

LAND, LAURA, Ph.D. *The Knowledge, Skills, and Attitudes That Are Foundational to Prepare Counselors-In-Training to Provide Trauma-Informed Counseling.* (2018)  
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Trauma is ubiquitous (Beck & Sloan, 2012; Kilpatrick et al., 2013).

Approximately 89.7% of U.S. residents reported experiencing at least one post-traumatic stress level event (Kilpatrick et al., 2013) as defined by the Diagnostic and Statistical Manual of Mental Disorder (5th ed.). Furthermore, trauma exposure has been recognized as a high priority public health risk (Beck & Sloan, 2012; Cook & Newman, 2014; U.S. Department of Health and Human Services, 2003). Events including the war in Afghanistan, devastating natural disasters such as Hurricane Katrina, and the terrorist attacks of September 11th have increased societal awareness of trauma and the potentially adverse psychological and physical consequences of exposure. This heightened awareness is expected to increase the number of trauma survivors recognizing the effects of trauma, and in turn, increase the proportion of individuals seeking mental health services. Since counselors working in various mental health settings will most likely be working with survivors of trauma, it is imperative that their education include the necessary information leading to a foundation of competence (Layne et al., 2014). Although not all counselors who encounter trauma-related issues are expected to have a specialty in trauma work, there is an increased need for trauma-informed care as counselors-in-training encounter trauma-exposed populations in their pre-service training (The Substance Abuse and Mental Health Services Administration, 2014).

Despite the high rates of trauma-exposure among U.S. residents, increased awareness of the effects of trauma, and the growing base of scientific literature, extensive

coverage of trauma is not a core component of the standard curricula in graduate counseling programs (Courtois & Gold, 2009; Layne et al., 2014; Litz & Salters-Pedneault, 2008; Logeran et al., 2004). Furthermore, official trauma counseling competencies to inform the education and training of counselors have not yet been identified (Layne et al., 2014; Mattar, 2010; Turkus, 2013). Counselor educators are challenged with integrating the appropriate trauma training and education, while trying to meet the many program goals related to program and institutional accreditation standards. However, trauma-informed training, a holistic, person-centered approach that incorporates the biological, psychological, cultural, and social impact of trauma on an individual (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014), requires students to possess unique knowledge, skills, and attitudes. Counselor educators must also consider the unique nature of the topic of trauma and the pedagogical approaches they use to effectively facilitate student learning.

When competencies or guidelines are lacking within a certain research area, consensus opinion from experts, aids in providing a framework for effective development and practice (Powell, 2003). This study utilized the Delphi method to capture multiple perspectives and explore consensus opinions among experts regarding the knowledge, skills, attitudes, and teaching practices counselor educators deemed as foundational to prepare master's counseling students to encounter trauma-exposed individuals. Second, by drawing from the collective opinions of counselor educators with expertise in trauma treatment, supervision, and education, the study sought to establish a baseline and move towards the development of a set of guidelines for trauma training and education specific to

the field of counseling, rather than adapting or adopting trauma guidelines and competencies developed by other disciplines. The findings of the current study arose out of the belief system of counseling professionals and may serve as an initial framework to support the professional development and training of counselor educators by providing an empirically derived set of trauma education and training guidelines. Findings may in turn aid in the further refinement and implementation of trauma training and curriculum.

THE KNOWLEDGE, SKILLS, AND ATTITUDES THAT ARE FOUNDATIONAL TO  
PREPARE COUNSELORS-IN-TRAINING TO PROVIDE  
TRAUMA-INFORMED COUNSELING

by

Laura Land

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Approved by

J. Scott Young  
Committee Co-Chair

Carrie A. Wachter Morris  
Committee Co-Chair

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## CHAPTER I

### INTRODUCTION

#### **Rationale for the Study**

Physical and psychological responses to emotional trauma is a high priority public health risk (Beck & Sloan, 2012; Solomon & Johnson, 2002), with approximately 89.7% of United States residents having experienced at least one posttraumatic stress-disorder level event (Kilpatrick et al., 2013) as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). The U.S. Department of Health and Human Services (2003) called for improved mental health strategies due to the ubiquity of trauma and the associated risk factors for adverse physical and psychological consequences (Green et al., 2010) including poor physical health conditions, increased rates of diagnostic comorbidity with psychological disorders (Galatzer-Levy, Nickerson, Litz, & Marmar, 2013), and substance use disorders (Kilpatrick et al., 2013). Considering the widespread prevalence and greater awareness of trauma exposure in our society (2013), increased recognition of the severity of its impact at different levels (see The Adverse Childhood Experiences Study, Edwards et al., 2003), and recent advances in the scientific, cultural, and relational understandings of the effects of traumatic stress (Briere & Scott, 2006; Courtois & Gold, 2009; Levers, 2012; Mattar, 2011), it is vital that mental health providers receive foundational education about trauma as an important aspect of mental health services.

In recent years, there has been an increased call for trauma education in graduate counseling programs (Cook & Newman, 2014; Courtois, 2002; Courtois & Gold, 2009; DePrince & Newman, 2011; Mattar, 2011) due to the prevalence of trauma in populations and developments in the field of counseling and allied professions (e.g., advancements in pedagogy, neurobiology, cultural considerations, and evidence-based practices).

Education about trauma and its effects are increasingly, though not universally included in the professional counseling curricula (Courtois & Gold, 2009; DePrince & Newman, 2011). Although trauma-related components are included throughout CACREP's standards (2015), there is a dearth of research related to the specifics of what counselor educators should incorporate into the curriculum of masters counseling programs to prepare counselors-in-training to a level of competence to provide trauma-informed care. This research study explored the lack of knowledge surrounding the preparation of counselors-in-training to provide trauma-informed counseling to exposed individuals.

### **Trauma and Posttraumatic Stress Defined**

Defining and conceptualizing trauma is dynamic, complex, and widely debated (Brewin, Lanius, Novac, Schnyder, & Galea, 2009; Weathers & Keane, 2017). The use of multiple definitions adds to the challenge of addressing trauma education (Vujanovic & Schnurr, 2017; Weathers & Keane, 2007). In the 19th century Pierre Janet and Sigmund Freud provided the first characterizations of the impact of traumatic events (Herman, 1992). As cited in Levine's (1997) book, *Walking the Tiger: Healing Trauma*, Freud defined trauma as "a breach in the protective barrier against stimuli leading to feelings of overwhelming helplessness" (p. 197) and met much contention regarding his

characterizations of the etiology of trauma (Herman, 1992). Contemporary definitions initially grew from research studies of soldiers' reactions to war (van der Kolk, 2007). As awareness increased about the adverse consequences of sexual and domestic violence, attention shifted to the examination of psychological trauma on multiple fronts, leading to the inclusion of the post-traumatic stress disorder (PTSD) diagnosis in the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980; Herman, 1992).

Conceptualizations of trauma evolved along with changes in mental health diagnosis (Courtois & Ford, 2013; Levers, 2012). A greater understanding of traumatic stress has developed since PTSD was first introduced as a diagnosis in the DSM in 1980 (Vujanovic & Schnurr, 2017). In response, the diagnostic criteria for PTSD has changed several times as both the definition of traumatic exposure and conceptualization of symptomatology shifted (2017). At present, trauma is defined by the DSM-5 as,

exposure to actual or threatened death, serious injury, or sexual violence by either directly experiencing the traumatic event(s), witnessing the event(s) in person as it occurred to others, learning that the traumatic event(s) occurred to a close friend of family member, or experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (American Psychiatric Association, 2013, p. 265).

Some writers have argued this definition pathologizes clients excluding important considerations and that it cannot be applied culturally in an ethical fashion (Droždek and Wilson, 2007; Lasiuk & Hagadoren, 2006; Mattar, 2011). For instance, Briere and Scott (2015) stated DSM-5 definition is limiting because actual or threatened death, serious injury, or sexual violence need not occur for people to perceive an event as traumatic.

Furthermore, trauma is subjective. An event may be experienced as traumatic for one individual and not for another (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012, p. 8).

It is crucial to understand the definition of psychological trauma in the DSM-5, as most clinical work in the United States is conducted using these diagnostic criteria. However, for the purposes of the proposed study, additional relational and cultural conceptualizations of trauma are necessary. Given the history and politics of diagnosis, which has sometimes been used in disparaging ways (Courtois & Ford, 2013), it is beneficial to consider various definitions of trauma derived from research, practice, and survivor knowledge (Briere & Scott, 2006; Courtois & Gold, 2009; Levers, 2012, SAMHSA, 2014). SAMHSA (2014) expanded on the definition of trauma as resulting from an event, series of events, or set of circumstances that is experienced by an individual as “physically or emotionally harmful or life threatening and that has adverse effects on an individual’s functioning, and mental, physical, social, emotional, or spiritual well-being” (p. 7). Levers (2012) added that the influences of trauma may manifest in various ways; some may be individually or collectively experienced, whereas others appear to be more culturally and historically based (Mattar, 2011). Other authors stressed how frequently trauma occurs in relational and cultural contexts and recommended the expansion of conceptualizations of trauma (Courtois & Gold, 2009; Dalenberg, 2000; Mattar, 2011). This recommendation is underscored by the benefits of the relational tenets of counseling to trauma recovery, and the relevance of different aspects of culture

to assessment, diagnosis, and intervention (Courtois & Gold, 2009; Wells, Trad, & Alves, 2003; Saakvitne, Gamble, & Pearlman, 2000).

In sum, understanding the many definitions and conceptualizations of trauma may lead to a greater recognition of an array of traumatic stress symptoms. In the proposed study, trauma is defined as exposure to or actual threat of an event, series of events, or circumstances that may be experienced individually or collectively as physically or emotionally harmful and that has lasting adverse effects on mental, physical, social, spiritual, and/or emotional well-being. Additionally, trauma may have a cultural, historical, sociopolitical, universal, and/or relational base. This definition explicitly includes relational and cultural considerations in the conceptualization of trauma (Briere & Scott, 2006; Courtois & Ford, 2013; Levers, 2012; Mattar, 2011).

**Trauma prevalence.** The prevalence of trauma and trauma exposure in society is evident (Beck & Sloan, 2012; Kilpatrick et al., 2013). Solomon and Johnson (2002) reviewed post-traumatic stress treatment outcome research and concluded that (a) most individuals in the United States have experienced at least one traumatic event, and (b) the sharp increase in published literature and new treatment related to post-traumatic stress can be understood in the context of increased experiences of traumatic stress. Beck and Sloan (2012) found among a national sample, 82.2% of participants reported exposure to a traumatic event. The prevalence of trauma exposure is cause for concern, as research has linked trauma exposure to adverse physical and psychological health conditions (e.g., depression, substance abuse, STD's, cancer, heart disease, lung disease, and diabetes

associated with early exposure to trauma (Anda, Felitti, Tendall, van der Kolk, & Redding, 2014).

### **Historical Approaches to Trauma Recovery**

The field of traumatic stress has rapidly developed, with three distinct generations of movements that have gradually shifted to more personalized approaches (Harris & Fallot, 2001; Salasin, 2011, van der Kolk, 2011). The first generation of approaches to trauma recovery addressed more of the clinical interventions and individual symptoms of PTSD among veterans (Salasin, 2011). Then, recognition of various groups with trauma histories (e.g., refugees, immigrants, and survivors of assault and natural disasters), in addition to veterans, spurred the need for a second generation of approaches (2011). The second generation of trauma intervention and recovery approaches concentrated on psychosocial and educational empowerment (Figley, 2002; Salasin, 2011). Often based on peer support models, approaches were designed to tap into self-healing forces and were intended to supplement clinical treatment. An important discovery was made that if approaches were not comprehensively integrated into a structured program, their effectiveness waned (2011). Finally, a third generation of approaches developed, known as the trauma-informed approach (Harris & Fallot, 2002). This approach introduced a new paradigm for trauma care guided by assumptions that every individual seeking services was a trauma survivor (Salasin, 2011). This trauma-informed approach moved from a hierarchical clinical model to a psychosocial collaborative model that is more person-centered (Harris & Fallot, 2001; Herman, 1992). This study draws heavily from this third-generation approach to trauma.

