reflects a commonly held perception in the social services that, “it’s more than a job” which speaks to the emotional nature of the work. Generally, people engage in social work or other front-line services because they find joy in working with people (Huxley et al.,2005) and because it satisfies a sense of purpose, as one participant noted “ I get pleasure from you know, providing that support”. Despite having larger case-loads, an increasingly neo-liberal environment and the complex nature of front-line service, workers remain highly committed to their roles. In a study conducted by Huxley et al. (2005) it was reported that regardless of high stress levels, the feeling that one is making a difference in the lives of others increased their overall job satisfaction and subsequently improved their perception of the service that they provide (Huxley et al., 2005).

An emotional investment may mean that service-providers experience heighten emotional reactions when internalizing the successes and failures of a service-user. These reactions may intensify when service-providers feel that they do not have the time or resources available to attend to service-users’ more nuanced emotional needs or their own personal wellness. Neo-liberal agencies would typically enforce that front-line workers remain objective, however, bracketing oneself from a situation is not only virtually impossible, it may prove a disservice to consumer survivors who feel objectified. The women in this study reflected a feminist approach to service provision, where service-providers are emotionally attuned to the people with whom they work (Neuman, 1997). “Somehow I have this- [service-users] tend to tell me things probably because I'm more like a mother to many of them.” While a strong and authentic investment in one's work arguably results in the best service delivery for clients, there may be emotional consequences for service-providers. Stress and burnout related to work, may simply be one of the consequences of being deeply committed to working responsibilities (Wies & Coy, 2013).

A deep personal investment is certainly a quality held by the front-line worker. The study participants often expressed the personal rewards and fulfillment gained through their practice. While a personal investment may be a natural outcome related to front-line service delivery, the nature of the 'case-management' role may prescribe a step beyond investment, towards a paternal conception of service provision, one that reflects a sense of beneficences in practice. With only the most genuine intentions, working on behalf of a service users' 'own good' may imply various connotations including, satisfying a workers sense of what is best for the service-user. It protects a sense of safety in practice, for example, privileging the potential for harm above right to self-determination, and/or the privileging of certain kinds of knowledge over others, such as, a workers 'expert' knowledge above lived experiences. I would suggest, that the nature of 'case-management' induces a culture of paternalism in service provision.

My sense is the area of paternalism that emerge from the responses is closer to that of beneficence, the obligation to help others which may manifest as preventing or removing harms and weighing the possible benefits versus the dangers on behalf of the service-user (Galambos, 1997). I am not implying that service-providers do not have a natural sense of accountability towards their service users, the emotional investment noted previously would confirm that, however, I believe the language of case-management and the structure of the organization compels service-providers to conceptualize themselves among the business-like structure of which they are a part of. This to me suggested that the structure of case-management engenders a sense of responsibility towards the agency and the system, but that the nature of social work and the emotional investment combined may create a culture that is perhaps more paternal than would be otherwise.

A contradiction may be located within the very essence of case-management. The first contradiction is that neo-liberal design privileges capitalist models of service provision above more human models such as feminism or anti-oppressive practice. The model may be incompatible when attempting to satisfy the needs associated in working with extremely vulnerable populations. Case-management mirrors business-like structures, based on rational and professional designations. The participants described how tensions can emerge when front-line staff are constantly confronted with emotionally laden situations while feeling required to remain stoic and 'professional'. Some of the women detailed the ways in which emotions associated with trauma can 'rub off' on service-providers. One woman discussed the loss of a service-user as traumatic, noting that given the workers' personal ethics and the presenting circumstances, the service-provider/service-user relationship may demand an emotional or personal response. The participant explained that other staff members were urging the participant to distant herself from a particular situation. “You're too involved, step back and let someone else do it, and it’s like no! I just want the person [service-user] to die with dignity.” The participant was in conflict between what she felt was an authentic and emotion response to a highly sensitive situation and the organization's managerial culture. “When you are working, there has to be this level of professionalism, you almost have to show people that you've got it together.” The conflict is imbedded in the dueling nature of emotional responsibility and ethical positioning versus the organizational construction of the case-management role.

