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ORIGINAL PAPER

Culturally Responsive Trauma-Informed Services: A Multilevel Perspective from Practitioners Serving Latinx Children and Families

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Abstract
Using a multilevel ecological framework, we take a qualitative approach to examining important cultural considerations that support successful implementation of trauma-informed services within the Latinx community. We conducted key informant interviews with community practitioners recruited primarily in the Phoenix, AZ metro area. Themes that emerged from interviews captured societal, community, and individual barriers to effective implementation of a culturally responsive trauma-informed approach. Specifically, multilevel barriers included socioeconomic circumstances, normalization of trauma exposure, and the transgenerational impact of trauma. Practitioners also reported approaching their work using relationship-focused and family-centered frameworks as facilitators to service engagement. We highlight the critical need for a culturally responsive trauma-informed approach that stresses the importance of context, recognizes transgenerational vulnerabilities, and promotes equity and the utilization of cultural humility in order to lessen the multilayered disparities in service accessibility experienced by minoritized communities.

Keywords Trauma-informed approach · Cultural responsiveness · Equity · Context · Latinx families

Introduction

Health disparities based on social status are both chronic and widely prevalent (Williams and Mohammed 2013), and trauma exposure is no exception. In fact, trauma exposure can represent both a health disparity in itself as well as become a mechanism by which disparities are perpetuated (Mikhail et al. 2018). Social status indices, which include race/ethnicity, cultural group affiliation, and socioeconomic status (SES), are associated with ongoing and extreme adversity early in life (Eckenrode et al. 2014; Carter 2007). For example, Latinx children in the United States specifically are at disproportionate risk for adverse childhood experiences (ACEs). A U.S. nationally representative survey indicated that 29.5% of Latinx children experienced at least one form of an adverse event before their fourth birthday, compared to the national average of 24.6% (Data Resource Center for Child and Adolescent Health 2016). ACEs includes direct and indirect exposure to community violence, child maltreatment (e.g., abuse and neglect), parental illness, substance abuse, incarceration and separation, bullying, poverty, domestic violence, accidents, natural disasters, forceful migration and war (Bartlett and Sacks 2019; Gilbert et al. 2015; Centers for Disease Control and Prevention [CDC] 2019). Discriminatory treatment and challenges associated with not being able to access social services due to documentation status may also represent a major source of adversity for the Latinx community, yet these experiences are not captured by traditional ACEs questionnaires (Suárez-Orozco et al. 2002). This is particularly important for groups that face additional structural and systemic inequities as ACEs can have a serious detrimental impact in the developmental trajectories of children, particularly when adversity exposure occurs early in life, is chronic or severe, or accumulates over time (Masten 2015).

Trauma is one of the deleterious consequences of childhood adversity exposure and is characterized by the diminished ability to cope as a result of experiences of

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an overwhelming and threatening event or set of circumstances (Substance Abuse & Mental Health Administration [SAMHSA] 2014; Bartlett and Sacks 2019). Following potential traumatic exposure, Latinx children and families can develop poorer social and behavioral outcomes and are more vulnerable to re-victimization compared to Caucasian youth (Stewart et al. 2017; Gjelsvik et al. 2013; Shapiro 1995). These poor outcomes are, in part, the result of structural and systemic inequities such as historical residence in violent neighborhoods, precarious financial conditions and isolation by race, ethnicity, and SES (Stolbach and Anam 2017; Williams et al. 2010; Zambrana and Logie 2000; Shonkoff et al. 2012; Ginzberg 1991). Unfortunately, these social circumstances also translate into increased obstacles to access and engage in mental health services that may mitigate the negative consequences of adversity and trauma (Stewart et al. 2017; Garland et al. 2005; McKay and Brannon 2004), including those utilizing a trauma-informed approach.

A trauma-informed approach recognizes the profound impact of trauma while acknowledging the role trauma has in individuals and communities to promote recovery (SAMHSA 2011). Although they represent distinct constructs both falling under the larger umbrella of trauma-informed approaches, the terms "trauma-informed care" (TIC) and "trauma-specific services" (TSS) are often used interchangeably in the literature (DeCandia et al. 2014). TSS are defined as programs and evidence-based clinical interventions (e.g., trauma-focused cognitive behavioral therapy) tailored to address trauma related mental health difficulties (e.g., post-traumatic stress disorder). TIC in broader, refers to the organizational culture across service settings (e.g., child welfare, mental health agencies, schools) seeking to incorporate an awareness of the comprehensive impact of trauma relative to child and family development and responding accordingly through direct practices and the implementation of policies and procedures (e.g., the intentional creation of a safe environment) (Hanson and Lang 2016; SAMHSA 2014; NCTSN 2007). Regardless of the differences in terminology, the augmented understanding of the pervasiveness of trauma, trauma-related outcomes, and disproportionate rates of trauma among racial-ethnic minority groups highlight the necessity to continue integrating trauma-informed approaches that emphasize the critical role of culture and context within child serving systems. To do so, particular attention should be given to the understanding of providers' experiences in implementing the trauma-focused delivery facet of such framework, an important characteristic of this framing and the focal point of this paper.