**Trauma-informed approach.** A “trauma-informed approach,” as defined by SAMHSA (2014, p. 4) is one where biopsychosocial case conceptualizations guide trauma recovery plans (Bala & Kramer, 2010). This approach is grounded in the following four assumptions: (1) “A trauma-informed approach is a program, organization, or system that realizes the widespread impact of trauma and understands potential paths for recovery; (2) Recognizes the signs and symptoms of trauma in clients, families, and others involved with the system; (3) Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and (4) Seeks to actively resist re-traumatization” (SAMHSA, 2014, pp. 9–10). It aligns well with key tenets of counseling in that both perspectives promote resilience, hold a belief in client recovery, focus on strengths rather than pathology, seek to establish trust and safety, promote considerations of cultural, historical, and gender issues, utilize evidence-based practices, promote empowerment, voice and choice, collaboration, and mutuality between the counselor and client (Harris & Fallot, 2001; Herman, 1992; Levers, 2012; SAMHSA, 2014). A trauma-informed approach aligns well with entry-level training because it encompasses the cultural, biological, psychological, and social impact of trauma on an individual. A critical dimension of a trauma-informed approach is that adopting this view may require a fundamental cultural shift that is intended to promote awareness of equality and safety. At times the very institutions and service systems that are intended to provide counseling services and supports to individuals are often inadvertently trauma-inducing or re-traumatizing. Trauma has no bounds regarding age, gender, socioeconomic status, race, ethnicity, sexual orientation, or geography. For individuals with mental and substance use

disorders, individuals within the juvenile and criminal justice system, and children and families in the welfare system, trauma is an almost universal experience (Ford, 2013).

**Cultural, relational, and medical approaches.** Parallel to third generation trauma-informed counseling movement, renewed interest in the relational (Briere & Scott, 2006; Courtois & Gold, 2009) and multicultural components (DePrince & Newman, 2011; Mattar, 2011) essential for trauma care have emerged in the research. These developments have occurred alongside the longstanding bio-medical conceptualization of trauma (Harris & Fallot, 2001; Levers, 2012; Mattar, 2011; van der Kolk, 2002). Growing attention to understanding the roles of culture, attachment, and biopsychosocial factors (e.g., sociodemographic, genetic, and structural brain correlates) implicated in risk and resilience, have paved the way for more intensive scientific study of PTSD (Vujanovic & Shnurr, 2017). This emphasis has focused on bridging the understanding of relationally responsive, culturally responsive, and empirically informed practices (DePrince & Newman, 2011). Rarely have these three schools of thought met within the context of trauma education (Mattar & Figley, 2010). This leads to a discussion of trauma education in the field of counseling.

### **Training in Counselor Education**

The bounds within which counselor educators prepare students are specific to time as well as the context of accredited master's counseling programs. Counselor education programs are governed by higher education accrediting councils and national associations which set forth standards and competencies to ensure academic quality, including The Council for Accreditation of Educator Preparation (CAEP), The Council

for Accreditation of Counseling and Related Educational Programs (CACREP), The American Counseling Association (ACA), and regional accrediting bodies, such as The Commission on Colleges of the Southern Association of Colleges and Schools (COCSACS). At the same time, this education is impacted by contemporary movements in the field of education (e.g., competency-based movement in education, evidence-based approaches to education, and traditional constructivist approaches to learning) (Fouad et al., 2009; Bray, 2010; Wilkinson & Hanna, 2016). Further, the field of counseling holds unique perspectives that impact the context of training and education and differentiate counseling from other mental health disciplines. For instance, the field of counseling retains a developmental perspective across the lifespan (Zalaquett, Fuerth, Stein, Ivey, & Ivey, 2008); adheres to a strengths-based approach (Eriksen & Kress, 2005); is contextually-focused (Comstock et al., 2008; Duffey & Kerl-McClain, 2007); affirms a person-centered/relational approach (Myers, Sweeney, & Witmer, 2001; Rogers, 1959); and promotes the use of evidence-based practices (Briere & Scott, 2006; CACREP, 2015), as well as cultural considerations in counseling practice (Foa, Keane, Friedman, & Cohen, 2009).

**Competency model of education.** Like many other education and allied mental health professions, counselor education is moving towards a competency-based model of education and assessment (Ancis, 2004; American Psychological Association, 2006; Burke, 1989; Chapman et al., 2004; Holcomb-McCoy & Myers, 1999). Competence has been defined in a variety of ways across disciplines, yet it is an expected outcome of training (Epstein & Hundert, 2002; Ridley, Mollen, & Kelly, 2011). Myers (1992)

affirmed that competency is an essential component of professionalism and that “competencies are the areas in which professionals should be capable of performing to a certain standard” and “that standard is typically set by a profession” (p. 3). Toporek, Lewis, and Crethar (2009) agreed that counselor competency was essential for ethical practice and should include the operationalized knowledge, skills, and attitudes necessary for counselors to engage in ethical and informed clinical practice (Ratts, Toporek, & Lewis, 2010; Sue, Arredondo, & McDavis, 1992). For the purposes of the proposed study, trauma-related competency is defined as the minimal knowledge, attitudes, and skills a counselor working with populations exposed to trauma ought to possess.

**Trauma education standards in counselor education.** CACREP has identified standards related to trauma as a mandatory part of graduate counseling programs (2015). While these standards are helpful in delineating general trauma-focused knowledge and skills for entry-level master’s students, they provide only minimal guidance for designing and implementing trauma training (Courtois & Gold, 2009). The 2016 CACREP Standards related to trauma include understanding procedures for identifying trauma and abuse and for reporting abuse (Standard 2.F.7.d.); crisis intervention, trauma-informed, and community-based strategies (Standard 2.F.5.m.); effects of crisis, disasters, and trauma on diverse individuals across the lifespan (Standard 2.F.3.g.); the impact of crisis and trauma on individuals with mental health diagnoses (Standard 5.C.2.f.); the impact of crisis and trauma on individuals with disabilities (Standard 5.D.2.h.); roles of college counselors and student affairs professionals in relation to the operation of the institution’s emergency management plan, and crises, disasters, and trauma (Standard 5.E.2.b.);

impact of crisis and trauma on marriages, couples, and families (Standard 5.F.2.g.); school counselor roles and responsibilities in relation to the school emergency management plans, and crises, disasters, and trauma (Standard 5.G.2.e.); and awareness and understanding of the impact of crisis, trauma, and disaster on individuals with disabilities; as well as the disability-related implications for emergency management preparation (Standard 5.H.2.g). Notably, the semantics related to trauma have often grouped trauma, crisis, and natural disaster together through much of the standards and counselor education literature.

The ACA also identified competency standards in their *Code of Ethics* that may inform trauma education and competent practice because a level of competence is deemed as essential for ethical and professional counseling practice (ACA, 2014). Specifically, the *ACA Code of Ethics* (2014) stipulated that counselors are only to practice within the boundaries of their competence. The field of counseling has long recognized the need for continuing education, so counselors could acquire and maintain knowledge of current scientific and professional information. Even so, most counselors only have a cursory knowledge of the impact of trauma and treatment (Cook, Rehman, Bufka, Dinnen, & Courtois, 2011). The *Code of Ethics* stipulated that counselors are to maintain competence in skills, remain open to new procedures, and remain informed regarding best practices to use with diverse populations (ACA, 2014). These standards related to counseling competence are important to consider when surveying educational practices and what foundational preparation of counselors-in-training is needed since these are the bounds within which counselor educators teach. Counselor educators must

provide instruction within their areas of knowledge and competence, as well as providing instruction based on current information and knowledge available (ACA, 2014, Standard F.7.b.). Ultimately, counselor educators are faced with the challenge of providing education in the face of the large and growing body of scientific literature on traumatic stress while meeting the professional standards set forth by the ACA (2014) and the 2016 CACREP standards (2015). DePrince and Newman (2011) indicated there are many stakeholders who have a vested interest in trauma education (DePrince & Newman, 2011). Thus, it may be beneficial to look to allied disciplines for direction on how to best implement foundational components of trauma education.

A review of the literature on trauma education yielded useful insights, controversies, best practices, and suggestions for future research. Yet, among this rich literature, there are relatively few sources explicitly addressing trauma education in counseling (Black, 2008; Courtois, 2002; Courtois & Gold, 2009; McCammon, 1995; Sommer, 2008). DePrince and Newman (2011) discussed that in general, there are a lack of higher education programs that emphasize trauma education. Furthermore, methodologies for describing and evaluating educational approaches are still developing in the profession of counselor education (Minton, Morris, & Yaites, 2014; DePrince & Newman, 2011; Sexton, 1998; Wilkinson & Hanna, 2016). An empirical knowledge base has been called for to first provide a foundation for trauma preparation in counselor education (Black, 2008; Courtois & Gold, 2009; Mattar, 2011; Sommer, 2008).

Several clinical educators in the counseling profession documented their experiences teaching trauma courses and have provided valuable recommendations for

increasing student resilience, reducing the risk of vicarious trauma, and creating safe frames for learning (McCammon, 1995; Pearlman & Saakvitne, 1995; Sommer, 2008). Although these works called for curricular inclusion and offered valuable pedagogical practices and anecdotal guidance, (Courtois & Gold, 2009; McCammon, 1995; Miller, 2001), they were not based on systematic research. There is a paucity of empirical research related to trauma training in counselor education (Black, 2008; Courtois & Gold, 2009; DePrince & Newman, 2011; Sommer, 2008).

One empirical study was found in the field of counselor education directly related to trauma education (Black, 2008). Black (2008) investigated the application of trauma treatment principles (i.e., in-class resourcing, titrated exposure to traumatic material, and reciprocal inhibition) applied to a classroom of ten students. Although this pilot course on trauma provided useful information, the results were based on students' answers to a 7-item questionnaire that the researcher created. There were no psychometrics established for this questionnaire and the course evaluations were based on students' self-report (2008). Also, with no comparison group, the impact that the implementation of trauma principles had on participants could not be adequately measured or generalized. Additionally, no specific content of the trauma curriculum was relayed. Without first establishing key trauma-related components, the systematic evaluation of trauma training in counselor education is stymied, and it remains difficult to assess how counselor educators are meeting the accreditation standards related to trauma and what information they are teaching to prepare counselors-in training for trauma work (Minton et al., 2014).

A conceptual article in the field of social work directly addressed effective trauma education. Carello and Butler (2014) suggested that trauma education in the classroom should mirror principles of trauma-informed care (Carello & Butler, 2014; Harris & Fallot, 2001). The authors presented guidelines for the application of five trauma-informed principles (Harris & Fallot, 2001). Harris and Fallot's five guiding principles to be incorporated into a program as indicators of a trauma-informed approach included ensuring physical and emotional safety; maximizing trustworthiness through clear service delivery; consistency, and establishment of interpersonal boundaries; maximizing the client's experience of choice and control; collaboration and power-sharing; and the prioritizing of client empowerment and skill-building to promote safety in the classroom for trauma-sensitive social work education (Carello & Butler, 2014).

Lastly, Newman (2011) conducted a pilot study that explicitly addressed trauma education in the field of psychology. In this empirical study, Newman developed a specialized course in traumatic stress for graduate clinical psychology students (2011). She developed a self-report model for assessing pedagogical goals and utilized mid-year evaluations, as well as pre- and post-assessment methods (2011). Eleven students participated in course evaluation of learning outcomes, self-assessment, and reactions by completing a 30-item survey specific to the course goals (2011). The mid-term evaluation contained seven relevant trauma course competencies that students rated as favorable including articulating the etiological theories of mental illness and applying this knowledge to case studies, planning and intervention, applying knowledge about the scientific basis for interventions, and collecting and analyzing data and assessments

(2011). Students reported the need for additional training in differential diagnosis, knowledge about the impact of diversity on assessment and intervention, and ethical research and clinical decision-making (2011). Newman utilized this course on trauma to discuss the implementation, challenges, and assessment of a specialized course in traumatic stress (2011).

