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Perceptions of Trauma-Informed Care in an Intimate Partner Violence Resource Center

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by

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Abstract

Every year, an estimated 10 million people experience intimate partner violence (IPV) in the United States (Huecker et al., 2021). The long-term implications of surviving IPV can be debilitating and limited community resources influence the likeliness of physical and psychological recovery. Trauma-informed care (TIC) is a set of practices that may produce improvements in the quality of life for IPV survivors. There are a variety of definitions of TIC and empowerment, which may serve as a barrier to implementing these practices. The present study examined employee and volunteer perceptions of trauma-informed practices and empowerment at a domestic violence agency. The four most commonly identified themes of TIC were awareness of the impacts of trauma, avoiding re-traumatizing, being understanding, and providing individualized services. Common themes identified in empowerment included the program being strengths-based, promoting autonomy, and providing choices. Descriptive analyses indicated the agency was implement these practices some of the time, indicating opportunity for improved consistency. Future directions of research on TIC and empowerment should emphasize the operationalization of both practices and individualizing improvement at the agency level to increase staff consistency.

Perceptions of Trauma-Informed Care in an Intimate Partner Violence Resource Center

Intimate partner violence (IPV) is a rising issue in the United States, with one of every four women and one of nine men being victims of partner violence (Huecker, 2021). Intimate partner violence can lead to worsened mental and physical health, lower quality of life, and in severe cases, death (Huecker, 2021). Physical conditions such as sexually transmitted diseases, gastrointestinal disorders, and joint disorders are more prevalent in both male and female survivors of intimate partner violence (Baccini et al., 2003; Bonomi et al., 2009). In addition, abusive partners often control economic, sexual, and social aspects of their partner's life using psychological aggression to maintain control (Akbag & Barakas, 2010). Experiencing physical, sexual, or psychological abuse increases the risk of developing anxiety disorders, social difficulties, and substance use (Bonomi et al., 2009). As survivors experience persistent abuse, they are at risk of further violence and falling into a pattern of victimization (Cho et al., 2017). Therefore, intervention and aid are important parts of breaking this pattern of abuse and mitigating adverse outcomes.

IPV Resources

Common services offered to IPV survivors include crisis hotlines, advocacy services, emergency shelter, and counseling. One nationwide survey found that 10% of requests made to domestic violence agencies were left unmet (Iyengar & Sabik, 2009). Some of these unmet requests are related to resource shortages, but others may be related to a lack of recognition of survivor needs. For example, recent critiques highlight that the domestic violence movement often fails to use an intersectional approach and, as a result, fail to meet the needs of already marginalized communities (Mehrotra et al., 2016). Many domestic violence agencies also tend to focus on safety as the main objective for IPV survivors (Kim, 2012). In this context, safety is

often defined legally as the separation of the victim from the assailant (Mehrotra et al., 2016). Inherently, that definition often means the separation of the survivor from their community and sometimes neglecting to combat the psychological effects of persistent trauma or abuse. These shortcomings may be supplemented using a trauma-informed model for services.

Trauma-Informed Care

Trauma-informed care can be defined in multiple ways. One definition provided by Bath (2008) lists three pillars of trauma-informed care: safety, connections, and managing emotions. The first includes ensuring the survivor has a safe place to live in addition to emotional feelings of safety. Complex trauma often undermines positive relationships, so the second pillar emphasizes building safe connections between the survivor and care providers (Bath, 2008). Lastly, trauma can lead to problems in regulating emotions, thus, emotion and impulse management is the final pillar (Bath, 2008). Bath's definition provides three encompassing pillars, while other definitions have more specific components and actions outlined.

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) identified six key principles of TIC: (1) safety, (2) trustworthiness and transparency, (3) peer support, (4) collaboration and mutuality, (5) empowerment, voice, and choice, (6) cultural-, historical-, and gender-based issues. These areas suggest practices that build a trusting peer community, cultivate self-advocacy skills, and acknowledge the intersectional identities of survivors are all part of TIC. SAMHSA (2014) also identified ten domains in which a trauma-informed approach may be implemented. These include agency areas such as governance and leadership, training and workforce development, and evaluation and quality assurance. SAMHSA's domains highlight that trauma-informed practices can go beyond direct client care and extend to the organizational practices of the agency.

Elliot et al. (2005) describes ten principles to keep in mind when implementing TIC in human services such as assessment, advocacy, crisis intervention, and healthcare. In developing these principles, a trauma committee agreed on the key principles of trauma-informed services (TIS) and how to implement these core elements in a trauma-informed service model. Their principles of TIS (see *Table 1*) highlight the need to empower survivors in a collaborative, culturally aware way in order to yield the greatest recovery from trauma.

1. The organization must recognize and understand the impacts of trauma and victimization on behavior.
2. TIC models must have the primary goal as recovery from trauma.
3. Trauma-informed services must employ an empowerment model.
4. Trauma-informed services should maximize the survivor's sense of control and decision making.
5. There must be relational collaboration between survivors and staff.
6. There must be a respectful safe place for survivors.
7. TIC should highlight survivor's strengths and resilience rather than pathology.
8. Trauma-informed services should work diligently to prevent retraumatization.
9. TIC should be culturally competent.
10. Trauma-informed services should encourage and value consumer (survivor) input.

Table 1. Displayed here are the ten principles of trauma-informed care according to Elliott and colleagues (2005).