The second contradiction then, is embedded in the ideological positioning of case-management. Case-management makes the assumption that the service user is the 'case' in need of 'management' provoking paternal characteristic and models. Simultaneously, the notion of 'management' may dehumanizes and reduce the social work role to a degree where professional autonomy is utterly negated raising internal conflicts. Service providers may be confronted with conflicts over moral responsibility, where they have competing interest among service users, the agency and structural pressures (Galambos, 1997).

Particularly in the mental health agency setting, language can play a significant role. The title 'case-manager' references the service-user as a 'case' which invalidates the uniqueness of the individual (Lawrence & Jeffrey, 2001). In the absence of critical reflection, the use of this language in already new-managerial spaces may contribute to the objectification of service-users instead of objectivity in the consideration of autonomy (Lawrence & Jeffrey, 2001). For example, participants referred to the agency's service-users as 'clients'. If a service-user eventually understands themselves as something in need of management (Lawrence and Jeffrey, 2001), it is likely that the service-user will experience this instances as dis-empowering. Service-providers may wish to address this contradiction, however, they may experience moral dilemmas weighing the agency's interests against the service-users' trust (Reamer, 1983).

The compounding effects of a deeply personal investment and a prescriptive case-management role may intensify the reality of working with trauma. A woman in this study communicated that “when you work with trauma, I find somehow it gets rubbed off, it gets given over, and that's how I feel.” Burnout and secondary traumatic stress are serious consequences associated with front-line service. One of the women spoke about the burnout she was experiencing and how it affected her mood, her personal relationships and her ability to provide service “you can feel it changing you, your mood it changed.” Burnout is the chronic experience of emotional and physical stress that is often a result of front-line service-provision or the exposure to large amount of traumatic-material, which can have negative effects on an individual's self-conceptions, working conceptions and a decreased investment in service-users (Gomez & Michaelis, 1995; Sprang et al., 2011). Individuals who become more involved in their work as opposed to those who operate from a more 'detached' working style are more likely to experience burnout (Gomez & Michaelis, 1995). While burnout and/or secondary traumatic stress may be a natural consequence of working in the human services, limited professional autonomy has also been shown to increase a workers' probability for experiencing burnout (Gomez & Michaelis, 1995). Thus, working with trauma may not be the only predictor for burnout, but a compounding result of stress, increased organizational pressures and perceived levels of support within the agency.

The participants reported varying degrees of experience, education, knowledge and comfort in addressing trauma. Part of the role of a primary case-manager would be to address crisis situations. A crisis could be anything from loss of housing, bed bugs, hospitalization, incarceration, death, etc. Front-line service-providers address these crises on a regular basis and in my experience often with a swift grace. Despite this reality there was a general perception that trauma is under-recognized in the mental health agency setting.

Sadly, trauma is a reality for many mental health consumer survivors (Cusack et al., 2006; Mueser et al, 1998; O'Hare & Sherrer, 2013). Especially for individuals who have a diagnosis that reflects a 'serious' or 'severe' 'mental illness', which would encompass disorders such as schizophrenia and other major mood disorders (O'Hare & Sherrer, 2013). Post traumatic stress disorder (PTSD) has also shown to be four to five times higher among mental health consumer survivors than among the general population (O'Hare & Sherrer, 2013).

The women in this study revealed a paradoxical relationship with trauma in the agency setting, reporting in the interviews that while trauma was present in all their service-users, the issue remained under-recognized in the mental-health agency setting. There have been several studies that have analyzed this phenomenon. Researchers have found that actual rates of trauma among the consumer survivor population are often much higher than recorded or documented by agencies and organizations (Cusack et al., 2006; Mueser et al., 1998; Putts, 2014). The reasons for under-diagnosing or the under-recognition of trauma in the mental health agency setting have not been definitively qualified, however, there are several theories as to why it occurs that were echoed by the study participants. Certainly, the under-recognition of trauma can negatively affect both service-users and service-providers (Salyer et al., 2004). Service-users may feel that the underlying and painful realities of their trauma are being disregarded, they may feel dehumanized as initiating discussion regarding personal trauma may be shameful and anxiety provoking, struggling to express a traumatic past (Putts, 2014). The study participants reported feeling isolated and at times helpless when they felt that the core issues were not being addressed. “I think a lot of people aren't comfortable talking about trauma because it can bring out feelings in both of us.”