Specific to trauma-informed approaches, disparities in access are more prominent for those residing in communities that experience racial segregation, fewer economic resources, or prevalent violence (Stolbach and Anam 2017). Moreover, despite the scientific evidence suggesting that culturally modified mental health interventions are more effective and fruitful in reducing disparities in service access for the Latinx community when compared to traditional models (Kalibatseva and Leong 2014), gaps in both research and practice for ethnic and racial minorities still remain (Pole et al. 2008), particularly within the still emerging literature on trauma-informed approaches (Hanson and Lang 2016). Given the increased risk for trauma within Latinx children and families, the structural barriers to service accessibility, and the clear but limited empirical research underscoring the benefits of adopting a culturally responsive approach in mental health (Dumas et al. 2011; Pole et al. 2008), in the present study we examine practitioners' perspectives of cultural considerations that support successful implementation of a trauma-focused delivery approach in services. In doing so, we hope to further clarify the understanding of a culturally responsive trauma-informed approach. Additionally, we seek to lessen the known multilevel disparities in mental health accessibility and improve outcomes experienced by Latinx children and families.

Trauma-Informed Approaches as Responsive Service Systems

Through the utilization of a trauma-informed approach, responsive child service systems are associated with positive childhood and family adaptation amid significant life adversity (Bartlett and Steber 2019). Moreover, the utilization of a trauma-informed approach has been linked to better health outcomes, and improved satisfaction with care for individuals who have extensive histories of traumatic exposure (Raja et al. 2015). Additional evidence suggests that the integration of trauma-informed approaches in both traditional health care settings and social services, particularly the trauma-focused delivery component, is associated with enhanced mental health outcomes (Suarez et al. 2014), as well as declines in substance abuse and post-traumatic stress symptomatology (Cocozza et al. 2005; Morrissey et al. 2005).

An often overlooked but fundamental principle of a trauma-informed approach involves cultural humility (Schulman and Gingrich 2017). Cultural humility is a process-oriented approach that emphasizes the profound understanding of cultural differences in service provision and utilization, such as how cultural contexts affect reasons for attending mental health interventions (Yeager and Bauer-Wu 2013). Cultural humility through culturally competent practices (e.g., acknowledgement of diverse values, beliefs, and behaviors) supports the understanding of the multilayered intersection between trauma and aspects of culture including race, ethnicity, gender, geographic location, socio-political particularities, and language. It also acknowledges the intricate

effect of structural inequity, and is sensitive to the unique needs and strengths of ethnic/racial minorities (SAMHSA 2014). Unfortunately, current guidelines in trauma-informed approaches do not sufficiently account for cultural humility as a facilitator of service delivery and engagement in working with ethnic/racial minorities. Evidenced by the findings from a systematic review by Hanson and Lang (2016) on the principal components of trauma-informed approaches from well-established frameworks (e.g., SAMHSA, The National Association of State Mental Health Program Directors, The Attorney General's National Task Force on Children Exposed to Violence, and The National Center for Mental Health Services), cultural humility did not emerge as a core component, nor did the profound and central role of structural inequities on traumatic exposure or service access. It also remains unclear what challenges practitioners perceive in implementing trauma-informed approaches within the community.

Culture and Barriers to Engagement in Trauma-Informed Services

Culture might explain some variability in individuals' and communities' trauma-related reactions and broad symptom expression (e.g., distress, avoidance, or hyper-arousal; Trepasso-Grullon 2012; Mainous et al. 2005), help-seeking patterns, healing mechanisms, and meanings ascribed to various traumatic experiences (Fortuna et al. 2019; Perilla et al. 2002; Marsella et al. 1996). Differences in understanding trauma reactions across cultures may impact the way individuals engage in services and how practitioners respond (Snowden and Yamada 2005). This body of scholarship supports the idea that the dissemination of evidence-based trauma-informed approaches should not only account for cultural nuances but also the unique challenges minoritized communities face in accessing services such as structural and precarious socioeconomic situations (Schnyder et al. 2016). As the literature on the benefits of implementation of trauma-informed approaches and specific components of these approaches grows, uncovering culturally relevant considerations will likely be vital in enhancing participation and engagement for Latinx families. Specifically, culturally responsive interventions must examine and acknowledge the unique and intertwined logistical, structural, social, and cultural barriers the Latinx community experiences in accessing programs.

Some of the most pervasive obstacles obstructing Latinx families from engaging in mental health services can be attributed to systemic conditions that perpetuate dynamics of inequities. These include low income, high unemployment rates, limited knowledge about services and programs, absence of appropriate health insurance, and acculturative stress (Kouyoumdjian et al. 2003; Smart and Smart 1995; Woodward et al. 1992). Immigration status has also been linked to disparities in mental health utilization (Bauldry and Szaflarski 2017), specifically for those families with a mixed or undocumented status. Furthermore, social isolation defined by limited social connections and lack of social supports has also been shown to be a predictor of lower service participation within this community (Hurtado-de-Mendoza et al. 2014). In addition, the way in which Latinx children and families engage and utilize mental health services can be influenced by social values, including stigma regarding mental health diagnosis, spiritual beliefs, and strong dependence on family members (Kouyoumdjian et al. 2003). These hardships within the Latinx community do not suggest that ethic-racial communities lack strengths, it rather highlights how barriers can, and should be overcome in the context of culturally responsive service provision. More research is needed to determine effective treatment frameworks specifically for children exposed to trauma that explicitly account for culturally relevant factors, particularly as they relate to structural inequities, that may influence the adequate engagement of families in services (Johnson et al. 2018).