The literature in counseling and allied professions, provides insight into the unique nature of trauma education and delineates critical interconnections to movements in counseling, psychology, and social work (e.g., culturally responsive practices, empirically informed services, neurobiological dimensions, and relational considerations) (Cook & Newman, 2014; Cook et al., 2011; Courtois & Ford, 2013; DePrince & Newman, 2011; Mattar, 2010; Wells et al., 2003; Turkus, 2013). Allied fields also provide empirical support that may aid in the establishment of a foundation for trauma training in counselor education. Researchers have called for further investigation of trauma education utilizing empirical means of inquiry and have indicated the need for a comprehensive framework for teaching trauma to graduate students (Black, 2006; Carello & Butler, 2014; Cook et al., 2011; Courtois & Gold, 2009, DePrince & Newman, 2011; Levers, 2012; Newman, 2011). It would serve the counseling field well to identify the key content, skills, and attitudes that trauma counselors must possess (Courtois & Gold, 2009; Newman, 2011). The identification of key elements of effective trauma counseling would facilitate the development of appropriate course material, as well as assessment strategies for measuring student learning. To date however, no researchers have empirically studied the knowledge, skills, and attitudes necessary for successful trauma

education and training (Courtois & Gold, 2009; Levers, 2012). Generally, faculty members are eager for guidelines for preparing counselors skilled in treating trauma; however, such guidelines do not yet exist (Carello & Butler, 2015).

### **Statement of the Problem**

Psychological responses to trauma is ubiquitous and exposure to traumatic events is a risk factor for adverse physical and psychological health conditions (Kilpatrick et al., 2013; Anda et al., 2014). Given that most graduate students will encounter trauma-related issues in their pre-service training and entry-level positions, regardless of specialty or context, trauma training is a necessary component of the counseling curriculum (Courtois & Gold, 2009). However, despite the greater emphasis on trauma education and training that has emerged as a result of rapid developments in the field of traumatology and greater societal awareness, the profession does not have a research-based understanding of the foundational knowledge, skills, attitudes, and teaching practices that are needed to prepare counselors-in-training to provide trauma-informed counseling. The preparation of students and what counselor educators are teaching has been only minimally examined (Black, 2008; Courtois & Gold, 2009; McCammon, 1995). For counselor educators to prepare counselors-in-training to effectively treat trauma, we must first reach agreement regarding the foundational knowledge, skills, attitudes, and teaching best practices that are being used within the field. Developing this baseline information would help counselor educators incorporate trauma education into their curricula by giving breadth and depth to the CACREP standards. Counselor educators need experts to reach agreement regarding the key components of effective trauma training, as this would serve

as a basis for implementing more sophisticated trauma education. Such clarity among experts will support ethical and informed trauma education and clinical practice with trauma-exposed populations. Currently, however there is a noticeable lack of research that has sought to determine what specifically counselor educators need to include in their curriculum to prepare students to encounter trauma-exposed populations and provide trauma-informed counseling.

### **Purpose of the Study**

The purpose of the proposed study is the formation of an empirically-based set of guidelines for trauma education that are specific to counselor education. To determine what trauma training is essential, consensus opinion among a set of recognized experts is needed. This will be accomplished using the Delphi methodology (Linstone & Turoff, 2002) to solicit opinions from a panel of experts as to what they deemed as the knowledge, skills, and attitudes that are foundational to prepare counselors-in-training to provide trauma-informed care as they encounter trauma survivors. The results of the research will be used to identify baseline that should be a part of master's students' preparation in graduate counselor education programs by identifying areas of consensus among counselor educators with expertise in trauma. The results can function as preliminary guidelines for counselor educators to prepare counselors-in-training.

Building upon the research from allied mental health fields in trauma education, the identification of the knowledge, skills, and attitudes that experts identify as foundational for the education and preparation of counselors-in-training to competently care for trauma-exposed individuals may be used to understand what pedagogical

components should be included in the education of counselors-in-training. It is possible that a lack of understanding of what is necessary for trauma preparation in counseling may be a part of why trauma education and training is so minimally emphasized in graduate counseling programs (Courtois & Gold, 2009), even though issues related to trauma are frequently encountered by students (2009). The Delphi method facilitated the process of knowledge generation by experts and explored what they deemed as the foundational components needed for the trauma training and education of entry-level counseling students in graduate counseling programs. Establishing crosscutting guidelines that are specific to counseling to form an empirically derived baseline will be a critical first step towards identifying components of effective trauma education. The proposed study addressed the following research question:

### **Research Question**

**Research Question:** What do a group of counselor educators with clinical expertise in trauma deem as the knowledge, skills, and attitudes that are foundational to prepare counselors-in-training in masters counseling programs to provide trauma-informed counseling?

A secondary aim was to investigate and collect data from the expert panel related to trauma pedagogy in counselor education. There was no intention of seeking consensus, nor analyzing this data as it was collected to be used for future research.

### **Need for the Study**

As the movement unfolds to incorporate trauma in the standard training of entry-level counselors (Courtois, 2002), it is imperative to ensure students are prepared with

foundational knowledge for entry-level trauma work (Courtois & Gold, 2009), since counselors-in-training will encounter trauma-related concerns in various settings regardless of context or specialty (Courtois & Gold, 2009; Layne et al., 2014). With little known about the content and teaching practices of trauma education, gathering relevant information to ensure students are prepared to an entry-level of competence in trauma seems expedient. To meet this end, obtaining knowledge from counselor educators teaching masters students about trauma to ascertain what they are teaching and how they are conveying this knowledge is necessitated. In turn, information gained may aid in the development of education and training in graduate counseling programs (Courtois & Gold, 2009; Mattar, 2010; Morotta, 2009). Foundational components of trauma training and education identified by counselor educators with expertise in trauma would help to fill the gap in service by incorporating trauma in more sophisticated ways into curriculum, aid in educators' professional development, and better prepare students to match the trauma exposure rates found in the general population with competent care (Kilpatrick et al., 2013). In turn, the development of curricula and assessment strategies for measuring these guidelines could be developed.

### **Definition of Terms**

*Attitude* is an individual's predisposed state of mind or emotional disposition regarding a value. It is precipitated through a responsive expression toward a person, place, thing, or event which in turn influences the individual's thought and action (Allport, 1935). The attitude of a person is determined by psychological factors like ideas, values, beliefs, perception, etc. (Ajzen, 2001).

*Culturally responsive research and evaluation* considers the context of culturally specific factors and demographic variables which may require special representation or attention in unique ways to acknowledge and account for culture and nondominant communities in the design, methodology, and analysis of a studies data gathering and interpretation. Frierson, Hood, and Hughes (2002) developed a model for culturally responsive evaluation (CRE) and have since expanded on the model (Hood, Hopson, & Frierson, 2005; Hopson, 2009). This ecologic description embeds culture within a larger, fundamentally interconnected social system that is composed of a “hierarchy of social forces” (Guzman, 2003, p. 174). The ecologic definition thus depicts the location of culture, as well as the context in which it is to be understood. It provides a conceptual bridge between culture and context, two terms that have significance in the cross-cultural literature (Guzman, 2003).

*Evidence-based practice* is “the integration of the best available research with clinical expertise in the content of patient characteristics, culture, and preferences” (American Psychological Association, 2006, p. 273).

*Knowledge* may be discipline specific content including concepts, theories, and foundational information.

*Pedagogy* is the discipline that deals with the theory and practice of education; it concerns the study of how best to teach including the teaching practices, approaches, methods, and theories employed to effectively teach (Westbrook et al., 2013).

*Re-traumatization* refers to the triggering or reactivation of trauma-related symptoms originating in earlier traumatic life events. It is a risk for those confronted with

new traumatic material or cues of an earlier adverse event (Carello & Butler, 2015; Pearlman & Saakvitne, 1995).

*Relational perspective* is a framework for the social sciences that emphasizes the salience of interpersonal relationships for mental health and well-being (Smith & Montilla, 2013).

*Skills* indicate an ability and capacity acquired through deliberate, systematic, and sustained effort to effectively and adaptively carryout complex activities or job functions involving ideas (cognitive skills), things (technical skills), and/or people (interpersonal skills).

*Teaching Practice* is the application or use of an idea, belief, method, theory, or approach.

*Trauma* may be experienced as individual or collective trauma resulting from exposure to or experiencing of an event, series of events, or set of circumstances experienced as physically or emotionally harmful or life threatening and that has lasting adverse effects on overall functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2014, p. 7). Trauma may be culturally, historically, universally, or relationally based (Mattar, 2011).

*Trauma competency* is defined as the necessary knowledge, skills, attitudes, and pedagogical practices counselor educators believe are necessary for an entry-level of competence in counseling practice (Rodolfa et al., 2005).

*Trauma-informed approach* is an approach developed by Harris and Fallot (2001). Trauma-informed care and trauma-informed approach are used interchangeably. This

approach describes clinical practice informed by the knowledge, skills, and attitudes essential to healing from the effects of traumatic stress (SAMHSA, 2014). A central tenet is that individual safety must first be ensured through efforts to minimize the possibilities for inadvertent re-traumatization, secondary traumatization, or new traumatizations in the delivery of services. TIC utilizes trauma theory to design service systems to improve clinical practice and service delivery. To be trauma-informed is to understand the ways in which violence, victimization, and other traumatic experiences may have impacted the lives of the individuals involved and to apply that understanding to the design of systems and provision of services so they accommodate trauma survivors' needs and are consonant with healing and recovery (SAMHSA, 2014). A trauma-informed approach includes research, clinical practice, and the voices of trauma survivors to inform conceptualizations of trauma and trauma care (Harris & Falot, 2001; SAMHSA, 2014), and "emphasizes physical, psychological, and emotional safety for both providers and survivors in the delivery of services to improve clinical practices (Hopper, Bassuk, & Olivet, 2010, p. 82; SAMHSA, 2014). A trauma-informed approach "1) realizes the prevalence and influence of trauma; 2) recognizes how trauma affects all individuals involved in the program, organization, or system; 3) responds with trauma-sensitive practices and policies; and 4) works against re-traumatization" (SAMHSA, 2012, p. 4).

*Trauma-related competency* is defined here as the minimal "knowledge, skills, and attitudes" (Hatcher et al., 2013, p. 1; Sue et al., 1992) that are foundational for counselors-in-training (i.e., entry-level master's counseling students) to possess as they encounter trauma-exposed individuals. Unlike other competencies which were developed

to apply to a generalized audience or those that are orientation specific (e.g., cognitive-behavioral), these competencies are designed to apply across trauma-exposed groups, disciplines, and theoretical stances (APA, 2004; Myers, 1992; Ratts et al., 2010; Sue et al., 1992).

*Vicarious traumatization* is the transformation that occurs within the counselor as a result of empathic engagement with and exposure to clients' trauma experiences, narratives, and their sequelae (Knight, 2012; Pearlman & Saakvitne, 1995). Such engagement includes listening to graphic descriptions of horrific events, bearing witness to people's cruelty to one another, and witnessing and participating in traumatic reenactments (Pearlman & Saakvitne, 1995). It is considered an occupational hazard to be considered for counselors who work with trauma survivors (Pearlman & Saakvitne, 1995), but it may be experienced by anyone confronted with the tragedies of others.