Some of the key similarities in different definitions of TIC include safety and the importance of trusting, collaborative relationships between staff and survivors. However, some TIC models define safety strictly as being away from the abuser, while others consider the emotional and psychological wellbeing to be part of survivor safety. Multiple definitions also underscore the importance in services being inclusive to all cultures, such as survivors from different racial or gender backgrounds. In addition, many conceptual frameworks of TIC emphasize that staff and clients are aware of the physiological and behavioral effects that trauma can generate, though no framework for staff training is directly provided by the definitions. Despite the emerging themes from various definitions of TIC, the variation in implementation

suggestions make it more difficult to standardize trauma-informed care across multiple help-seeking settings.

Implementation of TIC

Trauma-informed care (TIC) has been found to be effective in several settings. Lotty and colleagues (2020) used a quasi-experimental design to compare foster caregivers receiving standard foster care instruction and foster caregivers receiving TIC foster instruction in Ireland. The intervention group received *Fostering Connections*, a biopsychosocial trauma-informed approach to foster care, and the control group received standard instruction. Researchers assessed the caregiver's knowledge of trauma-informed fostering, fostering efficacy, and tolerance of child misbehavior (Lotty et al., 2020). Caregivers were also asked to report on observed emotional and behavioral problems in the foster children they worked with. Results showed that participants who completed the trauma-informed program had higher average scores for trauma-informed fostering, tolerance of misbehavior, and fostering efficacy as compared to the control group. Additionally, caregivers in the intervention group reported significantly higher improvements in the behavioral and emotional problems of the foster children they cared for as compared to the control group (Lotty et al., 2020).

Morrissey and colleagues (2005) conducted another quasi-experiment with participants from several trauma-informed centers. Pre- and post-intervention interviews were conducted with clients of the centers. Participants included women with co-occurring substance use and mental health disorders. Selected intervention sites met four specific criteria (see *Table 2*) regarding services provided, clients served, and being trauma-informed (Morrissey et al., 2005). The sites had varying trauma-informed models that were guided by manuals emphasizing personal safety, empowerment, and helping survivors understand the connection between

trauma, mental illness, and substance abuse. At 12-months post-treatment, 71% of the women went from severe baseline scores on the Posttraumatic Symptom Scale (PSS) to moderate or mild scores. Mental health outcomes were similar with 31% of women who scored severe on the Global Severity Index (GSI) scoring moderate or better at 12 months post-treatment. They also found that integrating mental health, substance abuse, and trauma-informed practices into counseling was more successful than participants in the comparison group receiving individual treatments for each aspect. Researchers posited a lack of interagency coordination may have contributed to these results through placing excessive burden on participants to track (Morrissey et al., 2005).

1. The site had to provide an array of services (e.g., peer-run services, outreach, assessment, trauma counseling, parenting classes, advocacy, and crisis intervention).
2. Staff providing services at the site are utilizing trauma-informed services.
3. Site services have integrated treatment for substance abuse, mental health, and trauma-related problems).
4. Sites involved survivors in advisory and service provision roles.

Table 2. The inclusion criteria for Morrissey and colleagues when locating trauma-informed sites.

Sullivan and colleagues (2017) surveyed residents at domestic violence shelters throughout Ohio to examine the effects of trauma-informed care. Participants were interviewed about the quality and impact of TIC during their first week of stay and again 30 days later or at their shelter exit date. The survey included standardized measures of trauma-informed practices and self-reported depression, safety-related empowerment, and self-efficacy. Data showed that the degree to which participants perceived their care as being trauma-informed was directly related to positive outcomes. Survivors who perceived their shelter stay as more trauma-informed reported greater improvements in safety-related empowerment and in self-efficacy (Sullivan et al., 2017). These findings highlight the importance of trauma-informed practices to

relevant survivor outcomes and the usefulness of assessing perceived use of these practices. However, this sample consisted of only 57 survivors across various shelters and may not be representative of all client experiences at domestic violence agencies or within other service areas (e.g., legal advocacy, outpatient therapy). It is important for individual agencies to conduct their own assessments of adherence to trauma-informed practices to implement individualized adjustments.

Chalakani (2020) conducted a single case-study at a behavioral health clinic. Organizational leaders were interviewed, and internal documents were analyzed to gain additional insight on employee's experiences and perceptions of the organization during a paradigm shift into trauma-informed practices. Staff resistance can be common during change and may be contributed to by employees' fear of the unknown, fears about the personal outcomes of organizational failure, or employees' perceptions of organizational faults (Mathews & Linski, 2016). Internal documents included items such as staff satisfaction surveys, meeting agendas, and employee demographic reports (Chalakani, 2020). Results from leadership interviews indicated that improved organizational communication appeared to facilitate implementation of TIC (Chalakani, 2020). Following analysis, Chalakani (2020) identified organizational practices that appeared to aid trauma-informed practices. In addition to client-focused and direct care changes, staff-focused recommendations included a need for more workforce engagement and to place higher value on employee perceptions. To improve communication during TIC implementation, it was recommended that more opportunities to voice concerns should be made available to all employees, including inviting resigning employees to exit interviews (Chalakani, 2020).