To alleviate some of these barriers, previous research provides insight into the role of cultural responsiveness in the provision of care. Specifically, Alegria et al. (2010) highlighted the importance of providing mental health services from a culturally competent framework by utilizing a relationship-building approach in services. Being culturally responsive (Whaley and Davis 2007) in interventions through the prioritization of relationships has been found to be critical to adequate engagement and service success (Beasley et al. 2017). Literature has also emphasized the notion that favorable outcomes in treatment are determined by how well programs are able to meet the social and contextual circumstances of those seeking help (Law et al. 2009). Although limited, research has demonstrated that positive service outcomes are associated with mental health interventions that include modifications that reflect the most salient cultural aspect of minorities (Nagayama Hall et al. 2016; Domenech Rodríguez et al. 2011; McCabe et al. 2005). These studies, however, have not yet examined culturally and contextual relevant intricacies specific to trauma-focused delivery approaches. Understanding both barriers and potential facilitators to access and service engagement for Latinx families can provide us with a critical understanding of considerations providers must be mindful of for the implementation of a culturally responsive trauma-informed approach. This is essential to service provision to enhance engagement and positive outcomes for minority communities.

Current Study

The present study aims to integrate two currently disparate lines of research on culturally responsiveness in care and

trauma-informed approaches by qualitatively exploring practitioners' perspectives on (a) the existing multilevel barriers for Latinx family engagement in trauma-informed services, (b) their own perceived barriers to implementation of the trauma-focused delivery facet of trauma-informed approaches from a culturally responsive lens, and (c) their recommendations of facilitators to enhance engagement and continued participation of Latinx families. Qualitative methodology is noted for its usefulness in providing insight in respect to implementation considerations of health services and programs (Tejada Tayabas et al. 2014). Trauma responses, as well as programs, treatments, and frameworks targeting trauma reactions are complex and long-lasting (Bath 2008); to address this complexity, we utilize an ecological perspective (McLeroy et al. 1988) to synthesize our research inquiry and findings (see Fig. 1). The ecological model suggests that interventions, similar to behaviors, are constantly affected by social environments. In addition, interventions are embedded within multiple contexts, all of which interact with each other, including: (a) the societal level (e.g., large societal factors, values, norms and beliefs); (b) the community level (e.g., neighborhood, school and community context); (c) the relationship level (e.g., family context, close relationships); and (d) the individual/personal level (e.g., individual differences). This model is useful in understanding the multifaceted nature of culturally relevant barriers and facilitators to services utilizing a trauma-informed delivery approach.

Methods

Participants

We interviewed 20 community practitioners who had relevant experience working with Latinx children or families who have been exposed to adversity and trauma. As we were interested in gaining the perspective from practitioners with practical expertise in this field, the research team used purposive sampling (Hennink et al. 2010) for recruitment. This sampling technique has been cited in the literature for its usefulness in clinical and qualitative research (Etikan et al. 2016). Specifically, we recruited practitioners from the Arizona ACEs Consortium in the Phoenix, Arizona metropolitan area which includes workgroups for both clinical and school-based practitioners. Workgroup members were approached by the primary investigators both in person and through an electronic mailing list (i.e., clinical or school-based). For our purposive sample, we identified well-networked professionals that worked extensively with the aforementioned community ($n = 10$). Then, we used a snowball sampling methodology to reach the remaining participants ($n = 10$), some of whom were located in other cities in Arizona. Participants were professionals in the community (62.5%), including those working in child welfare, healthcare, and school settings (37.5%). Professional roles of participants comprised clinicians (45.8%), school administrators (20.8%), training or other service provision (20.8%), and liaison or community advocates (12.5%). The majority of practitioners were female (87.5%). They ranged in age from 20- to 60-years old. Most of the sample (75%) identified as non-Hispanic white and 25% of the sample identified themselves as Hispanic or Latinx. In terms of professional

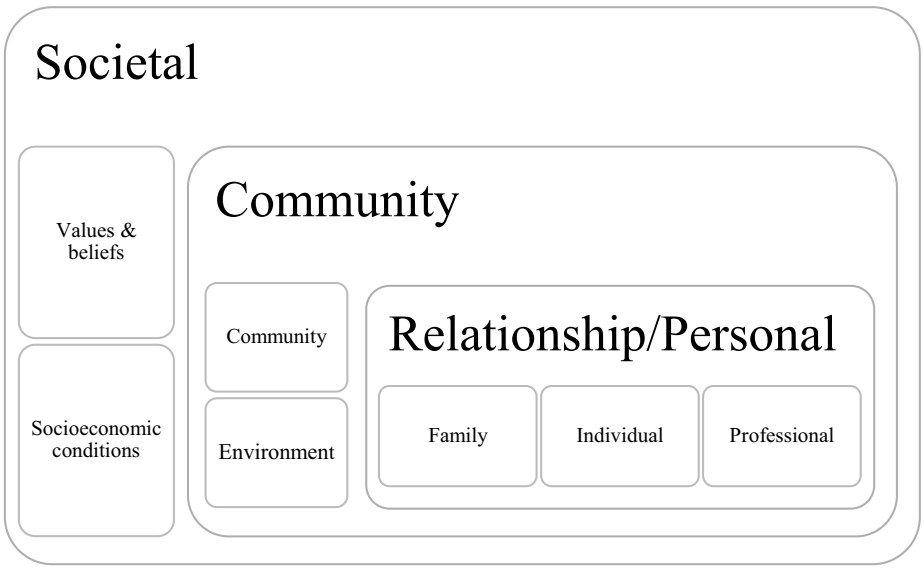

Fig. 1 Multilevel codes for barriers to implementation

experience, the majority of the practitioners reported being in their professional role between 1 and 3 years (25%), between 3 and 8 years (37%), 33% had more than eight years of experience, and only one participant had less than one year of experience in their specific role. The types of services practitioners provided included school-and home-based counseling, case management, advocacy, and clinical services at school and community agencies. Practitioners were also surveyed about their perceptions of their ability to define and successfully engage in trauma-informed services; most participants (85%) rated their ability to respond to children who have experienced trauma as either good or excellent (Table 1 provides additional details).