### **Organization of the Study**

In Chapter I, the author included an introduction of trauma training in counselor education. The problem statement described the need for research to address the changing landscape in higher education related to trauma training due to a growing societal awareness, the ubiquity of trauma and its potential adverse psychological and physical effects, advances in research and clinical work, and advances in the scientific understanding of trauma. Many individuals in the United States are exposed to traumatic events, thus widely experienced by counseling clients, significantly marginalized individuals, and vulnerable populations. As the counseling field coalesces in response to advances in science and trauma treatment, there is a need to further develop trauma

education. This study sought to solicit the opinions of counselor educators with expertise in trauma and explored the unique perspectives of our field to develop an empirically derived set of trauma guidelines for training programs and curricula alike. The research questions aligned with the goal of this study. Key tenets from a Culturally Responsive Research and Evaluation Framework (Frierson, Hood, Hughes, & Thomas, 2010), Vygotsky's Sociocultural Theory of Cognitive Development, and a Trauma-informed Approach (SAMHSA, 2014) formed the conceptual framework that guides this research study. A culturally responsive research framework (Hood et al., 2005) guided the inquiry and encapsulated the many prevalent discourses related to trauma and trauma education (i.e., biomedical model, relational model, cultural considerations, vulnerable populations, the counseling field, allied mental health fields, and andragogy) (Frierson, Hood, & Hughes, 2010). Utilizing this framework, multiple frames of reference (i.e., a wide range of culturally diverse counselor educators) and different viewpoints were considered (Lincoln & Guba, 1985). The Delphi method relied on expert participants' collective views related to effective practice (Linstone & Turoff, 2002). The diversity of the panelists, along with the panelists' knowledge and clinical trauma experience working with a variety of trauma-exposed populations, as well as diverse student populations, guided the selection of the panel. Creation of knowledge through collective construction is also a key tenet of sociocultural theory of cognitive development in educational psychology (Vygotsky, 1978). This theory posits that knowledge is shared and constructed, while honoring individual meanings and points of view (Vygotsky, 1978). Similarly, a trauma-informed approach (SAMHSA, 2014) blended the three critical

threads of research, practice, and trauma-survivor knowledge, to respect both the shared and individual viewpoints and encompass a greater understanding of the topic at hand (Powell, 2003).

In Chapter II, a review of current literature related to the development of trauma training and trauma pedagogy in counselor education is relayed. In Chapter III, the methodology for the study will be described along with how it will be applied to the study. In Chapter IV, the results of the study will be presented, and in Chapter V the interpretation of the findings, along with recommendations, implications for future research, and conclusions will be discussed.

## **CHAPTER II**

### **REVIEW OF THE LITERATURE**

Chapter I outlined the purpose of the current study and highlighted the lack of knowledge surrounding trauma training in counselor education programs and the need to better understand what counselor educators deem as the necessary components to prepare counselors-in-training to work with traumatized individuals. The purpose of this chapter is to provide a comprehensive review of the relevant literature and provide further detail regarding the gap in research on trauma education in CACREP-accredited graduate counseling programs. The chapter begins with an outline of the conceptual framework that was used to guide the study. Subsequently, a review of the extant literature on trauma education in higher education in general, and then specifically, in counselor education will be relayed.

#### **Conceptual Framework**

The various training efforts in trauma education reviewed suggest that the preparation of students requires a multi-faceted approach that aligns with the core values of counseling and supports student-centered learning (Bala & Kramer, 2007; Cook et al., 2011; Courtois & Gold, 2009; DePrince & Newman, 2011, Mattar, 2010). The current study utilizes a conceptual framework that draws from the key tenets of culturally responsive research (Frierson, Hood, & Hughes, 2010) and a trauma-informed approach (SAMHSA, 2014) to examine the necessary components to prepare counselors-in-

training (CIT) to provide competent services to clients who have experienced psychological trauma. Additionally, drawn from educational psychology, Vygotsky's sociocultural constructivist theory of education is posited as a possible framework for trauma-informed training and education in the classroom (Vygotsky, 1978).

### **Situating the Culturally Responsive Framework in the Research Inquiry**

Due to the complex nature of trauma and the uniqueness of the subject area of trauma, trauma training and education requires students to learn unique knowledge, skill sets, and develop specific attitudes in preparation to provide trauma-informed counseling as they encounter trauma-exposed individuals in their pre-service training. A culturally responsive framework informed the review and organization of the empirical literature in this study, as well as the research design (Frierson, Hood, & Hughes, 2010). After performing a thorough review of the literature on trauma education in counselor education and allied fields, it was evident that many knowledge bases for trauma education have been constructed and some, not yet mutually built upon (i.e., the bio-medical model, multi-cultural considerations, and the relational model).

As the field of traumatology and trauma-informed care continue to develop and progress separately and in collaboration with one another, so too should approaches and guidelines for trauma education constantly progress (Courtois & Gold, 2009). It may be useful for educators to employ a dynamic framework for this line of inquiry, such as social constructivism. This approach is marked by an attention to the process of education and learning, the generation and interpretation of meaning, and the collaborative

interaction between an individual and the group (McGroarty, 1998) that considers sociocultural contexts.

In review of the pertinent empirical literature, individual voices of authors, as well as themes from the collective voices of the research literature from various fields were analyzed to add to the richness and breadth of the study. The inclusion of these voices aligned with a culturally responsive approach in mirroring the constant interplay between the voices of educators, practitioners, and supervisors in the field actively working with trauma-exposed populations (Hood et al., 2005; SAMHSA, 2014; Vygotsky, 1978). A trauma-informed approach offered meaning that was in turn, shaped by the intent of the researcher(s), and guided the interest of the review in terms of directions in which to look, discourses to include, and the voices and perspectives framing the analysis (SAMHSA, 2014). While trauma-survivor voices are not directly represented in this study, the trauma-informed approach was used to frame the study as it views trauma and the effects of trauma through a broader lens based on Bronfenbrenner and Ceci's (1994) socioecological framework. The trauma-informed approach was formed by weaving together research knowledge, trauma practitioners' knowledge and experience, and the input and voices of survivors of trauma (SAMHSA, 2014). A trauma-informed approach, as well as a diverse panel, was used to better understand trauma by considering the contexts in which it occurs and the populations it especially impacts. This approach focuses not only on risk factors but protective factors across levels and systems. Using this approach expanded the focus beyond individual characteristics and effects to a systemic perspective that acknowledges the influences of social interactions,

communities, governments, cultures, and so forth, while examining the interactions between these various influences. The trauma-informed approach is based on Bronfenbrenner and Ceci's (1994) work on social-ecological frameworks and has been used to understand trauma and implement trauma-informed care. It understands that culture, developmental processes, and the specific era when trauma occurs all significantly impact how trauma is perceived, processed, and how an individual may seek help, the degree of accessibility, acceptability, and availability of resources.

This lens is contextual and integrates biopsychosocial, interpersonal, societal, and cultural characteristics. The literature was synthesized to form a collective voice to mutually build upon this topic and served as the means to understand and interpret the literature as the foundational aspects for trauma-informed counseling include cultural, relational, and biomedical considerations. As an inquirer utilizing a culturally responsive lens, the author worked to transparently reveal the process of meaning construction to better understand what counselor educators are doing to prepare counselors-in-training for trauma-informed counseling. As this study explored the means by which counselor educators were preparing students to provide trauma-informed counseling, the social constructivist theory of teaching and learning is posited as a possible pedagogical approach for counselor educators to implement this trauma training and education.

### **Sociocultural Constructivist Theory**

The sociocultural constructivist theory of learning, from the field of educational psychology, was developed by Russian psychologist Lev Vygostky (1978). Vygotsky emphasized social interaction as the core vehicle for student development (Vygotsky,

1978). From a sociocultural perspective, learning and development take place in both socially and culturally shaped contexts that are constantly shifting and changed (Rogoff, 1998). The fields of traumatology and pedagogy are rapidly advancing. Thus, a dynamic, multi-faceted framework for effective trauma education, including attention to content and process in the classroom was necessary. Sociocultural constructivist theory provided a system for exploring the interactions and interconnections between the teacher and the student, while also considering the sociocultural contexts within the classroom that impact learning.

Sociocultural constructivist theory includes three main components that are dynamically interrelated: (a) collaborative social learning; (b) the more knowledgeable other (MKO); and (c) the zone of proximal development (Vygotsky, 1978). These three elements will be used to organize concepts surrounding a possible model of trauma education for the field of counselor education. Prior to elaborating on these three components, a brief history and description of the theory will be described below.

The psychological education theory of sociocultural constructivism emphasizes social interaction as the core vehicle for cognitive development and learning (Vygotsky, 1934). This theory of teaching and learning asserts the construction of knowledge is a collective process in which knowledge is attainable via collaboration (Powell & Kalina, 2010). The viability of knowledge construction is based on its coherence with a collective or sociocultural belief structure (Powell & Kalina, 2010). Individuals and their behavior cannot be separated from their environmental contexts, so not only does an individual's cognitive process reflect their actions, but it also reflects their interactions with others,

culture, and society (Chen, 2003; Patton & McMahon, 1999). From a sociocultural perspective, learning and development take place in both socially and culturally shaped contexts that are constantly changing (Rogoff et al., 1995).

### **History of Sociocultural Constructivist Theory**

To better understand how a social constructivist framework applies to this study, a history of the progression from cognitive perspectives to an approach that emphasizes collaborative social contexts of learning and knowledge that are mutually constructed (Berger & Luckman, 1966; Bodrova & Leong, 2012; Gauvain, 2008). Constructivists adhere to the philosophical position that knowledge arises through a process of active collaborative construction (Mascolo, Pollack, & Fischer, 1997). Bruner (1990) and Piaget (1972) are the main constructivist theorists among the cognitive constructivists (Creswell, 2009), and Vygotsky (1978) is considered the main social constructivist theorist in educational psychology. The development of social constructivism was motivated by many factors and was informed by cognitive perspectives on teaching and learning (Bruner, 1994). These are important movements to understand within the constructivist point of view related to the pursuit of knowledge and understanding (Bruner, 1994). First, much of seminal psychological research drew attention to the activity of experts and intervention researchers who explored the use of interventions such as ‘thinking out-loud’ as a way of making problem-solving skills public and accessible to individuals with less expertise (Flower et al., 1992). For example, Duffey et al. (1986) relayed the value of engaging educators in public modeling where they would think out loud and use context for determining the meaning of a problem or an unknown. Another line of research

designed by Palincsar and Brown (1989, 1993) used the intervention of reciprocal learning in which group discussion was structured around four key strategies: predicting, questioning, summarizing, and clarifying. These four strategies were used by groups to engage with one another, construct the meaning of a text, and to determine together what sense they were making of the text (Palincsar & Brown, 1989). Participants took turns leading the discussion and the teachers supplied whatever support was needed to use the four strategies (Palincsar & Brown, 1989). Research indicated that discussion using these four strategies was a successful means of enhancing comprehension and provided evidence of a relationship between the quality of the interaction between the participants and the teacher, as well as among participants, and the nature of the learning that occurred (Palincsar & Brown, 1989). Notably, a heterogenous group of participants with diverse skills attained competence by using the learning dialogues more quickly than a homogenous group (Palincsar & Brown, 1984). Participants were able to provide feedback and build upon others' contributions, making greater gains and contributions to the discussion (Palincsar & Brown, 1984).