The reluctance to address trauma may be due to several contributing factors. Front-line service-providers and clinicians have been reported as not feeling competent to effectively address trauma and trauma-related issues (Salyer et al., 2004). It may be the case that service-providers do not have specific trauma-informed knowledge (Salyer et al., 2004) or that the knowledge they have is insufficient. As one woman expressed, “Perhaps a lot of staff are in the same position as me, they don't have the education or knowledge base to work with it [trauma].” Other studies point to front-line service providers feeling personally uncomfortable raising the issues, concerned that it may worsen situations or bring service-users into crisis (Conviers-Burrow et al., 2013; Sayler et al., 2004). This feeling was shared by one of the participants “Unless I'm prepared to deal with what comes out of it, you can actually make things worse.”

Workers are already inundated with larger case loads, increased efficiency benchmarks, everyday crises and the daily tasks of case-management. The intensity of issues related to working with the consumer-survivor population, may mean that service-providers tend to focus their energy on the often pressing psychiatric issues (Putts, 2014). “We are just addressing the cover of the problem right? Oh you have this kind of mental-health? Here's your medication. The main core problem is the trauma.” Another participant shared an experience in addressing trauma in the agency setting “And when we do recognize it, it’s like hey, he's a child solider and then we are moving on about how we are going to get him housing.”

Tensions emerged in the discourse surrounding trauma in the neo-liberal agency setting. The first contradiction is in the government's mandated efficiency guidelines that squeeze out spaces for service-providers to address the ambiguous and hard to define aspects of practice, this contradiction limits professional autonomy and isolates trauma in the agency setting. Second, while the women understood trauma to be pervasive among the service-user population, the reluctance to address the issue outright, suggested confusion and/or a reluctance or fear regarding the protocol to deal with such a prevalent issue. Lastly, some of the participants felt that trauma was better treated by medical professional or those with specific trauma-training. Given the highly sensitive nature of trauma it would seem reasonable that those who work closest with the service-users, often times case-managers, would be ideally located to address this issue.

The women in this study expressed their investment in their work which reflects an overall positive service-user/service-provider relationship. The women also conveyed varying levels of discomfort in addressing trauma which suggested a lack of formal education and training on trauma. All participants expressed their deep desire to have increased education and training on trauma-related issues, with practical tools to use on the front-line. While it may not be the most ideal role for front-line staff, the reality is that trauma presents itself every day in some of the most unlikely fashions. The ability to perceive the subtlety of trauma and have direct pathways to treatment can only improve overall wellness for both service-users and providers.

**Recommendations and Implication for Social Work**

Indisputably, trauma is an essential area and point of intervention in social work, spanning across all disciplines and is ingrained in our society (Breckenridge & James, 2010). As oppressive structures influences all aspects of social life, so too does trauma as it is cast under oppression’s long shadow. Trauma intersects with various parts of life, including mental health and addictions but also in communities and entire cultures. It is absolutely imperative that trauma be at the forefront of social works' knowledge.

Organizations ought to facilitate this work by supporting front-line service-providers' capacity to attend to the more subtle expressions of trauma in the everyday working context. Neo-liberal informed cost and efficiency measures, currently restrict this practice, with both service-users and providers bearing the consequences. The inescapable presence of neo-liberal ideology, ensures that there is no quick fix to this contradiction, however, workers and agencies can take steps to create spaces in which service-providers can feel confident in exercising their professional autonomy and engage with service-users in a way that strengthens relationships of trust so that service-users and providers can respond to trauma-related issues.