The Empowerment Model

Empowerment, which can be viewed as increased client self-efficacy, is a component in several definitions of trauma-informed care (Elliott et al., 2005; Goodman et al., 2016; Hales et al., 2019; Hopper et al., 2010; Sullivan et al., 2017). Research has demonstrated that when survivors feel more empowered during the help-seeking process, they report higher satisfaction with victim services, the court system, and accompanying police (Cattaneo & Goodman, 2010; Cattaneo, 2010). In addition, empowerment-based programs have been associated with greater improvements in depressive symptoms, PTSD symptoms, and overall mental health outcomes (Johnson et al., 2011; Morrissey et al., 2005).

Many domestic violence programs consider empowerment to be a major goal within their programs. However, having a shared and explicit definition of empowerment has been less clear in the literature. This makes it difficult to determine whether the services are actually empowering survivors (Kasturirangan, 2008). One widely accepted definition of women's empowerment is "the process by which those who have been denied the ability to make strategic life choices acquire such an ability" (Kabeer, 1999). Related terms to women's empowerment, include autonomy and agency, meaning someone can make decisions and make strategic life choices (Kabeer, 1999).

Under the Empowerment Process Model, empowerment is defined as any meaningful shift of power in the social world (Cattaneo & Goodman, 2014). Identifying goals and determining the best course of action is one of the three components in the model. Next, survivors should try to build up their self-efficacy, skills, and knowledge. Self-efficacy has been identified as a key factor in accomplishing goals. The third component of the model involves reflection on the impact of the survivor's actions. Social context is important because lack of

attainment of an “ultimate goal” does not mean that a client isn’t making considerable progress. The Empowerment Process Model contends greater knowledge of community resources more often leads to women feeling empowered. Because the Empowerment Process Model is rooted in survivor-centered practices, it is also important to have frequent check-ins about progress and goals.

Elliott and colleagues (2005) attempt to operationalize trauma-informed services for women with co-occurring domestic violence and substance abuse. The third principle suggests the employment of an empowerment model showing the overlap of trauma-informed services with empowerment. They define empowerment models as the use of collaborative relationships to facilitate the client’s ability to have control over her life. They contend the program should also provide an opportunity for clients to relate and validate each other during the healing process. The identified, ultimate goal of the empowerment model is for a survivor’s support and resource networks to expand such that they need professional services less often (Elliott et al., 2005).

While Elliott et al. (2005) and fellow researchers provided desired outcomes of utilizing empowerment, Fallot and Harris (2009) provide a complete protocol on operationalizing trauma-informed care as well as a measurement tool that assesses TIC of specific programs. In this organization evaluative protocol, one of the identified domains of TIC is prioritizing empowerment and skill-building in their clients. Some examples of the staff self-assessment questions corresponding to empowerment are featured in *Table 3.*

1. Do consumer-survivor advocates have significant advisory voice in planning and evaluation of services?
2. Does the program emphasize consumer growth more than maintenance or stability?
3. For each contact, how can the consumer feel validated and affirmed?
4. In routine service provision, how are each consumer's strengths and skills recognized?
5. Does the program communicate a sense of realistic optimism about the capacity of consumers to reach their goals?
6. How can each contact or service be focused on skill-development or enhancement?

Table 3. Featured are some examples of questions that programs should consider when assessing the quality of TIC they are providing, according to Fallot & Harris (2009).

Many definitions of empowerment share emphasis on restoring autonomy and decision-making for clients. However, there is little literature on how to operationally achieve such conditions and quantitative assessment of agency success in implementing empowerment. Without a shared, operational definition, agencies may struggle with quality assurance, and may not be empowering clients effectively or effectively training staff to do so.

The Present Study

Intimate partner violence has a variety of adverse effects on the physical and mental wellbeing of survivors. Trauma-informed care and empowerment of survivors can increase the effectiveness of services in combatting the negative impacts of IPV. Unclear definitions of TIC can create barriers in implementing these practices if agency staff do not have shared definitions of what implementation looks like. Similarly, having different definitions of empowerment can make it more difficult to teach staff how to effectively empower clients. Past research has examined the effectiveness of self-identified trauma-informed agencies but has not examined the uniformity of staff definitions within those agencies. Research has also examined client perceptions of TIC and empowerment but has not examined staff perceptions. Conducting assessments of these practices at the agency level can be effective in generating agency specific recommendations (Chalakani, 2020). The present study examined definitions of TIC and

empowerment in staff at a domestic violence agency. Additionally, the study examined staff perceptions of the implementation of TIC and empowerment practices at the agency.

Methods

Procedure

Participants included staff and volunteers at a midwestern YWCA falling under their victim services division. In this division, this YWCA has approximately 100 employees and volunteers. Only four of these individuals are considered supervisory staff so comparisons were not made between supervisors and supervisees in order to protect confidentiality. Out of the staff approximation, 25 participants consented to partake in the survey. There was considerable attrition during the survey, as four participants stopped immediately after consenting, two more stopped after completed the TIP scale questions, and an additional five participants quit after completing up to the SDPS scale. In total, fourteen participants completed the survey. Of these fourteen, one participant completed everything aside from the SDPS questions and some qualitative questions. Three of the respondents completed everything but chose to skip some or all of the qualitative questions. In addition, due to an error in the Qualtrics survey, demographic information is missing for two participants.

In total, demographic information was provided for twelve participants (n = 12). All of these participants identified as being women, and 92% of the sample identified as Caucasian. Forty-two percent of the survey respondents identified as being shelter staff or a client advocate (n = 5). One fourth of the sample identified as working in the Emergency Response Team (ERT; n = 3). Finally, a third of the sample were interns or volunteers within the ERT (n = 4). Length of employment was highly variable, with an average length being 4.33 years (*M* = 52 months, *SD* = 79.6 months).