As cognitive researchers began to recognize the demands of expert reasoning and problem solving, greater interest emerged in distributing this cognitive work (Bruner, 1994). This propelled the dissemination of the social constructivist concepts within the field of psychology. In the field of educational psychology, cognitive researchers hypothesized that by building upon a larger collective memory and the multiple ways in which knowledge could be structured among individuals working together, the collective group, with its shared perspectives and life experiences, could gain more success working

together than individuals working alone (Daiute & Dalton, 1993). Consequently, another reason for growing interest in the social dimensions of cognition developed from an awareness of the role that language plays in learning; specifically, to explain one's thinking to another person can lead to greater cognitive processing (Scardamalia & Bereiter, 1989). Indeed, a catalyst to understanding how social and cultural factors impacted cognition was the perspective that thought, learning, and knowledge are not only influenced by social and cultural factors but are *social phenomena* (Scardamalia & Bereiter, 1989). This perspective led to the conclusion that cognition was a collaborative process and the purpose of exploring cognitive development was to examine the transformation of socially shared activities into internalized processes (see Rogoff, 1998; John-Steiner & Mahn, 1996).

Social constructivist philosophy is not to be taken as a pursuit of knowledge with the intent of reaching a complete, accurate, and comprehensive description of the *real world* (Goodman & Elgin, 1988). Rather, social constructivists believe that cognitions promote the understanding of where to begin a line of inquiry that is derived from what is currently adopted, to continue to integrate and organize the implementation of further inquiry and invention (Goodman & Elgin, 1988). The epistemological basis for the social constructivist perspective is interpretivism, where knowledge is thought to be obtained through involvement with the content, instead of just sheer imitation or repetition (1988). So, the conversation turns to the search for knowledge based on the world of inter-subjectively shared, social, cultural, and historical constructions of meaning and knowledge (Gergen, 1985).

### **Key Tenets of Sociocultural Constructivist Theory**

Vygotsky's (1978) sociocultural constructivist theory of teaching and learning asserts three main tenets: collaborative social learning, the more knowledgeable other, and the zone of proximal development. These tenets are important because they align with the core humanistic roots of the counseling profession and are congruent with a trauma-informed approach. Social constructivists view the world in interactive ways; emphasize the collaborative nature of learning and the importance of cultural and social contexts of learning; and contend that knowledge is mutually built and constructed (Vygotsky, 1978). From social constructivists' perspectives, separating the individual from social or cultural influences is neither preferable nor possible (Vygotsky, 1978). Social constructivists stress the importance of culture and context in both understanding what occurs in society and constructing knowledge based on this understanding (McMahon, 1997). Learning is more than the memorization of knowledge. It is also a socio-cultural process in which learners are integrated into a knowledge community (Vygotsky, 1978). In Vygotsky's theory, the content of knowledge is influenced by cultural factors including language, beliefs, and skills important to that culture (e.g., computer skills, communication skills, or collaboration skills). Additionally, cognition is situated within social and physical contexts, and not within a student's mind. Ultimately, knowledge is tied to the situation in which it is learned and may be difficult to apply in other situations, so this theory posits that learning environments should be as close to real-life as possible.

**Collaborative social learning.** Social constructivists emphasize the social contexts of learning and that knowledge is mutually built upon and co-constructed. Vygotsky believed that higher cognitive functions develop as actual relationships between individuals (Vygotsky, 1978). By interacting with others, students get the opportunity to share their views and generate a shared understanding related to the concept being studied. From a social constructivist's perspective, learning opportunities are presented to students through social interactions in the co-construction of knowledge and understanding (Vygotsky, 1978). Knowledge is derived from interactions between people and their environments and also resides within cultures and histories (McMahon, 1997; Shunk, 2000).

**The more knowledgeable other.** The more knowledgeable other (MKO) refers to anyone who has a better understanding or ability than the learner as it relates to a specific task, process, or concept (Vygotsky, 1978). The MKO is normally thought of as being a teacher or coach, but it could also be peers, organizations, resources, practitioners, or even computers. The critical factor in considering the MKO is considering who is most likely to know more about the subject. It may be an expert counselor educator, the empirical literature, a trauma counselor, a supervisor, a national trauma association, an evidence-based resource webpage, and/or dialogic collaboration.

**The zone of proximal development.** With guided participation by the more knowledgeable other, social constructivists assert that an individual can engage in discoveries, gain meaningful understandings, and approach the zone of proximal development (Hausfather, 1996), where learning occurs. The zone of proximal

development (ZPD) refers to “the distance between the actual development level as determined by independent problem solving and the level of potential development as determined through problem solving in collaboration with more capable peers” (Vygotsky, 1978, p. 86). With two developmental levels, the level the individual has reached and can problem-solve independently and the level of potential development (ZPD) that the individual could attain under guidance or in collaboration with peers, the ZPD level is believed to only advance in collaboration with others (Hausfather, 1996). To ensure advancement in the student’s level of competence, guidance, also referred to in this theory as ‘scaffolding,’ must be adjusted during the learning process to fit each student’s current level of performance (1996). The teacher’s role and teaching practices they employ in the classroom can help to structure the task of learning about trauma in a way that supports students’ success.

### **The Counselor Educator’s Role in a Constructivist Classroom**

Today, classrooms represent a composition of diverse cultural backgrounds, with students possessing various strengths and abilities (Cannella & Reiff, 1994). From this perspective, the teacher’s role is to customize the educational process and content to facilitate the learning process. Such an environment is student-centered and democratic in nature, with a focus on students’ learning and competence building, rather than teachers’ strict adherence to one traditional pedagogical approach (1994). This models to the students a collaborative style, that honors their voices and invites them into a safe egalitarian-style classroom which mirrors a trauma-informed approach (Palinscar, 1998). The teacher may invite students to contribute to the educational curriculum, so that they

have an investment in the learning process and the learning outcomes. The teacher sets up the boundaries of safety and supports in the classroom. In these ways, the classroom becomes a collaborative community of learning and support that mirrors a trauma-informed collaborative therapeutic alliance (Palinscar, 1998).

In a classroom modeled after tenets of sociocultural constructivist theory, the teacher may need to scaffold, or guide and assist the emerging competencies of the students (Palinscar, 1998). Communication is the essence of the socio-cultural experience when students are learning and problem solving (Bruer, 1994). Through language and culture, teachers and students negotiate meaning, so the role of teacher reflects that of a facilitator, and not of a director or sole authority. The teacher stimulates students' exploration of various concepts (Scardamalia & Bereiter, 1989). Students are active thinkers and co-constructors of knowledge, rather than passive listeners. Teachers utilizing social constructivist approaches provide complex learning situations related to real life in which multiple solutions are possible (Rogoff, 1998). Moreover, educators who apply social constructivist theory in the classroom find that imbalance facilitates learning, that contradictions between the student's current understanding and life experiences create an imbalance, leading the student to inquire into his or her own beliefs and then try out new ideas (Vygotsky, 1978). Therefore, instructors who adopt this approach should take a nonjudgmental stance and encourage errors, instead of minimizing or avoiding them. Students should also be challenged by their instructors to perform open-ended investigations, working to solve problems with realistic and meaningful contexts (Palinscar, 1998). This activity enables the learner to explore and

come up with either supporting or conflicting possibilities. Teachers who are informed by this approach make a conscious effort to move from “traditional, objective didactic, memory-oriented transmission models” (Cannella & Reiff, 1994) toward a more student-centered pedagogy, fostering collaborative discussion and exchange of ideas within the learning community. Such facilitators encourage all members to engage, while maintaining a safe and trustworthy learning environment. Social constructivist theorists attach as much meaning to the process of learning as they do to the acquisition of new knowledge.

To summarize, context is a critical consideration in trauma education, as students often bring in their own trauma histories and narratives into the classroom (Pearlman & Saakvitne, 1999). Due to the unique nature of trauma and course content, this education calls for effective teaching approaches to best transmit this education. Trauma education requires more than the dissemination of knowledge and facts. Aligning with key tenets of the counseling profession, teaching from a social constructivist framework encourages the co-construction of knowledge through collaboration and the approach is person-centered, or student-centered.

Vygotsky (1978) emphasized three main processes as essential to learning: connections between people, sociocultural and historical influences, and the contexts in which they act and interact in shared experience (Crawford, 1996). Individual knowledge alone is not adequate to attain the levels of learning and comprehension that results from collective collaboration may produce. This is especially important to consider in trauma education as resources, knowledge, and support services of other entities and allied fields

may be necessary for the care of the individual. Additionally, the biological, relational, and cultural models are foundational for effective trauma education and the conceptualization of trauma, so modeling the incorporation of multiple sources of knowledge and how to find and draw upon resources to collaborate is important (Briere & Scott, 2006; Courtois, 2002; Herman, 1992, Levers, 2012; Mattar, 2011).

### **Competence**

A long-standing construct in the field of education and learning is that of competence. Competence is a core component of counselor education (Rodolfa et al., 2005). Competency mentioned in this study refers to the knowledge, skills, and attitudes needed for effective professional practice (Sue et al., 1992). The American Counseling Association in its *Code of Ethics* stated that competence is considered essential for ethical and professional counseling practice (ACA, 2014). Toporek et al. (2009) argued that competencies for counselors and counselor educators are not only efficacious for learning but they are essential to ethical clinical practice. Myers (1992) asserted that competency is an essential component of professionalism since “competencies are the areas in which a professional should be capable of performing to a certain standard and that standard is typically set by a profession” (p. 3). Sue et al. (1992) further affirmed that counselor competencies should include the operationalized knowledge, skills, and attitudes and provide specific guidelines for counselor educators engaged in ethical and informed practice (Ratts et al., 2010). Given the unique subject area of trauma, teaching this topic area requires more than the transmission of content knowledge alone. Counselor education has a unique voice, distinct from that of social work, marriage and family

therapy, or psychiatry and the counseling profession's trauma training and education would be well-served to reflect this uniqueness. In the counseling profession, organizations such as the Council for Accreditation of Counseling and Related Educational Programs (CACREP) professional organizations such as the American Counseling Association (ACA) provide guidance in the form of standards and codes for counselors and counselor educators seeking guidelines in specific areas, such as trauma.

The bounds within which counselor educators prepare students to a level of competence is specific to time, culture, and the particular context of the Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited master's counseling programs (CACREP, 2015). Professional organizations such as the ACA and CACREP identify the standards for required course content in different areas and set forth specific standards, competencies, and ethical mandates related to trauma training (ACA, 2012; CACREP, 2015). While the 2016 CACREP standards addressed the required minimum content for programs to include, it was left up to the particular counseling program as to the level of emphasis each placed on the content area as well as the manner in which each program chose to meet the standards (CACREP, 2015).

National and state standards for counselor education address the need for trauma preparation and appropriate responses, however they do not address the specific type or degree of attention necessary to maximize the effectiveness of trauma intervention (Courtois & Gold, 2009). The current standards for counselor education, the 2016 CACREP standards, specify that counselors should possess knowledge of the "effects of crisis, disasters, and trauma on diverse individuals across the lifespan," as part of the

human growth and development standards of professional counseling identity (CACREP, 2015, Section 2.3.g). Additionally, part of the counseling and helping relationships section stipulates that counselors are to possess knowledge regarding “trauma-informed and community-based strategies . . .” and “procedures for identifying trauma and abuse . . .” (CACREP, 2015, Section 5.m & Section 7.d). The CACREP standards do not indicate what type or of knowledge and skill proficiency are necessary pertaining to trauma care and response (McAdams & Keener, 2008). In similar fashion, the National Board of Certified Counselors (NBCC) stipulated in its ethical code that counselors are to only offer the professional services for which they are trained or have supervised experience in (NBCC, 1997, p. 2), and the ACA specifies in its Code of Ethics that counselors are prohibited from performing their role without adequate preparation (ACA, 2005, p. 9). As evidenced by these stipulations, a required but unspecified standard of competence is alluded to for counselor educators to account for in their responsibility to prepare students in trauma training. This is problematic in that trauma education and training is unique. The preparation of counselors-in-training to provide competent trauma care requires attention to affective as well as intellectual integration in students. Additional skill sets and attitudes for work with trauma-exposed individuals are called for, along with consideration of how the teacher may best relay this subject matter to facilitate student learning. Given the unique subject area of trauma, teaching this topic area requires more than the transmission of content knowledge alone.