Trauma-informed care is likely the only formal model intended to address trauma in the agency setting. The term refers to a model of practices, policies and procedures with the purpose of ensuring that all staff obtain a comprehensive understanding of trauma, trauma-triggers and the ways that service provision may actually exacerbate traumatic experiences (Conviers-Burrow, 2013). The trauma-informed model encourages that front-line staff engage with service-users in a manner that fosters trust and engagement (Pence, 2011) rather than an experience that stigmatizes and shames trauma-experiences. The women expressed that having more knowledge about trauma was essential, additionally, as front-line service-providers are constantly confronted with trauma, some of the women in this study pointed to the benefits of having tools to address trauma, acutely and in the long-term.

There is a great deal of research on the effectiveness of trauma-informed Cognitive Behavioral Therapies (CBT) in the agency setting (Black et al., 2012; Ingeborg et al., 2014). A study looked at service-users' perceptions of trauma-focused CBT and the effectiveness of the treatment, the results were positive as the participants noted that talking about trauma was difficult but also the most helpful, learning skills to reduce stress were also viewed positively (Ingeborg et al., 2014). Supervisors are key organizational leaders and play a role in fostering a working environment that is conducive to the trauma-informed model (Sprang et al., 2011). A trauma-informed agency model, like any practice is not flawless and would require continuous critical reflection adapting to best suit an agency's needs. However, this model would bring trauma to the forefront of service provision, while working to remove stigmatization on the topic which may be experienced as oppressive. Agencies can access Canadian, trauma-informed workshops, toolkits, and programs on-line and through the Manitoba Trauma Information and Education Center (<http://trauma-informed.ca/>), to learn more about trauma and recovery and to become trauma-informed.

As the interviews drew to a close, many of the women shared their wish for greater trauma education. “I think that we do not acknowledge and prepare front-line workers for what they are going to see. When you are doing social work, you should have trauma classes every year of the course, every year,” It is essential to address trauma at the individual level, however, we are doing a disservice to ourselves and our communities if we avoid the larger societal impacts of trauma and collective trauma. The most effective means to foster greater trauma awareness is to work simultaneously on a personal, cultural and structural level. One of the ways that we can begin to bring greater awareness and practical knowledge of the issue to the forefront is to incorporate trauma-education into our colleges and universities. As trauma may be a part of every social work discipline, it is clear that social work students ought to be educated on specific trauma-knowledge and its emotional, physical, psychological and social impacts (Breckenridge & James, 2010). Trauma can influence an individual's personal functioning, their relationships with others and their communities (Breckenridge & James, 2010). Collective trauma or cultural trauma impacts many of the populations that social workers serve. The ability to comprehend the complexities involved and begin to learn about ways to facilitate healing for both communities and their individual members is essential (Breckenridge & James, 2010). My practice would have greatly benefited from trauma-education during my undergraduate or graduate degrees. I felt under-prepared and startled by the intensity and prevalence of the issue, I too felt helpless, feeling inadequate in my skill-set to address the issue when it presented itself. Naturally, one learns through practice and experience in the field is incomparable, however, the formal education would certainly increase my confidence and decreased my anxiety towards the topic. Increasing education in our schools will also work to raise awareness on an issue that has been historically silenced.

Lastly, I would like to address stigmatization in mental health and the significant influence it can have on the under-recognition of trauma. As I listened to the women share their feelings and concerns on the topic of trauma, it appeared that the apprehension towards the issue, the fear that initiating discussion with a service-user would bring them into crisis, was pushing trauma to the fringes of their practice. This led me to further consider the ways that stigma can oppress already marginalized groups of people. Given the amount of time service-users spend with front-line staff and the closeness of their relationships, an emphasis on the necessity of specialized care such as, psychiatric treatment may mystify trauma for front-line workers, creating fear and doubt, marginalizing the issue. I am not proposing that this specialized care is not relevant or that front-line service-providers ought to actively delve into traumatic histories, I am referencing the times when trauma presents itself in everyday practice.