In regard to training, 83% of participants reported receiving training on both empowerment and TIC within the YWCA (n = 10), while 8% reported receiving training on neither (n = 1). In regard to training received outside of the YWCA, 42% of the sample had received training on both models (n = 5), and 25% did not receive training on either model (n = 3). Further classifications of trainings utilized are shown below (*see Table 4*).

Training within the YWCA
Received training on empowerment: 83% (n=10).
Received training on TIC: 92% (n=11).
Received training on both: 83% (n=10).
Received training on neither: 8% (n=1).
Training outside of the YWCA
Received training on empowerment: 58% (n=7).
Received training on TIC: 58% (n=7).
Received training on both: 42% (n=5).
Received training on neither: 25% (n=3).

Table 4. Displayed here is a breakdown of the trainings utilized by YWCA staff.

Procedures

Participants were recruited through their YWCA email to participate in an anonymous Qualtrics XM survey. The survey was advertised in an email sent to all YWCA staff and volunteers within the victim services division. Flyers describing the purpose of the study and ways to access it were also placed around the YWCA workspace (see Appendix A). The survey was promoted by researchers and agency supervisors as an optional survey to assess agency practices. At the request of YWCA staff, a paper copy of the survey was made available as an alternative. If a staff member or volunteer requested to fill out the survey in paper form, they requested the paper form from the research team and then anonymously returned it in a marked envelope in the YWCA main building.

A consent form was at the beginning of the survey for potential participants to learn more about the study and decide whether or not they would like to participate (see appendix B).

If a participant chose not to consent, the survey ended in the online version. The survey was completely anonymous and consisted of four measures including a demographic questionnaire (see Appendix C), the Trauma-Informed Practice Scale (see Appendix D), the Survivor-Defined Practice Scale (see Appendix E), and several qualitative questions (see Appendix F).

Measures

Demographics Questionnaire. This measure was created by investigators in order to learn more about the study sample as well as their roles in the organization. Demographic information including participants' age, race/ethnicity, gender, and employment or volunteer status were obtained at the end of the survey.

Trauma-Informed Practice Scale (TIP). Staff's perceptions of trauma-informed practices were measured using an altered version of the TIP scale (TIP; Sullivan et al., 2017). Questions were revised to assess staff perceptions of trauma-informed practices rather than client perceptions. For example, an item in the original TIP scale: "Staff are supportive when I'm feeling stressed out or overwhelmed" was revised to "Staff are supportive when clients are feeling stressed out or overwhelmed". Convergent validity has been demonstrated through strong correlation with the Short-Revised version of the Working Alliance Inventory (WAI-SR) and the Client Satisfaction Questionnaire-8 (CSQ-8; Hatcher & Gillaspy, 2006).

Survivor-Defined Practice Scale (SDPS). To analyze staff's perceptions of the empowerment model, an altered version of the SDPS was utilized (Goodman et al., 2016). Questions were revised to assess staff's perceptions of empowerment rather than client's perceptions. For example, an item in the original scale: "Staff helps me to shape goals that work for me" was revised to "Staff here help clients to shape goals specific to each client". The SDPS has displayed convergent validity through significant, positive correlations with measures of

informal social support (Social Support Network Scale), client satisfaction (CSQ-8), and safety-related empowerment (Measure of Victim Empowerment Related to Safety; Goodman et al., 2016).

Qualitative Questions. Four open-ended qualitative questions were included in the staff survey. The first two questions asked participants to define trauma-informed care and empowerment in their own words. The next two questions asked participants to provide any examples they had of either concept being utilized at the YWCA. Responses were analyzed to spot arising themes involving TIC and empowerment.

Data Collection

The survey was administered using the program Qualtrics XM. Survey responses were recorded and stored anonymously via Qualtrics, which is a HIPAA-compliant and secure program. Only the primary investigators had access to the anonymized data.

Analytic Strategy

For purposes of the study, two different analytic techniques were implemented. Both quantitative and qualitative analyses were conducted.

Descriptive Statistics. Descriptive statistics such as means, and standard deviations were used to examine the overall scores of the validated measures. This assisted researchers in determining the overall views of TIC and empowerment at the evaluated agency.

Thematic Analysis. The qualitative survey responses were examined using thematic analysis. The goal was to locate any similar themes in staff's definitions to determine their approximate understanding of empowerment and TIC. Firstly, all the responses were read by researchers to become familiarized with the data. Then, a code book was developed based on the themes that arose in participant responses. Next, researchers assessed responses based on the

code book. The themes and definitions identified in coding were also compared to the theories definitions of empowerment and TIC previously identified in the literature.

Results

Descriptive Statistics

The TIP scale is a Likert-type scale with answers ranging from 0 (not at all true) to 3 (very true). Overall, participants indicated that trauma-informed practices were being implemented somewhat consistently (M = 2.4, SD = 0.67). The TIP scale is comprised of six subscales: environment of agency, access to information on trauma, opportunities to build connections, emphasis on strengths, inclusivity, and trauma-informed parenting. The breakdown of scores for each subscale is listed below (*see Table 5*). The SDPS is a Likert-type scale with answers ranging from 1 (strongly disagree) to 4 (strongly agree). Overall, participant scores indicated that the empowerment model was being implemented fairly consistently (M = 3.25, SD = 0.96, *see Table 5*).