Procedures

The primary investigators conducted all interviews and a notetaker was present to capture highlighted verbal and non-verbal data. Prior to the interview, participants were consented and completed a survey to obtain demographic data and inquire about their qualifications. The interview format was semi-structured and ranged from one to one and a half hours. In addition, the interviewer and notetaker complete a post-interview debriefing immediately upon conclusion of the interview. All interviews were audio recorded. A trained third-party contractor transcribed the interviews, prior to which all identifying information was removed to ensure confidentiality. Participants received a $25 gift card to compensate for their time and participation. The Arizona State University Institutional Review Board (IRB) approved the study's procedures, and all authors certify responsibility of this manuscript.

Interview Guide Development

The practitioner interview guide was developed by the primary investigators and informed by review of the literature on evidence-based guidelines to trauma-informed services (e.g., SAMHSA, Menschner and Maul 2016). The interview guide included questions about relevant training, experience, and the utilization of current practices (see Table 2 for examples). Multiple questions were in open-ended format and allowed interviewers to capture pertinent information not directly relevant to the larger study's focus (e.g., feedback on possible intervention adaptations). To allow for a comprehensive understanding of both barriers and facilitators to implementation of trauma-informed approaches from a culturally sensitive perspective, participants were asked about challenges in working with Latinx clients who had undergone traumatic experiences and anticipated barriers in services engagement (e.g., "Tell me about some of the barriers you either have experienced or anticipate."). To explore

Table 1 Practitioners' perceptions of their ability to engage in trauma-informed services

Rate your ability to	Frequency (%)				
	Poor	Fair	Neutral	Good	Excellent
Define childhood trauma	0 (0)	0 (0)	1 (4.2)	11 (45.8)	12 (50)
Understand the sources of trauma for children	0 (0)	0 (0)	0 (0)	9 (37.5)	15 (62.5)
Recognize the warning signs and effects of trauma	0 (0)	0 (0)	1 (4.2)	9 (37.5)	14 (58.3)
Respond to children who have experienced trauma	0 (0)	1 (4.2)	2 (8.3)	10 (41.7)	11 (45.8)

Table 2 Sample questions by domains

Domain	Sample question
Relevant training/ experience	Tell me about your career background? How long have you been practicing? Do you have specialized training for working with clients who have experienced trauma? Tell me about your experience working with children/families who have experience trauma? How do you define trauma? How do screen for trauma?
Barriers	What are some of the challenges/barriers in working with children/families who have experienced trauma? What are some of the challenges in incorporating parents? Tell me about some of the barriers you either have experienced or anticipate in implementing trauma-informed services? What are some of the challenges in treating client(s) who have experienced trauma
Strategies	How do you include successfully parents in trauma-informed services? What specific characteristics you consider when implementing these services? When treating a patient/client who has experienced trauma, what are signs you look for to know you are being received well? What context do you think works best for helping parents and children in trauma-informed services?

facilitators, we inquired about considerations and current recommended practices for effective implementation in services from a trauma-informed approach (e.g., "What context do you think works best for helping parents and children in trauma-informed services?").

Data Analysis

Qualitative data analysis of the transcribed interviews was conducted using ATLAS.ti 7 software (Muhr 2012). We utilized a template approach (Patton 2002) to guide the broad theme identification process and to generate a preliminary codebook using both prompts from the interview guide and thematic analysis (Braun and Clarke 2006) of six random transcriptions. To enhance trustworthiness, we held debriefing sessions between team members (Guba and Lincoln 1982; Shenton 2004). A final version of this codebook was used to complete the thematic analysis of all interviews. Trained research assistants, under close supervision of the lead author, coded all data. To ensure accuracy and to strengthen the reliability and credibility (Guba and Lincoln 1982) of the coding process, we used "analysis triangulation" (Patton 2002) in which "two or more persons independently analyze the same qualitative data to later compare findings" (Patton 2002, p. 560). Upon completion of coding, the lead author queried present and emerging codes across interviews. In addition, discrepancies were discussed among team members by referring to the coding template until consensus was reached to ensure codes reliably reflected the content of the transcribed interviews (Curran et al. 2010; Lempp and Seale 2004).

Results

Multilevel Barriers to Service Engagement and Delivery

Emerged themes highlighted systemic considerations trauma-informed occurring within mental health delivery that deeply connect to race and poverty. Themes largely related to multilevel barriers to service engagement and reflect historical patterns of marginalization and exclusion of minorities. This does not suggest that strengths do not exist within the Latinx community, but rather to contribute to an understanding of how these systemic barriers can be mitigated in the context of service provision. Multilevel barriers include societal, community and relationship/interpersonal factors the Latinx community experience as a result of marginalization. Relevant and meaningful quotations from the interviews representing our themes are presented in Table 3, organized according to the ecological model mentioned previously.

Societal Barriers

Generally, practitioners reported an awareness of trauma that is transgenerational and is more common in low-income communities with limited resources and high violence exposure. At this level, practitioners identified societal values and beliefs that related to the negative perception of trauma and stigma associated both with mental health conditions and with interventions as barriers to Latinx family engagement. Practitioners also acknowledged structural inequality including unfavorable socioeconomic circumstances that included families living in isolated communities and under impoverished conditions.

Stigma of Trauma and Mental Health Practitioners shared that they most commonly learned about children's and families' trauma exposure through conversations and observations rather than formal screening. They felt that the recommended formal screening and labeling of trauma would alienate Latinx parents who typically perceived a stigma around mental health. The negative perception of trauma and mental health issues was a prominent theme. This theme included the misutilization of the word trauma by families to overcategorize experiences deemed to be disturbing, and the undesirable attributions of the word within this community. Similarly, practitioners identified that the stigmatizing perceptions associated with these services lessened the likelihood of Latinx families to engage in services.