One of the women spoke about her hope that trauma-related issues would be brought to the forefront of practice, that other issues such as addiction were once stigmatized even within mental-healthcare but that exposure and education allowed service-providers to deliver more comprehensive care. Social workers can have a role in politicizing and deconstructing the hegemonic positioning of trauma in the agency setting. Respecting and valuing service users' experiences and perceptions, social workers can avoid compounding experiences of trauma through the recreation of traumatic structures (Sapey, 2013). I recommend further research on this topic that seeks to gain a greater grasp on the ways that service-users experience trauma in the mental health agency setting.

**Limitations**

This study is limited by the size and scope of the project. While I conducted five thorough interviews, the population would have been better represented by more voices. Additionally, I recruited from one agency making this a commonality among the participants. Recruiting from multiple agencies would have likely diversified the results. While the female focus of this study created an opportunity to analyze the specific perceptions of women in front-line practice, it would be interesting to gain a different gendered perspective on trauma. Lastly, a tension for me throughout this study was privileging the voice of service-providers over service-users. I attempted to exalt the voice of the participant and stay true to their perspectives, however, felt conflicted by the lack of voice from those directly affected by the service. For future studies, it would be highly valuable to gain the perspective of individuals who use services, privileging their voice.

APPENDIX A

Email Recruitment Script

Sent on Behalf of the Researcher

by the Holder of the Participants’ Contact Information

Vanessa Heaney Bsw

Masters Candidate in Critical Analysis of Social Work

Study Title:

Front-line Service-providers' Perceptions of ‘Trauma’ in Relation to Service Users in the Neo-liberal Context

Sample E-mail Subject line: McMaster study about front-line service-providers' perceptions of ‘trauma’ in the neo-liberal context

Dear Employees,

Vanessa Heaney, a McMaster student, has contacted the Cota Health ACT Team asking us to tell our employees about a study she is doing on service providers' perceptions of ‘trauma’ in relation to service users in our workplace. This research is part of her Master of Critical Analysis of Social Work at McMaster University.

The following is a brief description of her study. She has asked us to attach a copy of her information letter to this email. That letter gives you full details about his study.

If you are interested in getting more information about taking part in Vanessa’s study please read the brief description below and or CONTACT VANESSA HEANEY DIRECTLY by using her telephone number or email address. Tel: 905-330-0418 or heaneyvk@mcmaster.ca . The researcher will not tell me or anyone at COTA Health who participated or not. Taking part or not taking part in this study will not affect your status or any services you receive at COTA Health.

Vanessa Heaney is inviting you to take part in a 45-60 minute one on one interview that will take place during a lunch hour or at a convenient time and place for you the participant. She will work out those details with you. She hopes to learn what front-line service-providers like you, think about the concept of ‘trauma’ in relation to the service users against the neo-liberal backdrop. She would also like to gain your perception regrading how the concept of ‘trauma’ as it relates to the service users affects both service user and service providers’ wellbeing.

Ms. Heaney has explained that if for any reason (even after you have signed the consent form) you no longer wish to participate in the study that you can stop (withdrawal) your participation at any time.

In addition, this study has been reviewed and cleared by the McMaster Research Ethics Board. If you have questions or concerns about your rights as a participant or about the way the study is being conducted you may contact:

McMaster Research Ethics Board Secretariat

Telephone: (905) 525-9140 ext. 23142

Gilmour Hall – Room 305 (ROADS)

E-mail: [ethicsoffice@mcmaster.ca](mailto:ethicsoffice@mcmaster.ca)

Sincerely,

APPENDIX B

PARTICIPANTS NEEDED FOR

RESEARCH IN UNDERSTANDING ‘TRAUMA’ IN MENTAL HEALTH AGENCIES.

I am looking for volunteers to take part in a study that seeks to gain a greater understanding of front-line service providers' perceptions of 'trauma' as it relates to services users.

You would be asked to: Provide ONE 45-60:00 minute, one on one

interview.

Refreshments will be provided.