Measure and Scale Name	Mean	Standard Deviation
TIP Scale		
Agency Environment	2.47	0.59
Information on Trauma	2.27	0.76
Opportunities for Connections	2.06	0.79
Emphasizing Strengths	2.17	0.90
Inclusivity	2.29	0.81
Support for Parenting	2.24	0.79
SDPS Empowerment	3.25	0.97

Table 5. Shown are the average scores of each subscale within the TIP scale, as well as the average scores for SDPS measuring empowerment.

Themes of Trauma-Informed Care

During qualitative analysis, themes were defined as statements of similar meaning that were identified by at least three participants. In total, 12 out of the 14 participant completers

answered the qualitative questions about defining TIC. The themes identified using this method included awareness of the effects of trauma, avoiding re-traumatization, being understanding, and providing individualized services. Another theme that was only identified by two participants was empowering clients. Respondents identified examples of implementing TIC as including keeping confidentiality, providing options, educating clients, and forgiveness of clients for misbehavior.

Theme 1: Awareness of the effects of trauma

Seven participants identified an awareness of the effects of trauma to be an element of trauma-informed care. Trauma can have many negative impacts on a person psychologically and physically. In order to provide trauma-informed care, staff and interns must be aware of all of the ways that trauma can alter a person's disposition and behavior (*see Table 6*).

Theme 1:	"Trauma-informed care means being aware of the effects of trauma on the mind and body..."
	"Trauma-informed care is being able to understand and see the signs of trauma."
	"Care that takes into consideration clients' past trauma and tries to be conscious and aware of it"

Table 6. Examples of TIC Theme 1 about awareness of effects of trauma.

Theme 2: Avoiding Re-Traumatization

Three participants expressed importance in avoiding to re-traumatize clients. In order to assist clients in a trauma-informed way, they felt staff should be conscious of how they interact with clients, in order to avoid triggering or re-traumatizing (*see Table 7*).

Theme 2:	"Be mindful of not retraumatizing someone and believing them and empathizing with them."
	"Promoting healing recovery rather than retraumatizing."
	"…seeking to not re-traumatize."

Table 7. Examples of TIC Theme 2 about avoiding re-traumatization.

Theme 3: Being Understanding

Four respondents stated that being understanding, respectful, and non-judgmental towards clients is an essential part of TIC. Given the complex ways that trauma impacts behavior and thought processes, they felt it was important to give grace when a clients are struggling (*see Table 8*).

Theme 3:	"It focuses on the client's needs and strengths. It meets clients where they are at in their journey."
	"We have no room to judge a client for their reactions and should give informed, option-based care."
	"Trauma-informed practice is about approaching client work with understanding and training in trauma, and openness to the client's empowerment."

Table 8. Examples of TIC Theme 3 about being understanding.

Theme 4: Providing Individualized Services

Four participants also identified the importance of individualized services in being trauma informed. Because each client experiences different victimization has different values, their journey to recovery and the support needed may not be the same (*see Table 9*).

Theme 4:	"Confidential space for folks, being aware someone went through a trauma and meeting them where they are. They know their life best."
	"Meeting clients where they're at."
	"First, seeking not to harm, then operating within one's scope to help the individual, based on what the individual wants."

Table 9. Examples of TIC Theme 4 about providing individualized services.

Themes of Empowerment

During qualitative analysis for empowerment, themes were defined as statements of similar meaning that were identified by at least three participants. In total, all 14 participant completers answered the qualitative questions about defining empowerment. The themes identified using this method included being strengths-based, promoting client autonomy, and providing choices. Other themes that were only identified by one or two participants were providing a safe space, eliminating power imbalance, and increasing clients' confidence. Respondents identified examples of implementing empowerment as providing resources, being client-driven, and practicing clear communication.

Theme 1: Being Strengths-Based

Seven respondents identified that being strengths-based is a key component of empowering clients (*see Table 10*). By emphasizing the strengths that a client already has, clients may be more likely to increase their self-confidence and self-efficacy through skill-building.

Theme 1:	"Encouraging clients in their strengths…not being controlling."
	"Empowerment when working in social services can be assisting a client with recognizing their strengths and implementing those strengths into each aspect of their care.
	"That the participants are the best decision makers for themselves & their children. That they are the expert in their situation."

Table 10. Examples of Empowerment Theme 1 about using a strengths-based approach.

Theme 2: Promoting Client Autonomy

Ten participants identified promotion of client autonomy as an integral part of empowerment (*see Table 11*). In order to empower clients, staff should encourage clients to actively participate their recovery process.

Theme 2:	"Helping someone learn to do something for themselves so they have the tools and know how to do it on their own in the future or to help someone else."
	"Empowerment is about being provided space to be present and safe, and to begin feeling validated in one's own expertise over themselves."
	"Knowing that people know what is best for themselves, and they have the individual power and inner wisdom to make choices and change in their lives."

Table 11. Examples of Empowerment Theme 2 about promoting client autonomy.

Theme 3: Providing Options to Clients

Several participants indicated that to empower clients, one must provide choices for the clients to make (*see Table 12*). Survivors of IPV may not have been allowed to make decisions regarding their life during abuse, so participants felt staff should seek to restore this.

Theme 3:	"Holding space for choice-making…offering options and supporting their choices."
	"Empowerment means being able to make informed choices and decisions (personal, social, physical, emotional, spiritual, etc) based on what is best for each person."
	"Empowerment means taking a strengths-based approach to problem solving and ensuring that the client is the lead decision maker."