Structural/Historical Socioeconomic Conditions Another relevant theme that emerged was related to challenges Latinx families experienced related to transgenerational and precarious socioeconomic circumstances that deeply connect to structural inequity patterns, including residing in impoverished and isolated communities where access to mental health services and social support are limited.

Community and Contextual Barriers

At this level, participants noted barriers associated with the communities and environments that Latinx families are immersed in including mistrust in services and systems. At this level, practitioners also suggested engaging families in services was often difficult due to beliefs that trauma exposure is the norm as well the experience of ongoing and pervasive exposure of trauma within the community.

Family Mistrust in System A particular theme that emerged was the mistrust in service systems and providers experienced by Latinx families that stemmed from previous negative experiences within the system by families. Practitioners indicated that this mistrust hindered families' engagement

Table 3 Barriers to implementation, sub-categories and examples from data

Code	Example
Societal	
Stigma of trauma/mental health	"I think culturally, as well, we come across some barriers where seeking help for mental health or just resources has a negative stigma to it. So how do we overcome those stigmas and still be able to deliver services in a way that people are willing to accept?"—School Administrator "[A challenge is that] I do feel like the word trauma is getting used in places it shouldn't. I wish there was another like friendly word for it because you hear trauma and people freak out." "People shut down and don't want to talk about it."—Clinician
Impoverished/isolated communities	"Accessibility. If they are isolated, there is no way that they can make it to our school district. If they're isolated in support systems, there's no way that they're going to entrust in us to be able to provide support if they don't know what receiving support is in the first place, or if they've never been able to or been in a position or willing to."—Community Advocate "When you're working in a low-income neighborhood like this, its very prevalent, trauma is, and there is poverty everywhere. I mean we have kids here that will hoard we do free breakfast, free lunch, and they will hoard food because they don't have any at home."—Clinician
Community	
Mistrust in system	"A challenge is, for a lot of the families that we work with, they've been abused in systems and coerced in systems of care. And there can be a lack of trust or a misunderstanding of the role and of different providers."—Clinician "If they're isolated in support systems, there's no way that they're going to entrust in us to be able to provide support if they don't know what receiving support is in the first place, or if they've never been able to or been in a position or willing to."—Community Advocate
Normalization of trauma	"For the families that I work with there's a lot of generational trauma, so it's become very normalized and just kind of it's their experience and their life and so they don't always identify their experiences or difficulties as trauma or adverse experiences, and so they don't have a lot of knowledge in that."—Community Advocate "I think the other challenge we have is really the language barrier between adults and kids, and what kids identify as trauma to them versus what a parent would identify, right. And our generations are so different. Some of our parents approach it like, "Oh, I had to deal with way worse and I'm fine." So, you're not really in that bad a situation."—Social Worker
Continuous adversity exposure	"And so, especially working with parents, we see a lot of behaviors that are stemming from some of the adverse childhood experiences that they have, but parents don't have a whole lot of knowledge to that, and sometimes they're not so open to it because, again, it's kind of just their experience in what they've also been through."—Clinician "I even have a dad who bought his 4th grade son a BB gun to protect his 3rd grade sister if he's not there. Because out in the community, I do not know, I guess there is always fights and he needs to protect his sister. And just to think that a 4th grader was given the task by his dad. Who are we to tell them that his dad's wrong?"—Social Worker
Relationship/personal	
Family level trauma within relationships	"Working with parents, we see a lot of behaviors that are stemming from some of their adverse childhood experiences that they have, but parents don't have a whole lot of knowledge to that, and sometimes they're not so open to it because, again, it's kind of just their experience in what they've also been through. So, it can be really challenging to help them"—Social Worker "When you're mentioning the parents, a lot of our kids, it is their parents. And it's active in its current, and it's every day they're affected by it. It's heartbreaking, but it's very real."—School Administrator
Family level logistical obstacles to accessibility	"Many times, those families have not been able to navigate their insurance or lack of insurance and have not been able to get those services, or they've attempted it and they don't have transportation."—Clinician "They do great with online resources. Granted, that some of them may not have technology in their homes. Some of them may not have access to a printer. Some of them may not even know how to use a computer."—Social Worker

Table 3 (continued)

Code	Example
Individual level unaddressed personal trauma	"[A barrier is that] cumulative effect, too. Usually if there's more than one traumatic kids here, a lot of them have had that one event, maybe two events, but most of them are living in this chronic level of just stress, constantly stressed out."—School Administrator "Some challenges in engaging families, I think that the avoidance of surviving trauma. I mean avoidance, as a PTSD symptom, can become sort of globalized in families."—Clinician
Professional level perceived lack of relevant training	"I think the biggest thing is educators, first of all, don't have any training in going to school. They are never given any opportunities to learn about this topic. And I think there's so many academic pressures that it is overwhelming for them to think about academics and trying to build a relationship with the kid or kind of go outside of the box when they're working with them or using different approaches. Because our schools are not designed to be trauma-informed."—Clinician "[A challenge is] that I think there's a lot of misunderstanding, too, of where families are coming from and all that they face every day. For our clientele, who are living in a shelter, they do not have enough resources to go to stay with a friend or they cannot get a hotel to get safe. They grew up maybe in a domestic violence experience in their own childhood. So, I think that there's a social justice aspect and misunderstanding often for clinical providers. That is a big challenge. And I think naming that can be a help for families, like."—Social Worker

in mental health related programs both at school and in the community.