The American Counseling Association has endorsed many competencies in specialized areas, yet no one set of official trauma competencies, nor guidelines

surrounding trauma education and training have been officially endorsed. There is a dearth of empirical research related to trauma education in counseling and how educators are embedding trauma training in the curriculum (Courtois & Gold, 2009; Turkus, 2013; Levers, 2012). The literature revealed several reasons for the scant literature on trauma education which correspond to the historical development of trauma (Mattar & Figley, 2010) and significant growth in the field of traumatology due rapid advancements in field (e.g., Cook et al., 2011; Gray, Elhai, & Schmidt, 2007), as well and changes in trauma-related standards (i.e., CACREP standards for trauma education changed from 2009 to 2016). Given the 2016 CACREP (2015) standards related to trauma training in counselor education are somewhat vague, the literature from various counseling associations (e.g., AMHCA, ACA Trauma Interest Network, etc.) and allied professional fields (e.g., APA, SAMHSA, CSWE, AAMFT, STN, etc.) provided insight surrounding what should be included in trauma education in terms of knowledge, skills, and attitudes (Myers, 1992; Sue, Arredondo, & McDavis, 1994), and what teaching practices to employ to best relay trauma course material. Although trauma training standards from various allied mental health fields provide useful information, instead of simply adapting trauma training and education components developed for other disciplines, educational guidelines for trauma should arise out of the unique values and core tenets of the counseling profession.

### **Competencies for Trauma Education**

As noted, many competencies, guidelines, and standards exist related to trauma education and training and only recently have competencies and guidelines for trauma education and training been formally published by allied professional mental health fields

(Kaslow et al., 2009). For example, the field of psychology held a national consensus conference at Yale University in 2013 to develop a comprehensive model of trauma-focused, empirically-informed competencies- knowledge, skills, and attitudes that professionals should possess when working with traumatized populations (Cook & Newman, 2014). The American Psychological Association (2015) officially approved the model, called the New Haven Trauma Competencies, and published their official Guidelines on Trauma Competencies for Education and Training. The guidelines, approved by the American Psychological Association Council of Representatives in 2015, describe five primary competencies (e.g., scientific knowledge, individual and cultural diversity, ethical and legal issues, assessment, and intervention) set forth as guidelines for education and practice in the United States (2015). They articulate five broad essential competencies and behavioral anchors, each with a subset of knowledge, skills, and attitudes needed. These competencies are to serve as guidelines for all trauma practice regardless of the model used for trauma-focused practice, for trauma education programs' curriculum development, and may also be utilized as benchmarks for measuring proficiency (Kaslow et al., 2007; Nash & Larkin, 2012; Rodolfa et al., 2005).

The American Psychological Association trauma guidelines mentioned above coincide with various allied mental health professions, sharing similar foundational and functional competencies, but these are specific to the field of psychology and included developmental considerations (American Psychological Association, 2015). Of notable interest, the teaching practices utilized and methods of evaluation to assess student learning outcomes included multiple choice exams, problem-based learning, written

essays, review of recordings, vignettes, performance-based exams to assess specific skills, and client simulations (American Psychological Association, 2006; Kaslow, 2004). Additionally, kindred allied mental health fields have published trauma competency training standards (Kaslow et al., 2009), such as social work (Council on Social Work Education, 2012) marriage and family therapy (Nelson et al., 2007), trauma training guidelines on an international level were developed by the International Society for Stress Studies (ISTSS) and the Task Force on International Trauma Training (Weine, 2002), and the expert consensus treatment guidelines by the Complex Trauma Task Force (CTTF) (Cloitre et al., 2012). Layne et al. (2011) published the Core Curriculum on Childhood Trauma (CCCT) that provided a trauma-informed and evidence-based framework for graduate education but these competencies support practice with traumatized children, and do not include competencies for professional counselors working with adult trauma survivors. The New Haven Competencies produced trauma guidelines for adults and children; however, professional counselors were not included in this dialogue (Cook & Newman, 2014; Webber et al., 2016). The production of evidence-based competencies or guidelines specific to a profession are critical as they provide useful resources for developing trauma training, education, and curricula design (Kaslow, 2006).

### **Approaches and Models of Trauma in Allied Fields in Higher Education**

Over the past two decades, trauma has become one of the most prominent fields of study in the social sciences, humanities (Berger & Quiros, 2013) and cultural studies (Visser, 2011), with critical interconnections developing between other movements in psychology (i.e., culturally responsive practices, empirically informed services, trauma-

informed services, neurobiological considerations, etc.; DePrince & Newman, 2011) and allied fields (e.g., counseling, medicine, social work, and marriage and family therapy). There has been an increased call for trauma education and training which mirrors the cultural complexities and ubiquity of trauma in our present-day society (Beck & Sloan, 2002; Kilpatrick et al., 2013). There has been an emergence of literature and research addressing trauma training in graduate education (Briere & Scott, 2006; Courtois & Gold, 2009; Kaslow et al., 2009; Layne et al., 2014; Litz & Salters-Pedneault, 2008; Logeran et al., 2004; Mattar, 2011; Nelson et al., 2007; van der Kolk, 2009). Mattar (2011) stated, “the field of trauma psychology and allied fields are experiencing sustained growth that requires the establishment of standards in trauma education” (p. 13).

Conceptualizing what educators need to know to best instruct students and promote student learning has been the driving force for educational research for more than a century (Ball, 2000; Bransford, Darling-Hammond, & LePage, 2005; Journell, 2013). In order to aptly expound on knowledge, teachers need to comprehend what counts as knowledge in specific subject areas to effectively teach students (Shulman, 1986). Effective teaching combines content knowledge and pedagogy in distinctive ways that are unique to the specific subject area (Hill & Ball, 2004). Consequently, effective teaching involves a grasp of the specific content of the subject area and, also, the most useful ways (i.e., teaching practices, approaches, models, and methods) of representing the subject (Shulman, 1986). Four distinct educational models used in higher education that impact trauma education emerged from the research literature including the

competency model, the biomedical model, cultural considerations, and the relational model.

**Competency-based model of education.** The competency-based model of education (CBE) was introduced in the United States in the 1960's in teacher education (Bowden & Masters, 1993) and evolved as a concept that has been applied to various higher education and training systems (Burke, 1989). Competency-based education (CBE) is a student-centered model of learning (Hatcher et al., 2013) that guides the educational process toward the attainment of the “knowledge, skills, and attitudes needed for effective professional practice in service of the public” (Hatcher et al., 2013, p. 1). The model aids in the formulation of competencies and curricula geared towards competence benchmarks, or outcomes, for students (Spady, 1977, p. 11); in turn, producing graduates with the knowledge and skills in “explicitly identified competency domains” (p. 4). A concern that led to greater adoption of CBE was that courses emphasized knowledge at the expense of the ability to apply the knowledge and to perform the skills needed in the workplace (Tuxworth, 1989).

According to Nelson (2007), education is moving toward an approach committed to outcome-based education which includes competency-based curricula and learning outcome assessment (2007). CBE promotes a shift from the assessment of knowledge to an emphasis on making sure students learn and apply specific skills (Nelson, 2007). A key tenet of CBE is that what the students should know and do is clearly defined. This has also been a point of contention. Tuxworth (1989) noted criticism of CBE in that some believed it was a reductionist approach that overanalyzed competence. This was due in

large part to defining competence too narrowly (Debling, 1989). The main goal of CBE is to facilitate the refinement of learning outcomes and curricula to make them more relevant to workplace environments and vocational needs (Bowden & Masters, 1993). Under a competency-based approach, education reform and curricula redesign look to individuals deeply involved in the vocation to determine and endorse the competency standards to ensure they are accurately based on the needs (Nelson, 2007). Another model pervasively referred to in the trauma education literature used to train graduate students is the biomedical model of education.

**Biomedical model of trauma education.** The prevalent ethos in the field of trauma education in psychology has historically focused on neurobiological dimensions (Field, Jones, Russell-Chapin, 2017; Mattar, 2011), ascribing to the biomedical model in its conceptualization of trauma (van der Kolk, 1996; Engel, 1977). While the medical model yields invaluable information, even those professionals within the medical field see the merits of broadening this approach to disease to include psychosocial and cultural dimensions (Briere & Scott, 2006; Bonanno, 2004; Levine, 2010; Perry, 2000; Siegel, 2008, 2012). Problems lie both with solely operating out of a bio-medical approach and to the exclusion of this model. Evaluating the literature, researchers expressed a concern that maintaining a nomothetic conceptualization of trauma may place education in danger of pathologizing clients and generalizing client cases, by using one generalized set of Western-European diagnostic criteria (Brown, 2007; Marsella, 2010; Mattar, 2011). Conversely, a problem of excluding medical advances from education is that students may be at a disadvantage if their educational training does not include the scientific

developments that have provided valuable knowledge about the neurobiology of trauma and dissociation, differential diagnoses, recognition of implicit/non-verbal aspects of trauma, psychopharmacology, and efficacious clinical practice (Briere & Scott, 2006; Turkus, 2013).

The literature reveals that most counselors only have cursory knowledge about trauma, to say nothing of the biological impact of trauma (Courtois & Gold, 2009; Cook et al., 2011; Pearlman & MacJan, 1995; van der Kolk et al., 1995). The stage has been set for future integration of neurobiology in trauma education (Miels, 2011). While the biomedical model constitutes an important component of trauma education, it may be advantageous to further expand the conceptualization of trauma education beyond the biomedical model.

Historically, this dominant model of disease, the biomedical model, has not made room in education within its framework for the behavioral, social, cultural, and psychological dimensions (Bandi, 1977; Levers, 2012; Siegel, 1999; van der Kolk, 1994). This is not true of all educational agencies specializing in trauma (Mattar, 2011), such as The International Society for Traumatic Stress Studies (ISTSS). The ISTSS values the insertion of the word 'culture' in science and meaningfully accounts for it with the development of their *Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations in Clinical and Community Settings* (Foa et al., 2008; Weine et al., 2002). The ISTSS and the Task Force on International Training (Weine, 2002) spearheaded trauma training guidelines on a national level (Weine, 2002). The ISTSS acknowledges the relevance of ethical principles

while moving a step forward to account for the cultural mediation of what is traumatic and consider the various coping mechanisms people may use (Mattar, 2011). There is growing attention to bridging understanding of the emotional and physical processes in the etiology and treatment of PTSD with biological and sociocultural domains of understanding (Helms, Nicolas, & Green, 2010; Levers, 2012; Marsella, 2010).

**Multicultural approach to trauma education.** In conjunction with the relevant literature related to the biomedical model, an emphasis in the literature calls for cultural considerations in trauma education (Berger & Quiros, 2013; Courtois & Gold, 2009; DePrince & Newman, 2011; Mattar, 2011; Wells et al., 2003). Courtois and Gold (2009) called for the inclusion of trauma in graduate training programs in psychology and other professions. Since, there have been additional calls for cultural considerations to be incorporated into the core curriculum within trauma psychology (Berger & Quiros, 2013; Mattar, 2011, Mattar & Figley, 2010; DePrince & Newman, 2011). Mattar (2011) has been a strong proponent arguing for the inclusion of cultural considerations in trauma education, training, and research in the field of psychology and allied fields, given the changes in the U.S. population and key factors (e.g., age, ethnicity, disability status, gender, sexual orientation, socioeconomic status, etc.) related to trauma education (Bryant-Davis, 2010; Courtois & Gold, 2009; Fouad & Arredondo, 2007; Marotta, 2009; Mattar, 2011; Sue et al., 1992; Villegas, 1991; Weine et al., 2002).

A review of the literature on culture and trauma resulted in both empirical articles and books tackling this subject in depth, and several conceptual articles addressing culturally responsive research to address the study, assessment, and treatment of trauma.