For more information about this study, or to volunteer for this study,

please contact:

Vanessa Heaney

Social Work Department: Critical Analysis of Social Work McMaster University

905-330-0418

Email: [heaneyvk@mcmaster.ca](mailto:heaneyvk@mcmaster.ca)

This study has been reviewed by, and received ethics clearance

by the McMaster Research Ethics Board.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Call Vanessa Heaney  905-330-0418  Or  Email:  [heaneyvk@mcmaster.ca](mailto:heaneyvk@mcmaster.ca) | Call Vanessa  Heaney  905-330-0418  Or  Email:  [heaneyvk@mcmaster.ca](mailto:heaneyvk@mcmaster.ca) | Call Vanessa Heaney  905-330-0418  Or  Email:  [heaneyvk@mcmaster.ca](mailto:heaneyvk@mcmaster.ca) | Call Vanessa Heaney  905-330-0418  Or  Email:  [heaneyvk@mcmaster.ca](mailto:heaneyvk@mcmaster.ca) | Call Vanessa Heaney  905-330-0418  Or  Email:  [heaneyvk@mcmaster.ca](mailto:heaneyvk@mcmaster.ca) | Call Vanessa Heaney  905-330-0418  Or  Email:  [heaneyvk@mcmaster.ca](mailto:heaneyvk@mcmaster.ca) |

APPENDIX C

July 2nd 2014

**LETTER OF INFORMATION / CONSENT**

**A Study about front-line service providers’ perception of ‘trauma' in relation to service users.**

|  |  |
| --- | --- |
| **Student Investigator:**  **Vanessa Heaney**  School of Social Work  McMaster University  (905) 330-0418  Email: [heaneyvk@mcmaster.ca](mailto:heaneyvk@mcmaster.ca) | **Supervisor:**  **Dr. Mirna Carranza**  School of Social Work  Hamilton, Ontario, Canada  McMaster University  (905) 525-9140 ext. 23789  E-mail:**carranz@mcmaster.ca** |

**Purpose of the Study:**

I am interviewing health care professionals connected with the Cota Health Assertive Community Treatment (ACT) team to better understand front-line service providers' perceptions of ‘trauma’ in relation to service users. I am doing this research as a thesis project and in partial requirement of my Master’s of Social Work degree.

**The Procedures Involved in this Study:**

If you agree to participate in this study, you will asked to participate in a face-to-face interview that will last approximately 45-60 minutes and be held at a mutually agreeable location. I would like to digitally record the interview, but will do so with your permission only.

I will be asking you about whether you see trauma in the front-line work you do in the mental health agency setting, how you recognize it and what forms it takes. I will also be asking you about agency policies, routines and practices around dealing with trauma among clients. I have attached my interview questions to this email to give you a better idea of the questions we will discuss.

**Potential Harms, Risks or Discomforts:**

The risks involved in participating in this study are minimal. Some of the questions may lead you to reflect on experiences that you have found frustrating or difficult. You may also worry about how others will react to what you say. You do not need to answer any question you would prefer to skip. The steps I am taking to protect your privacy and maintain your confidentiality are described below.

**Confidentiality:**

Your participation in this study is confidential. I will not use your name or any information that might identify you. However, we are often identifiable through the stories we tell, references we make and opinions we express. Also, the Cota group from which I am recruiting is relatively small. Please keep this in mind through the interview and also in deciding where you would like to be interviewed.

All data connected with this study will be kept secure via a password protected computer. Data will be stored and transported using an encrypted USB key. I will keep any written documents in a locked drawer in my home office, where only I will have access to them. Only myself and my supervisor, Dr. Mirna Carranza, will have access to the transcripts, but any transcript that Dr. Carranza sees will have identifying information removed. The research data will be destroyed and paper copies shredded approximately one year following the successful defense of the thesis.

**Potential Benefits:**

The research will not likely benefit you directly. This research may fill gaps in our understanding of trauma in the mental health agency setting. It is my hope that the interviews, thoughts and perceptions that you share, will contribute to a greater overall understanding of trauma as it relates to service users in the mental health agency context.