Continued Exposure to Trauma and Normalization Practitioners repeatedly noted that a major challenge in implementing services that come from a trauma-approach was the fact that the Latinx families they work with are continually exposed to sources of trauma, including from a transgenerational perspective, impeding families' effective participation and practitioners' knowledge and ability to engage families successfully. A frequent theme that emerged summarized the beliefs around normalization of trauma exposure. This theme included practitioners' perspectives that families believed trauma exposure was normative in both their community (e.g., neighborhood violence, and constant threat to physical safety) and within their own family unit. Families' anticipation of recovery after exposure to adversity was also discussed as part of the notion that trauma exposure was ordinary and expected.

Relationship and Interpersonal Barriers

Practitioners identified individual, or parental-, family- and practitioner-level, obstacles within and working with the Latinx community. Individual barriers included themes that encompassed pervasive individual trauma reactions stemming from their repeated exposure to traumatic events. Family-relevant barriers included practitioners' perceptions that trauma exposure occurred within the family unit and that families could face problems accessing services due to logistical barriers. Practitioner-level barriers included a perceived lack of ongoing culturally sensitive training, specifically regarding how culture intersects with services that are trauma-informed.

Individual Barriers Participants discussed that parents' own exposure to persistent events could result in traumatic reactions that contribute to children's unaddressed struggles with trauma responses. This was noted as a barrier to successful engagement in services, in part due to parents themselves being in constant survival mode.

Family Barriers Participants suggested that the presence of transgenerational trauma within the family unit or primary relationships (e.g., within the context of the caregiving system) contributes to difficulty engaging Latinx families in trauma-informed services. Practitioners noted the profound challenge of engaging parents who might be of the presence of trauma or who might, in fact, be perpetuating it. Logistical obstacles to service accessibility were noted as another facet of family-level barriers, including a lack of access to technology or transportation and lack of awareness of how to navigate the service system successfully.

Practitioner Barriers The theme summarizing practitioner-level barriers largely related to practitioners' perceived lack of culturally sensitive training and minimal competence on how to identify and address trauma from a cultural lens. School-based providers, in particular, highlighted that educators lacked training on how to recognize behavior that might originate from a child's trauma history. Rather, such students are often mislabeled problematic children. Because students spend a large amount of time in the school system, practitioners considered limited professional training of school staff as a barrier to building relationships and

engagement of Latinx families in services that are trauma-informed. Similarly, practitioners recognized that a barrier to successful service implementation originates from their own unawareness of the social and contextual circumstances that limit families' engagement in services. Practitioners highlighted the need to approach services from a social justice perspective.

Strategies for Incorporating a Trauma-Informed Approach Within the Latinx Community

Practitioner interviews were further queried for themes that indicated their current strategies and their perceptions of recommended practices for effective implementation of trauma-informed services with the Latinx community. Practitioners suggested that their work was primarily about building a meaningful individual rapport with families rather than following a specific treatment curriculum (e.g., suggested guidelines to screen for trauma or strict adherence to available guidelines). Specifically, practitioners mentioned that the exploration of trauma exposure was mostly identified through conversations, observations, and in spending time growing a relationship with children and their families. A clinician noted an effective practice was:

> "Spending a lot of your time trying to genuinely build that relationship with them and getting that rapport where you're able to deliver services in a way that they're willing to receive."

There was also a focus on themes that related to the utilization of a family centered approach by utilizing active listening skills and recognizing practitioners' active role in the practitioner-family relationship. Practitioners alluded to the fact that this was a best practice within this community as the recommended formal screening and labeling of trauma might make parents hesitant to participate due to a perceived negative stigma around trauma and services. For example, a social worker noted:

> "[Most important are] the parents and actually giving them a voice and actively listening to what they need makes them feel like they are being heard."

Another specific theme that emerged alluded to the ongoing need for practitioners in different systems (e.g., school or community mental health agencies) to be culturally competent. Cultural competency was found to be both a barrier to engagement when practitioners lack training and awareness of such, and a strategy to approaching families when they possessed this skill. Practitioners indicated that culture extends beyond the recognition of a family's race and ethnicity. They referred to their own intentional efforts around culturally competent behaviors as well as their own awareness of how to use these skills when trying to communicate with families from diverse backgrounds, particularly when engaging in a trauma-informed approach mindset and providing education around these topics. A salient quote from a community advocate is:

> "If you stop and think about the way we talk to people, when you look about cultural differences and we look at all those kinds of things, what you're saying, the message, can be somewhat similar but it's just how are you delivering that, right? How are you saying it, and are you saying it in a way that they can understand?"

Further, practitioners acknowledged that being culturally competent required the recognition of cultural variations in trauma responses and their lack of this understanding can hinder service engagement. An important consideration to buffer against this obstacle was the critical identification of the role of the broader community in service participation. The understanding of how culturally, communities can help in the engagement process seemed to be of important consideration. A clinician noted:

> "My experience has been that the Hispanic population can be ashamed of their child, their children with differences, and not even knowing that that is typical and normal. But they often tend to not want to participate, and they don't necessarily want to be a part of that conversation or they don't want people to know about it. So, making sure that we communicate about it in a way that is inclusive for families for participating. And the more we include all of their family and their community; it seems like that their response to it is a little bit better."

Discussion

This study used a qualitative approach to examine cultural considerations for the implementation of the trauma-focused delivery facet of a trauma-informed approach through the identification of multilevel barriers and facilitators from a community practitioner's perspective. Further, recommended practices to enhance engagement and continued participation of Latinx families were addressed. Importantly, the barriers that emerged from our theme analysis are not characteristics of families, but rather are a reality of their contexts, which reflect the generational and pervasive nature of structural inequities within our society. Overall, this study highlights: (a) the importance of acknowledging both historical and structural social forces in understanding families' risk and exposure to trauma and subsequent service engagement, (b) the value of utilizing an ecological framework in conceptualizing barriers experienced by practitioners when engaging Latinx families in trauma-informed services, and

(c) the necessity of focusing on the family and building meaningful relationships as a critical aspect of implementing a culturally responsive trauma-informed approach with Latinx families.