Several conceptual articles suggested how to include culture in trauma education (e.g., Brown, 2007; Bryant-Davis, 2010; Droždek and Wilson, 2007; Kirmayer, Lemelson, & Barad, 2007). One work that addressed the challenge of trauma education included LaRoche and Christopher (2009). Their work pointed to the important variables of power and privilege which are necessary to discuss and that contribute to the complexity of trauma education (LaRoche & Christopher, 2009). Valisner (2009) expanded on the challenge stating that in general the term *culture* has been more of a politically correct insertion into scientific writing, leaving meaningful work accounting for culture by the wayside. Others joined in this review of culture as a word not clearly articulated in trauma research, care, or education (Ancis, 2004; Schwartz, White, & Lutz, 1992).

Many empirical works support the importance of cultural considerations in trauma education in graduate programs. The following culturally responsive research highlights the cultural complexities of trauma which may provide useful insights to enrich trauma education. Empirical articles included various research methodologies with different foci to approach the study of trauma. Helms et al. (2010) addressed the controversial issue of the impact of ethno-violence and racism in developing symptoms of post-traumatic stress disorder. Their methodology included a contextual approach as well as the researchers' cultural self-assessment in the treatment of clients, an understanding of the populations studied, and the impact of racism (Helms et al., 2010). Nichols and Green questioned the current PTSD criteria and urged practitioners to consider the assessments and research methods used to capture the impact of ethno-violence and racism (Helms et al., 2010). They further developed the idea that racism is a threat to an individual's life and thus

questioned the utility of the PTSD criteria when applied to underprivileged, ethnically diverse groups (Helms et al., 2010).

Sturm, Baubet, and Moro (2010), also raised questions about the diagnosis of PTSD and the soundness of the criteria when considering cultural contexts. Sturm et al. (2010) presented case studies utilizing an ethno-psychoanalytic approach which integrated psychoanalysis and anthropology to understand the multiple contextual layers and cultural meanings of refugees and immigrants seeking asylum. Their study highlighted the co-construction of cultural meanings between the therapist and patient and drew attention to the importance of understanding these layers to be able to fully understand traumatic experiences (2010). Droždek and Wilson (2007) discussed the importance of using a societal-level lens to investigate experiences of collective healing from trauma. These authors presented strategies for collective healing and societal notions of justice and the way society handles reconciliation. The authors asserted that societal healing and reconciliation are strongly embedded in local sociopolitical, cultural, and historical contexts (Droždek & Wilson, 2007). Their model of collective healing is vastly different from the victim-centered models prevalent in the field of traumatology (i.e., biomedical models) (Droždek & Wilson, 2007). Kira (2010) discussed factors of cumulative trauma and collective identity trauma in trauma treatment. He analyzed the variance in individuals' reactions to trauma to differentiate between single and cumulative trauma experiences (Kira, 2010). The results implied an argument against evidence-based practices for trauma assessment and intervention among patients from other cultures and underprivileged groups (Kira, 2010). From these results, he proposed a

paradigm shift within trauma assessment, to a multi-systemic, multimodal, and multi-component therapy model (MSMCT) to include individual, family, and community interventions (Kira, 2010). One way to begin this shift may be to utilize Fouad and Arredondo's (2007) questions which raised critical lines of inquiry for culture-centered instruction. The answers to these questions may serve as a baseline for educators to survey their training goals and curricula.

Investigation into the relevance of cultural considerations in trauma education yielded evidence to support the necessity of emphasizing cultural considerations in trauma education. First, research affirmed there is a high rate of trauma exposure and PTSD in the general population, but specifically among individuals challenged with severe mental illness, such as bipolar disorder, major depression, and schizophrenia (Shevlin, Houston, Dorahy, & Adamson, 2008). Mueser et al. (1998) state the prevalence of PTSD among individuals with severe mental illness is three times as prevalent when compared to the general population. Second, there are controversies within the mental health field surrounding the universal diagnosis of PTSD. The controversy surrounds universal claims about the diagnosis of PTSD and notions of treatment and resilience (Mattar, 2011; Sturm et al., 2010; Rosen, 2004). Proponents of multiculturalism in the trauma field question the Western philosophical underpinnings of trauma and whether PTSD as a diagnosis is even appropriate to capture traumatic experiences (Helms, et al., 2010). Third, various racial/ethnic cultural groups are at a much higher risk of exposure to and experiencing PTSD (Alim, Charney, & Mellman, 2006; Bernal & Santiago, 2006). Fourth, the consideration of subjective reactions to trauma are greatly impacted by an

individual's cultural context (Maresella, Friedman, Gerrity, & Scurfield, 1996; Mattar, 2011). Lastly, the mental health field experiences disparities in racial-ethnic minority service provision (i.e., socioeconomic status, LGBTQIA community, uninsured, immigrant/refugee, problems engaging and retaining clients from different backgrounds, under or over diagnosis, lack of interpreters, lack of access, etc.; Atdjiiian & Vega, 2005; Smith, Rodríguez, & Bernal, 2011; U.S. Department of Health and Human Services, 2001). All these factors provide evidence as to the relevance of cultural considerations in trauma education. The factors speak to the vulnerable populations and real-world challenges counselors-in-training will likely encounter in their professional work (Courtois & Gold, 2009; Mattar, 2011).

Given the significance of the issues examined above, educating students to effectively engage with multiple cultural encounters, while staying current on evidence-based treatment poses challenges, but research offered helpful suggestions for incorporating cultural considerations in trauma education. First, research indicated that the development of culturally informed trauma curriculum could guide training and educational practices (American Psychological Association, 2006; Mattar, 2011; Triffleman & Pole, 2010; Sue & Zane, 2006). Second, teaching with an emphasis on the cultural context of trauma and bringing relevant research to the class was suggested (Arnett, 2008; Bernal, Jimenez-Chafey, & Domenech Rodriguez, 2009; Smith et al., 2011; Sue, Zane, Hall, & Berger, 2009). Third, promoting organizations, structures, and cultures to support cultural competence was prevalent throughout the literature related to culture, trauma, and education (Fouad & Arredondo, 2007; Gallardo, 2009; SAMHSA,

2014). Finally, Bala and Kramer (2004) suggested the need to form a wider conceptual framework to understand PTSD. Cultural competence has been defined as a dynamic and ongoing developmental process that requires a commitment and is achieved over time (U.S. Department of Health and Human Services, 2003, p. 12).

Integrating what has been drawn from the literature, cultural considerations in trauma education should be mindful that the conceptualizations of trauma reflect clients' historical, spiritual/religious, and sociopolitical histories (Hays, 2008; Mattar, 2011; Rousseau & Kirmayer, 2009) and consider the key questions that arise from the literature pertaining to culture and trauma. Historically the use of a biomedical approach has been used at the expense of a cultural one (Mattar, 2011). Mattar (2011) posited the question, "How do we best integrate the biomedical model with a contextual and/or ecological perspective?" (p. 49). Green et al. (2009) relayed the many cultural dimensions to be considered such as race, ethnicity, language, sexual orientation, age, disability, acculturation level, gender, education, politics, and history, etc., which, he stated, have often been reduced in research to narrowly refer to race or ethnicity (Mattar, 2011; Tucker & Herman, 2002).

The evidence-based practice discourse is at the forefront of the matter of whether a thorough integration of culture and trauma will be possible (Mattar, 2011). Trends in the research literature on trauma treatment moved towards systemic and reliable methods of trauma treatment which were sometimes manualized or normed in ways that may not account for the realities of the communities and the trauma treatments utilized to serve clients (Mattar, 2011). A challenge noted in conducting research to improve treatment and

education was found in accounting for cultural considerations; that is, cultural variables were hard to operationalize (Mattar & Figley, 2010). While there are not yet a set of cultural guidelines for trauma education, the research offers a rich case for the significance of the inclusion of cultural considerations in trauma education.

**Relational model of trauma education.** The specialized skills and foci needed when working with trauma survivors present a unique emotional challenge to helping professionals which have often been met with relational principles and techniques (i.e., positive therapeutic relationship, empathy, unconditional positive regard, countertransference, transference, boundaries, attachment, etc.; Levers, 2012; Rogers, 1959; Sommer, 2008; Turkus, 2013). These softer foci represent some of the most efficacious and supported findings of treatment outcome literature (Briere & Spinnazola, 2009; Courtois & Ford, 2013; Courtois & Gold, 2009; Levers, 2012), on the other hand, the same considerations which call for a relational approach to trauma education in counseling have also been voiced as concerns for counseling education because attending to the relational components in the classroom pose a unique challenge (Black, 2008; Carello & Butler, 2014; Cunningham, 2004; Turkus; 2013). Educators are likely teaching trauma survivors in their own classrooms and issues of safety and vicarious trauma arise (Black, 2006; Courtois & Gold, 2009; Cunningham, 2004; Pearlman & Saakvitne, 1995). The relational tenets espousing a humanistic and client-centered approach are efficacious to treatment because healing from trauma may occur the context of a corrective therapeutic relationship (Briere and Scott, 2006, Herman, 1992, Levers, 2012; Rogers,

1959). The importance of these relational components and concepts that researchers have emphasized in the literature surrounding best practices for trauma training will be discussed.

Traumatic events have the potential to create relational and personal difficulties in trauma survivors, including issues with boundaries, emotional regulation, mistrust, and for some, ambivalence about recovery (e.g., Cloitre et al., 2010; Cook & Newman, 2011; Courtois & Ford, 2013; Courtois & Gold, 2009). Human-induced trauma, especially, creates a wound that is relational in nature with the psychological, emotional, physical, cognitive, and/or developmental derailments and disturbances attributed to another person or persons (van der Kolk, 1996). Part of the healing process may occur in a corrective therapeutic relationship utilizing the tenets of a relational model (Carello & Butler, 2015; Gilbert, 2009; Harris & Falot, 2002; Norcross & Wampold, 2011) which emphasizes empowerment and the reciprocally interacting worlds of experience influencing each other and facilitating change (e.g., Heppner & Roehlke, 1984; Stoltenberg & Delworth, 1987; Stolorow, Atwood, & Brandchaft, 1994). Students should be trained to recognize and expect the relational processes and characteristics that clients may present, as well as receiving training to address ways to actively work with these issues (Cook et al., 2011; Wells et al., 2003). Empathic clinical skills, self-awareness regarding the impact of learning about and providing complex trauma treatment, students' histories of trauma, as well as traumatic exposure over the duration of the course may impact the study of trauma and treatment (Courtois & Ford, 2013; Miller, 2001). The client-clinician therapeutic relationship is understood as central to the treatment process while noting and cautioning students that this relationship may mirror the traumatic

interpersonal dyad of previous trauma (Pearlman & Saakvitne, 1995; Loganbill, Hardy, & Delworth, 1982; Stoltenberg & Delworth, 1987).

Relational concepts prevalent throughout the literature concerning best practices for trauma education included an attention to parallel process, safety, vicarious trauma, and a trauma-informed approach applied in the classroom. First, attending to the parallel process (Berger & Quiros, 2013; Ganzer & Ornstein, 1999) research indicated that educators should underscore the possibilities of reactions or reenactment between the counselor and client. The client may react to the counselor in ways that carry out their psychology of the perpetrator and/or identification with the aggressor (Berger & Quiros, 2013).