**Participation and Withdrawal:**

Your participation in this study is voluntary. Some of you may recognize my name or know me from the undergraduate practicum I completed at Cota, but this should not in any way make you feel pressured to participate. If you decide to be part of the study, you can stop (withdraw) at any time, including after signing the consent form, part-way through the study or up until approximately one month following the date of the interview at which time I will have started my analysis. If you decide to withdraw, there will be no consequences to you. In cases of withdrawal, any data you have provided will be destroyed unless you indicate otherwise. If you do not want to answer some of the questions you do not have to, but you can still be in the study.

**Information about the Study Results:**

I expect to have this study completed by approximately September, 2014. If you would like a brief summary of the results, please let me know how you would like it sent to you.

Questions about the Study

If you have questions or need more information about the study itself, please contact me at:

*905 632-7603 or via email* [*heaneyvk@mcmaster.ca.*](mailto:heaneyvk@mcmaster.ca)

This study has been reviewed by the McMaster University Research Ethics Board and received ethics clearance.

If you have concerns or questions about your rights as a participant or about the way the study is conducted, please contact:

McMaster Research Ethics Secretariat

Telephone: (905) 525-9140 ext. 23142

c/o Research Office for Administrative Development and Support

E-mail: [ethicsoffice@mcmaster.ca](mailto:ethicsoffice@mcmaster.ca" \t "_blank)

**CONSENT**

“**Front-line Service-Providers' Perceptions of 'Trauma' in relation to Service Users: In the Neo-Liberal Context”**

The participant shall indemnify and save harmless Cota and its directors, officers employees, agents and volunteers from all losses based upon, occasioned by or attributable to anything done or omitted to be done by the researcher, its directors, officers, employees, agents, volunteers, in connection with the research project provided.  The researcher, Vanessa Heaney is solely liable for the delivery of the research.

* I have read the information presented in the information letter about a study being conducted by Vanessa Heaney***,*** of McMaster University.
* I have had the opportunity to ask questions about my involvement in this study and to receive additional details I requested.
* I understand that if I agree to participate in this study, I may withdraw from the study at any time up until approximately a month after my interview.
* I have been given a copy of this form.
* I agree to participate in the study.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Participant (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I agree that the interview can be audio recorded.

… Yes.

… No.

2. …Yes, I would like to receive a summary of the study’s results.

Please send them to this personal email address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

or to this home mailing address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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… No, I do not want to receive a summary of the study’s results.

Appendix D

# Interview Questions

**Front-line Service Providers' perceptions of 'Trauma' as it relates to Service Users**

## Vanessa Heaney, (Master of Critical Analysis of Social Work, Student)

## (Department of Social Work – McMaster University)

**Information about these interview questions**: This gives you an idea of what I would like to learn about. I am interested in front-line service providers' perceptions of trauma as it relates to service users. Interviews will be one-to-one and will be open-ended (not just “yes or no” answers). Because of this, the exact wording may change a little. Sometimes I will use other short questions to make sure I understand what you told me or if I need more information when we are talking such as: “*So, you are saying that …?*), to get more information (“*Please tell me more?”),* or to learn what you think or feel about something (“*Why do you think that is…?”).*

**1) Could you tell me about your job on the team?**

Prompts: responsibilities, duties, etc.

**2) Can you please describe your impression of the organization's structure?**

Prompts: Who do you feel accountable to? Any organizational pressures? i.e. time or efficiency related?

**3) As a front-line service provider in this field, what comes to mind when thinking of the term 'trauma' i.e. your working definition of trauma?**

**4) In your professional role as a front-line service provider at this agency or others, can you tell me about a time when trauma was raised or made a priority? Please describe.**

Probe: Client trauma and Service Provider trauma.

**5) How would you rate your comfort level in discussing trauma with your clients? Please tell me about that.**

Prompt: Can you give me examples?

**6) Do you ever feel that 'trauma' is something that is under-recognized in terms of overall wellness? Yes or No, please describe.**

Prompts: In terms of service users' wellness or your own wellness.

**7) Is there anything I have missed or that you would like to add about this topic?**

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