The underutilization of mental health services by minorities in the United States is one of the greatest ongoing health disparities (Nagayama Hall 2019; Flores and Vega 1998). A strong body of literature suggests that there are substantial disparities in trauma exposure by racial and ethnic group affiliation (Gjelsvik et al. 2013), outcomes in the aftermath of exposure, and in accessing relevant care (Steward et al. 2017; Alegria et al. 2002; Harris 2018). Our findings are consistent with previous literature on the identified mental health disparities faced by ethic/racial minorities, particularly the body of research that links access disparities with precarious social conditions including isolated and impoverished communities with high violence rates (Stolbach and Anam 2017). Particularly, this contributes to a limited literature body examining obstacles to family engagement in trauma-informed services for Latinx children and families (Gaillots 2010). This is critical in the current context in which exposure to adversity and trauma seem to be on the rise for minoritized communities (e.g., family forceful migration and separation and hate crimes; Bouza et al. 2018; Edwards and Rushin 2018). We highlight the need for enhanced practitioner training opportunities and resource development from a social justice perspective to aid in the understanding that barriers to services are perpetuated through the dynamics of marginalization. The combination of social inequities, disparities in trauma-related outcomes, ongoing adversity exposure, and less access to services places Latinx children and families at amplified risk for poor social and behavioral outcomes and makes our work on trauma-informed approaches both pertinent and critical not only for the field but also for other communities at risk of exclusion.

An ecological perspective was helpful in providing a wholistic understanding of practitioners' experiences of the multilevel mechanisms that operate and contribute to the successful implementation of trauma-informed services within Latinx families. This is particularly valuable because it remains unclear how culturally relevant mental health treatment and intervention programs are to minority communities (Kumpfer et al. 2002). The inclusion of cultural responsiveness remains a particularly underdeveloped area for the body of work on trauma-informed approaches (Hanson and Lang 2016). Because trauma reactions are largely embedded in the context in which they are present (Miller et al. 2019), understanding cultural considerations of trauma through the acknowledgment of multilevel barriers to engagement augments perspectives on culturally relevant recommended practices that have the potential to influence service outcomes. We believe the chosen multilevel theoretical framework was instrumental in unpacking the interconnection between ecologies, particularly, as it highlighted the profound role of the impact of continuous adversity exposure across levels. Under this framework, it is also important to note that barriers and strategies to implementation can be intertwined and might function together in a continuum. That is, cultural competency is seen as a desired skill among practitioners and a facilitator of service engagement for Latinx families, but a lack of cultural competence was perceived as a barrier to service engagement. This alludes to the complexity of trauma exposure and the inherited complexity in mitigating its multifaceted impact (Bath 2008). Further, acknowledging these multilevel obstacles provides us with a critical qualitative perspective useful in developing a culturally responsive trauma-informed model that centers cultural humility, equity and social justice as critical pillars to responsive care (Schulman and Gingrich 2017).

Broadly, practitioners identified barriers in family engagement of trauma-informed approaches that exemplify a critical limitation to service implementation. More specifically, we found practitioners experienced multilevel barriers to implementation that included negative societal values, poor socioeconomic circumstances, families' logistical obstacles, normalization of trauma exposure, trauma within the family unit, stigmatization of mental health services, and social isolation. Practitioners felt that their lacked relevant training in responsive practices might exacerbate the experience of these barriers. Though not clear in current guidelines, the essence of a trauma-informed approach entails seeing adversity and trauma from an ecological and cultural position (SAMHSA 2014), which is a perspective that traditional clinical models have yet to embrace (Maercker and Hecker 2016). Though our findings are consistent with previous research on access barriers to mental health for Latinx families (Hurtado-de-Mendoza et al. 2014), our specific research, to our knowledge, is one of the first to examine practitioners' perspectives of the multilevel barriers Latinx communities face when accessing trauma-informed services. One area our findings are inconsistent with extant literature is regarding immigration status as a constraint in service access for Latinx families. Specifically, undocumented and mixed-status families can face real and perceived limitations in accessing services, and hesitancy to service engagement (Bauldry and Szaflarski 2017). Despite this being documented in the literature, practitioners in the present study omitted explicit mention of families' immigrant status. Future research should specifically explore how families' immigration statuses influence their experience engaging in services from a trauma-informed lens, particularly as this deeply relates to structural factors to service engagement.

This study also aimed to examine practitioners' perspectives on current recommendations in trauma-informed

approaches to enhance engagement and continued participation of Latinx families. Previous research suggests that while there is a universal biological response to adversity and trauma, cultural factors can influence individuals' experiences, subsequent reactions to exposure, and treatment preferences (Perilla et al. 2002). Therefore, it is crucial to the efficacy of services for Latinx families that researchers and practitioners focus efforts on recognizing cultural considerations that impact the implementation of a culturally responsive trauma-informed approach. One of the recommendations identified by practitioners in the present included approaching families from a relationship-focused and family-centered style. This is consistent with earlier literature suggesting that the acknowledgment of cultural and contextual considerations of families lessens service obstacles by decreasing mental health stigma, helping increase service adherence, and facilitating rapport building (Alegria et al. 2010). We also found practitioners were intentional in being culturally competent as a salient strategy to approaching their work, despite their desire for more explicit training in this area. Their approaches included considering the dynamics of families and their culture. This supports the literature suggesting that culturally responsive mental health approaches are needed to minimize deterrents in seeking help experienced by minoritized communities (Bernal et al. 2009). Bridging the gap between the literature on culturally responsive services and trauma-informed services is needed to continue to reduce mental health disparities.