Table 12. Examples of Empowerment Theme 3 about providing options to clients.

Barriers

In addition to identifying themes those arose in defining TIC and empowerment, participants were asked to identify barriers that impede their ability to implement these practices. In total, all 11 of the 14 participant completers answered the qualitative questions about barriers. Three of these 11 participants reported they were unable to identify any specific barriers. One barrier that was identified by four participants was job constraints (see *Table 13*). Job constraints were described as some staff viewing the agency position as "just a job" or not being paid enough to implement TIC, not having enough time in their role, and not seeing their role as consequential to implement TIC.

Barrier 1:	"Need more time to implement trauma informed practices."
	"Some of the staff take this very seriously and others just shrug it off as just a job.
	"Also not getting paid a living wage"
	"Implementation is limited by my limited role. I can be part of the little things with individuals I interact with, but do not see how my small role impacts the larger changes needed in society."

Table 13. Examples of Barrier 1 about job constraints are listed above.

Other barriers that were only identified by one or two participants were working with non-trauma informed partners, lack of consistent training, lack of direction from supervisors, inconsistency among staff, lack of time, and personal limitations of individual staff. These barriers relate back the importance of having shared definitions of TIC and empowerment, including across coworkers, supervisors, and agency partners. These barriers also speak to the importance of structural decisions within and outside of an agency impacting the implementing of TIC.

Discussion

The present study sought to examine staff, intern, and volunteers' perceptions on trauma-informed and empowerment practices at the YWCA of Kalamazoo. The goal of the study was to analyze staff's definitions and implementation of these practices to determine how consistently these treatment models were used. Overall, descriptive analyses indicate trauma-informed care and empowerment are occurring some of the time. This shows a preliminary level of consistency among the staff while indicating opportunity for improvement in increasing consistency.

Participant identified themes of trauma-informed care support Elliott et al.'s. (2005) principles of trauma-informed services (see *Table 14*). The themes identified relate to principle one about the impacts of trauma, principle six about respect, principle eight about preventing retraumatization, and principle 10 about individualizing services based on survivor input. In regard to empowerment, respondents identified themes that were also most aligned with Elliott et al. (2005). They related to principle three in promoting empowerment overall, principle four in increasing survivor decision making, and principle seven in emphasizing strengths. The identified barriers to implementing these practices also highlight principle five in fostering collaboration between different levels of staff and survivors.

1. The organization must recognize and understand the impacts of trauma and victimization on behavior.
2. TIC models must have the primary goal as recovery from trauma.
3. Trauma-informed services must employ an empowerment model.
4. Trauma-informed services should maximize the survivor's sense of control and decision making.
5. There must be relational collaboration between survivors and staff.
6. There must be a respectful safe place for survivors.
7. TIC should highlight survivor's strengths and resilience rather than pathology.
8. Trauma-informed services should work diligently to prevent retraumatization.
9. TIC should be culturally competent.
10. Trauma-informed services should encourage and value consumer (survivor) input.

Table 14. Displayed here are the ten principles of trauma-informed care according to Elliott and colleagues (2005).

Findings from this study indicate that although many participants had received training on these topics, they still did not feel entirely comfortable in effectively implementing such practices or doing so consistently. This fits with findings reported by Bruce et al. (2018), that self-rated competence of TIC was the most consistent predictor of the frequency of use of TIC by healthcare providers. IPV resource agencies should make considerable effort to produce uniform definitions of trauma-informed care and empowerment. In addition, trainings provided to staff, interns, and volunteers should be more comprehensive, in order to avoid only having introductory-level understanding of these complex practices. This is supported by past literature that demonstrate training at IPV resource centers is most successful when these models are implemented at a systemic level (Campbell et al., 2001; Hamberger et al., 2004; Harwell et al., 1998; McLeer et al., 1989).

The most commonly identified theme of TIC was that staff must be aware of the impacts of trauma, but even this theme was not identified by all participants. This finding is logical as the most commonly listed theme, given this element of TIC is uniform across most definitions (Bruce et al., 2018; Elliott et al., 2005; Goodman et al., 2016; Hales et al., 2018, Hopper et al., 2010;

Sullivan et al., 2005). When staff recognizes the pervasive nature of sexual victimization, client's feelings and experiences are validated, thus improving survivor's sense of hope in recovery (Elliott et al., 2005). Unfortunately, public services intended to support survivors of trauma may use coercive practices that are trauma-inducing (SAMHSA, 2014). Similarly, SAMHSA (2014) states that in order to maximize efforts of TIC, trauma-specific assessment and treatment should be made available in organizational, community-based contexts. This highlights the importance of implementing TIC and empowerment practices being consistent and system wide in their implementation.

The sample's most commonly reported theme of empowerment was offering choices and decision-making to the clients. This supports Elliott et al.'s (2005) definition of empowerment, which places emphasis on valuing client's knowledge, working collaboratively, and validating clients' choices. It also relates to the ultimate goal that resources are extended to the client such that they become less reliant on professional services throughout the course of assistance. According to research, allowing clients to regain choice and control over their own life, is the only way a client will be able to pursue their goals (Elliott et al., 2005). Fallot and Harris (2009) similarly identify client involvement and choice-making as essential to building up client's skills and accomplishing given tasks.