Lastly, our findings suggest that practitioners engaging in trauma-informed approaches understand the role of cultural competency to service delivery, but do not fully embrace the process of cultural humility to promote equity in mental health service accessibility. This supports recent advances in theoretical perspectives suggesting culturally competent services alone neglect to account for the role that structural inequities have in perpetuating health disparities (Abrams and Moio 2009; Powell 2016), and the necessity to embrace a perspective whereby cultural competent practices and cultural humility function together to decrease service inequity, and promote access to care for all (Campinha-Bacote 2019). Further, this underscores the essential need to explicitly tailor service frameworks to the unique context and priorities of minoritized communities (Schulman and Gingrich 2017). It also provides us with important service considerations on the pathways to recovery within diverse populations (Nagayama Hall 2019). Future work on culturally responsive trauma-informed approaches should focus on comprehensively exploring cultural humility in the implementation of trauma-informed services as a tool to continue aiding practitioners in recognizing the profound connection between trauma, culture and structural challenges. Considering this can be critical in ongoing efforts to overcoming multilevel barriers to service engagement.

Implications

The current study has important implications for both research and practice. Our findings highlight the importance of integrating a culturally responsive perspective in trauma-informed approaches, especially given the higher burden of trauma exposure and the underutilization of services within Latinx communities. It is critical to leverage socially responsive research and practices that are both inclusive and receptive to the unique needs and strengths of diversity. Based on our findings, a culturally responsive trauma-informed approach should recognize the vital role of social and contextual particularities that function at multiple levels and that influence whether or not families are able to successfully engage in services. Responding to culture and trauma should be a simultaneous process and should be incorporated within ongoing training and professional development opportunities for practitioners. A culturally responsive trauma-informed approach should also emphasize the significance of families' lived experiences, the promotion of equity, and the utilization of cultural humility. Specifically, we propose that a culturally responsive trauma-informed approach should:

- Support the understanding of the intersection between trauma and culture at multiple ecological levels
- Acknowledge the profound role of cultural values and beliefs in families' interpretations of trauma and in their expectations for their level and type of engagement with services
- Actively strive to build a safe space by grounding services in building relationships and rapport with families
- Understand the important connection between trauma exposure and structural inequalities by acknowledging the social and historical layers of adversity and trauma exposure

Limitations

Although this study has important contributions, it is not without limitations. As with any qualitative research design, the generalizability of this research is limited. This study is based on the perceptions of 20 community practitioners in a specific geographic location of the United States. Moreover, we recognize that the Latinx community is a heterogeneous group, and additional research is needed to elucidate further considerations in implementing culturally responsive trauma-informed approaches within this diverse population. Our primary goal was to explore practitioners' perspectives on barriers to and recommended practices in implementation of the trauma-focused delivery facet of trauma-informed approaches, and the practitioners we interviewed did not subscribe to one specific model in TSS. Thus, we were unable to uncover barriers of specific models of TSS;

future work should investigate differences between TSS frameworks, particularly as they apply to various behavioral health systems (e.g., schools, clinical practice, community-based practice). Participants also served a wide variety of families who engaged in services for various reasons, so we were unable to investigate differences in practitioners' perspectives based on the reason's families were receiving services. Understanding how families' reasons for engagement (e.g., mandated vs. voluntary; point-of-entry [clinical, schools, justice system, etc.]) influences practitioners' and families' experiences with trauma-informed services will be important for future work on culturally responsive trauma-informed approaches. Further, the present study was intended to unpack the barriers that influence trauma-informed service engagement among Latinx communities. Though it was our primary focus, is not to say strengths do not exist within the Latinx community, but rather to augment our understanding of how structural barriers to service accessibility can be lessen in the context of responsive service provision. Future work should specifically explore the unique cultural strengths of Latinx communities as facilitators of engagement in trauma-informed services. Our study findings are best understood under the particular contextual characteristics in which it took place and may not generalize to other minoritized communities. Further, these results derive from providers' insights, which are valuable in identification of themes across families but lack the detail families would provide of their personal experiences and positions. More work is needed from the perspective of Latinx families themselves in identifying culturally relevant practices and positive treatment outcomes, particularly as they relate to specific facets of trauma-informed approaches. Likewise, further work is needed to explore and recognize the complexities in implementing culturally responsive trauma-informed approaches at the organizational level. This information could provide the field with valuable strategies for program development and the creation of more inclusive policy efforts.

Conclusion

We sought to understand barriers to implementation of trauma-focused service delivery within a culturally responsive framework in order to promote the need for a culturally responsive trauma-informed approach that focuses on equity, centers social and family context, and emphasizes the value of cultural humility. Considering culture in the implementation of trauma-informed approaches is vital as this can influence the way in which families engage in services. This study enhances the literature in a number of ways including the identification of multilevel barriers to service engagement diverse communities face in accessing trauma-informed services and in identifying relevant strategies that are culturally relevant in hopes to help mitigate the existing multilayered disparities in mental health accessibility experienced by Latinx children and families.

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Compliance with Ethical Standards

Conflict of interest All authors of this manuscript certified responsibility of the final version. All authors declare that there is no known conflict of interest.

Ethical Approval University IRB approval was obtained (IRB approval number 00006925) and adhered to. Informed consent was obtained for all human subjects' research; this research did not involve animals.

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