Study Limitations

Largely, the themes and barriers identified in this survey parallel past research (Bruce et al., 2018; Elliott et al., 2005; Goodman et al., 2016; Hales et al., 2018, Hopper et al., 2010; SAMHSA, 2014; Sullivan et al., 2005). However, one inherent limitation is that this was an agency case study, so results may not generalize to other agencies. Individualized program assessment within an agency may be recommended as, similar to the present agency, there are likely ways

each agency fits with overall trends in the fields and ways they do not. Future research should consider doing agency case studies at multiple sites to compare how findings may or may not reflect perceptions of staff in other IPV resource centers.

Another limitation of this survey was the low response rate within the agency. The total sample had only 25 responses (n = 25) out of an estimated 100 individuals and attrition was also high. Fourteen participants completed the survey completely, although one of these participants chose to skip the SDPS measure and some qualitative questions. Three more of these completers chose to skip some or all of the qualitative questions. Finally, demographic information was not available for two of the fourteen responses, due to researcher error. It is also possible there are staff characteristics that led to individuals to not engage in the study at all Given almost all of the respondents identified as White, which is not representative of the demographics within the agency. Given the sample obtained, these results may not accurately represent perceptions of all staff, intern, and volunteers. Future research should endeavor to obtain samples that are representative of agency staff to ensure case study results are representative of the agency as a whole. Additionally, due to there only being 25 participants, comparisons cannot be made within groups at the agency (e.g., ERT versus shelter staff; volunteers and interns versus employees), as was originally intended in study methodology. Assuring that sampling procedures result in individuals from all intended subgroups being represented is vital in order to assess if various subgroup characteristics is associated with different perceptions of TIC and empowerment.

Finally, these findings are limited by the additional attribution tied specifically to the study's qualitative questions. The tendency for respondents to skip qualitative questions may be expected given these questions require a higher response effort than multiple choice questions. One way to combat attrition rates related to qualitative research would be to increase collaborative

efforts between researchers and agency leadership at the agencies being reviewed for case study analysis. These efforts should focus on ways to make survey completion more accessible and reduce barriers to completion while still maintaining confidentiality and the optional nature of research (e.g., providing paper copies, leaving time to fill out surveys during staff meetings).

Conclusions

The purpose of this case study was to examine staff, intern, and volunteer perceptions of TIC and empowerment within the YWCA of Kalamazoo. There were several identified themes within definitions and implementation of both TIC and empowerment. The four most commonly stated themes of TIC were awareness of the impacts of trauma, avoiding re-traumatizing, being understanding, and providing individualized services. Common themes identified in empowerment included the program being strengths-based, promoting autonomy, and providing choices. The themes identified in the qualitative questions are most consistent with Elliott et al.'s (2005) definitions of both TIC and empowerment (*see Table 14.)* Although there was some shared themes in participant definitions, these were not widespread and indicate the need for increased consistency. Analysis of the TIP and SDPS scale also indicated opportunity for improved consistency in implementation. This is consistent with the participant identified barriers to implementing these practices, as several participants expressed difficulties in working with non-trauma informed partners, inconsistency within the staff, and overall insufficient training.

Future directions of research on TIC and empowerment should emphasize the operationalization of both practices. Although many staff had received training on both TIC and empowerment, the models were only being implemented somewhat consistently and definitions varied. Agencies seeking to increase their efficacy in trauma-informed and empowerment-based

practices should work to cultivate an agency-wide definition of such practices and provide frequent opportunities for training on both models. These trainings should also be directed related to concrete action steps for implementing such practices and should be individualized to the roles of the staff or volunteers in attendance. Most importantly, agencies similar to this case study should seek to identify action steps that can be taken by staff at all levels of the organization to implement these practices and individualize them to their specific agencies.

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Appendix A: YWCA Recruitment Poster

This flyer was placed around the ERT and shelter workspaces in order to recruit survey participants.

Appendix B: Consent Document

Western Michigan University
Department of Psychology

Principal Investigator: Amy Naugle, Ph.D.
Student Investigator: Kailyn Alderman
Additional Investigator: Tabitha DiBacco, M.A.

You are invited to participate in this research project titled *"Perceptions of Trauma-Informed Care in an Intimate Partner Violence Resource Center"*

STUDY SUMMARY: This consent form is part of an informed consent process for a research study, and it will provide information that will help you decide whether you want to take part in this study. Participation in this study is completely voluntary. You may choose to not answer any question. The purpose of the research is to gather employee and volunteer perceptions of trauma-informed care and empowerment. In addition, this data will serve as Kailyn Alderman's honor's thesis for the requirements of the Bachelor of Science with honors degree. If you take part in the research, you will be asked to provide demographic information about yourself and to answer closed and open-ended questions regarding your understanding of trauma-informed care and empowerment. The survey should take approximately 10-20 minutes to complete.

Your replies will be completely anonymous, so do not put your name anywhere on the survey. Given the organizational collaboration in improving training, there is risk that responses will be recognized by supervisory staff. This risk is minimized through the data collected being anonymous and only researchers having direct access to the data you provide. Individual participant responses will not made available to supervisors. Although there are no direct benefits to participation, survey data may allow for useful data about empowerment and trauma-informed practices at the Kalamazoo YWCA and updates to training as warranted. Your alternative to taking part in the research study is not to take part in it.

The de-identified (anonymous) information collected for this research may be used by or distributed to investigators for other research without obtaining informed consent from you.

Should you have any questions prior to or during the study, you can contact the principal investigator, Amy Naugle, at (269) 387-4726 or amy.naugle@wmich.edu or the student investigator, Kailyn Alderman, at (810) 444-3264 or knc7456@wmich.edu. You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298.

This consent has been approved by the Western Michigan University Institutional Review Board (WMU IRB) on February 14th, 2022.

Participating in this survey online indicates your consent for use of the answers you supply.

I agree to participate in this research study	(Survey following upon clicking)
I do not agree to participate in this research study	(Browser closes)

Appendix C: Demographic Questionnaire

You will now be asked to provide some personal history and demographic information.

1. **How old are you? _____ years**
2. **How would you describe yourself? (select all that apply)**
    a. Hispanic/Latinx
    b. African American/Black
    c. Asian
    d. Native Hawaiian or Pacific Islander
    e. Caucasian/White
    f. Other- please describe: _____
    g. Prefer not to answer
3. **What is your gender identity?**
    a. Woman
    b. Man
    c. Genderqueer or nonbinary
    d. Other- please describe: _____
    e. Prefer not to answer
4. **Which best describes your role at the YWCA?**
    a. Shelter staff or non-residential advocates
    b. Emergency response team staff
    c. Volunteer or intern
5. **On average, approximately how many hours a week are you at the YWCA as a staff member, volunteer, or intern? _____**
6. **How long have you worked for the YWCA? Please indicate if your answer is in months or years. _____**
7. **Since being hired at the YWCA, which of the following have you received training on? Check all that apply.**
    a. Trauma-informed practices
    b. Empowerment-based practices
    c. I have not received training on either of these topics
8. **Have you received training on either of the following outside of the YWCA? Check all that apply.**
    a. Trauma-informed practices
    b. Empowerment-based practices
    c. I have not received training on either of these topics outside of the YWCA
9. **What barriers do you see as impacting your ability to implement trauma-informed or empowerment practices at the YWCA?**
10. **Do you have any other thoughts or comments you would like to share?**

Appendix D: Altered Trauma-Informed Practice (TIP) Scale

Please indicate how true the following statements are overall based on your interactions with clients and staff at the YWCA with 0 being not at all true and 3 being very true.

1. Staff respect clients' privacy.
2. Staff are supportive when clients feel stressed out or overwhelmed.
3. Clients decide what they would like to work on in the program
4. Clients have the opportunity to learn how abuse and other difficulties affect responses in the body.
5. Clients have the opportunity to learn how abuse and other difficulties affect peoples' mental health.
6. Staff treat clients with dignity
7. Staff respect the strengths clients have gained through life experiences.
8. Staff respect the strengths clients get from their culture or family ties.
9. Staff understand that the clients know what's best for themselves.
10. Clients have the opportunity to connect with each other.
11. Clients have opportunities to help other survivors of abuse.
12. This program creates opportunities for clients to learn how abuse and other hardships affect peoples' relationships.
13. The strengths that clients bring to relationships with their children, family, or others are recognized by staff in this program.
14. Staff respect the choices that clients make.
15. In this program, clients can share things about their life on their own terms and at their own pace.
16. This program gives clients opportunities to learn how abuse, and other difficulties affect peoples' abilities to think clearly and remember things.
17. Clients have the option to get support from peers or others who have had experiences similar to their own
18. Staff can handle difficult situations
19. Clients learn about how to handle unexpected reminders of the abuse and difficulties they have endured.
20. Clients can trust staff.
21. Peoples' cultural backgrounds are respected in this program.
22. Peoples' religious or spiritual beliefs are respected in this program.
23. Staff respects peoples' sexual orientations and gender expressions.
24. Staff understand what it means to be in a client's financial situation.
25. Staff understand the challenges faced by people who are immigrants
26. Staff understand how discrimination impacts peoples' everyday experience.
27. Staff recognize that some people or cultures have endured generations of violence, abuse, and other hardships.

28. This program treats people who face physical or mental health challenges with compassion.
29. Clients have the opportunity to learn about how children react emotionally when they have witnessed or experienced abuse, and other hardships.
30. Staff help clients explore how children's relationships can be affected by witnessing or experiencing abuse, and other life difficulties.
31. Clients can learn about how their own experience of abuse can influence relationships with their children.
32. The program provides opportunities for children to get help dealing with the abuse and other hardships they may have experienced or been affected by.
33. Staff support clients to strengthen relationships with their children.

Appendix E: Survivor-Defined Practice Scale (SDPS)

The following questions have to do with services and support clients receive from this program. Please circle the number that best reflects your opinion, with 1 meaning strongly disagree and 4 meaning strongly agree.

1. Clients feel respected by staff in this program.
2. Staff help clients to shape goals that work for them.
3. Staff here support clients' decisions.
4. Staff here do not expect clients to be perfect.
5. Staff here support clients even when things are not going well.
6. Staff here make sure that services are right for what clients need.
7. Staff here offer choices.
8. Staff here believe that decisions about clients' lives are theirs to make.
9. Staff here respect the way that clients deal with things, whether or not they agree with it.

Appendix F: Qualitative Questions

The following questions are open response questions for you to answer to the fullest extent possible.

1. How would you define trauma-informed care?
2. How would you define empowerment?
3. Give some examples of what implementing trauma-informed care at the YWCA looks like.
4. Give some examples of what implementing empowerment-based practices at the YWCA looks like.