Another pervasive component throughout the literature surrounding trauma educational practices was that attention to ongoing dialogue and exploration of transferences and counter transference was necessary (Carello & Butler, 2014; Cunningham, 2004; Miller, 2001; Sommer, 2008). It is critical for counselor educators to prepare counselors-in-training to recognize when either they, or their client experiences anxiety or notice a somatic reaction that is challenging to explain (Cunningham, 2004; Miehl, 2014). One must be able to perceive a client's simultaneous need for and fear of closeness as a trigger of their own loss, rejection, and anger (Cunningham, 2004; Lanyado, 2016; Miehl, 2014). On psychological and emotional levels, a trauma survivor's spirit, and sometimes the will to live, as well as beliefs about the world and oneself, dignity, sense of security, thinking, and feelings have all been impacted. Usual ways of handling stress become inadequate (ACA, 2011, p. 1). Two of the most common

therapeutic mistakes made when working with trauma survivors, also relevant for educators, are colluding with the client in minimizing the effects of trauma and eagerly jumping into processing the trauma narrative before the client is ready or at the exclusion of other factors impacting the client (Carlson & Dalenberg, 2000; Courtois & Ford, 2013; Gold, 1997; Herman, 1992; Levers, 2012; Levine, 1992) as this could lead to re-traumatization. Students, alike, are at risk for vicarious trauma (Cunningham, 2004; Pearlman & Saakvitne, 1995; Sommer, 2008), so minimizing the risk for students when exposing them to the course material about trauma would show congruence (Black, 2006) with trauma treatment practices if education followed the directive, first, do no harm.

***Trauma-informed approach.*** In keeping with the relational components necessary for competent trauma care and education, a mental health trend growing out of the awareness of the ubiquity of trauma in the U.S. is known as a trauma-informed approach, used interchangeably with trauma-informed care (Fallot, 2008; Harris & Fallot, 2001; Jennings, 2004). A trauma-informed approach supports trauma care and practices that recognize the widespread impact of trauma on survivors and promotes trauma-specific and trauma-sensitive treatment, rather than the use of mental health methods that may exacerbate the effects of trauma (Fallot, 2008; Harris & Fallot, 2001; Herman, 1992). The literature surrounding trauma-informed care arrived at a consensus offering key principles of trauma-informed care (Fallot, 2008). Trauma-informed treatment includes: (a) safety from physical harm, and re-traumatization, (b) an understanding of the trauma survivor as a consumer of mental health care in open and genuine collaboration with care providers during all phases of treatment delivery, (c) an

awareness that symptoms should be viewed in the context of the survivor's life experience and culture, and (d) an understanding that symptoms are adaptive attempts to cope and survive the traumatic event(s) rather than maladaptive behaviors indicating that something is wrong with the survivor (Fallot, 2008; Harris & Fallot, 2001).

The Substance Abuse and Mental Health Services Administration (SAMHSA) published their trauma-informed approach which was collectively informed by evidence-based practices, the voices of trauma survivors, and trauma practitioners (SAMHSA, 2014). In May 2012, SAMHSA convened a group of national experts who identified four key elements of a trauma informed approach: "1) realizing the prevalence and influence of trauma; 2) recognizing how trauma affects all individuals involved in the program, organization, or system; 3) responding with trauma-sensitive practices and policies; and 4) actively working against re-traumatization" (SAMHSA, 2012, p. 4). Correspondingly, SAMSHA defines "trauma-informed care" used interchangeably with a trauma-informed approach, as a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma, that emphasizes physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment" (Hopper et al., 2010, p. 82). This approach also involves vigilance in anticipating and avoiding institutional processes and individual practices that are likely to retraumatize individuals with trauma histories, and it upholds the importance of client participation in the development, delivery, and evaluation of services (SAMHSA, 2012). This approach aligns with professional counseling's key tenets of non-maleficence, advocacy, cultural

considerations, orientation to systems and context, consideration of evidence-based practices, attention to resiliency, and consideration of developmental factors across the lifespan. Additionally, this approach mirrors the student-centered, collaborative, non-hierarchical approach of the social constructivist theory of education.

### **Core Counseling Tenets**

Counselor education has a unique voice, different from that of social work, marriage and family therapy, psychiatry, or psychology and the counseling profession's trauma training and education would be well-served to reflect this uniqueness. The profession of counseling offers a unique perspective which bridges the bridging the gap of service delivery from classic cognitive behavioral therapy and relational psychotherapy to include a scientist-practitioner approach, attention to relational components, as well as cultural considerations (Briere & Scott, 2006; Courtois & Ford, 2013; Levers, 2012; Mattar, 2011). Counseling is a professional therapeutic relationship where the educational, career, or personal goals work towards changes in behavior or lifestyle, relief from suffering, changes in self-perception or thoughts, or increased insight or awareness and understanding (Brammer & MacDonald, 1996). Professional counseling is defined by the American Counseling Association as, "a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals" (ACA, 2010). The therapeutic alliance in counseling is unique because it enables a person to grow in ways that they choose and work towards goals that they specify (Egan, 2010). In this way, counseling's humanistic roots reflect a person-centered approach, which mirrors that of a trauma-

informed approach, and a social constructivist educational approach, which are student-centered. Counseling is also a collaborative process where the counselor joins in with the client. This joining eliminates power dynamics and like the social constructivist educational theory, offers a non-hierarchical climate of trust for learning and care.

Seligman (2004) suggested that a positive therapeutic alliance in counseling includes the following characteristics: a safe, protective environment for clients, encouragement of collaboration where the counselor and the client play an active role, mutual respect is genuine care is shown, goals and procedures are agreed upon, and the client and counselor pursue the shared goals with the belief that they are attainable (p. 212).

Research has continually supported that the qualities of a positive therapeutic counseling relationship are the best predictors of positive counseling outcomes, regardless of the theory or techniques utilized (Assay & Lambert, 1999; Courtois & Ford, 2013; Norcross, 2001; Sexton & Whiston, 1994).

Key tenets of counseling include respect, congruence, empathy, genuineness, and unconditional positive regard for the individual (Rogers, 1957). Carl Rogers was a key proponent in establishing the core conditions necessary for a successful counseling relationship (Rogers, 1957). Rogers characterized congruence as being honest, transparent, open, and real in communication with clients (Rogers, 1957). He also stressed the importance of having unconditional positive regard for clients and holding a nonjudgmental, accepting stance (Rogers, 1961). This regard and acceptance of the client creates a relationship of warmth and safety where the client feels safe and valued as a person (Rogers, 1961). Empathy, or understanding a client's feelings as if they were

yours, also communicates safety and encourage clients to address more difficult issues (Bohart, Elliott, Greenberg, & Watson, 2002). Rogers's core conditions, along with commitment, respect, trust, and confidentiality are all considered foundational principles and are used in the majority of counseling approaches (Kottler & Shepherd, 2015). Counseling promotes an individual's autonomy and freedom of personal choice (Kottler & Shepherd, 2015).

The counseling profession promotes an understanding of the individual from a holistic view, taking into account developmental considerations, across a lifespan, and in the context of time and culture (Bandura, 1977; Vygotsky, 1978; Lerner, 2002). The counseling field also promotes the utilization of evidence-based approaches, as well as incorporating relational principles and techniques (Briere & Scott, 2006; Foa, 2011). Cultural, relational, spiritual, emotional, psychological, and neurobiological components are all important considerations in counseling and counselor education. An additional principle that sets counseling apart from other professions, is a focus on resilience and strength, as opposed to pathologizing. A belief in recovery and the recognition of supports, strengths, and post-traumatic growth is important in the counseling profession especially as it relates to trauma healing and aligns with a trauma-informed approach (Harris & Fallot, 2001; Herman, 1992; SAMHSA, 2014).

### **Trauma Competence in Counseling**

Currently, the profession of counseling promotes the use of evidence-based practices for those who have been traumatized, there are many trauma-specific professional organizations within counseling and counselor education, and many outlets

for scholarship in our journals, with an increased number of articles and presentations on trauma-related issues. Trauma and its effects are increasingly, although far from uniformly, taught in counselor education curricula (Courtois & Gold, DePrince & Newman, 2011). As advances in trauma treatment have burgeoned and trauma-treatment and interventions have developed, an assumption has been made throughout various fields that the scientist-practitioner approach, such as cognitive behavioral therapy, manualized treatment procedures, and treatment outcome research represent the answer to psychological trauma-related pain (Courtois & Ford, 2013). While prolonged exposure (Foa, 2011), cognitive processing therapy (Resick & Schnicke, 1993), trauma-focused cognitive behavioral therapy (Cohen, Mannarino, & Deblinger, 2006), and eye movement desensitization and reprocessing (Shapiro, 1995) have proved beneficial for many trauma survivors, there is clearly a need for more efficacious treatments. As the profession of counseling advances, the rediscovery of non-science treatment components that have sometimes been rejected by empirically-focused researchers, are purposefully being integrated into the empirical trauma therapy (Courtois & Ford, 2013). These components, known for their soft foci, include the person-centered or relational components which stress the importance of a caring, genuine, and empathetic therapeutic relationship. These interpersonal components the field of counseling have long promoted attention to the client-counselor connection and attunement, transference and countertransference, boundaries, and attachment responses. The use of these relational techniques and principles are not yet common in trauma treatment in other professions. Many evidence-based approaches in empirical trauma therapy don't consider time, affect-regulation

capacities, or stages and bi-directional movement during trauma treatment. The foundational interpersonal components of counseling represent the most consistently supported research outcome literature in that the context of a caring and supportive therapeutic relationship is more likely to be successful when the counselor exhibits the qualities of unconditional positive regard, empathy, compassion, and self-awareness (Gilbert, 2009; Lambert & Barley, 2001; Norcross & Wampold, 2011). Along with the growth in evidence-based treatments, and relational considerations, further development of cultural considerations in trauma treatment has occurred. Trauma training in counselor education is a mandated part of counselors training, yet, little empirical research has been done to assess how counselor educators are integrating this education to prepare students. There are currently no trauma counseling competencies or training guidelines to inform the profession. Counselors provide care for trauma-survivors in a unique way, considering the cultural, developmental, relational, and neurobiological components. It is important for counselor education to establish a baseline of foundational knowledge related to trauma competency given that counselors-in-training will likely encounter trauma-related issues in their preservice training (Courtois & Gold, 2009). Providing counselors-in-training with appropriate education for trauma work enables them to recognize and assess trauma-related issues so that they can provide a referral for appropriate care of clients and not place themselves or their clients at risk. Counseling has validated the ubiquity of psychological trauma, supported evidence-based treatments and theoretical models of trauma, and promoted a number trauma therapies. Now, the field is doing the work of synthesis to bridge the gap between evidence-based practice,

relational interventions, and cultural considerations to provide a comprehensive framework for trauma education and training in our counseling programs.

### **Trauma Counseling Education and Pedagogical Considerations**

Over the past several decades, the knowledge base surrounding trauma and trauma training and education has rapidly advanced, expanding the professional literature (Cook et al., 2011; Courtois & Gold, 2009; Friedman, Keane, & Resick, 2007; Mattar, 2011; Turkus, 2015). Consequently, a greater emphasis on education and training in trauma has emerged (Courtois & Ford, 2009; Kilpatrick et al., 2003; U.S. Department of Health and Human Services, 2003; U.S. Surgeon General, 1999). This extensive trauma literature grew from the 19th century practices of psychotherapy in Europe, then waned through most of the 20th century, only to be catalyzed again in the 1970s by difficulties observed in Vietnam War veterans (Friedman, Resick, & Keane, 2007; Herman, 1992; van der Kolk, 2007). A renewed awareness culminated in the inclusion of the posttraumatic stress disorder (PTSD) diagnosis in the DSM-III (American Psychiatric Association, 1980), and has been accompanied by a greater societal awareness of trauma, increased government recognition, and media coverage (DePrince & Newman, 2011; Herman, 1992; van der Kolk, 2007). Additionally, contributing to an increased awareness of trauma and the burgeoning literature base was the growing acknowledgement of the widespread nature of domestic violence, abuse, and sexual assault that arose via the feminist movement, alongside advances in science and neurobiology (Breire, 2006; Cook et al., 2011; DePrince & Newman, 2011; Harris & FalLOT, 2001; Herman, 2002; Miller, 2001; van der Kolk, 2007). To say nothing of the national and international events that

have deepened the public awareness of various types of traumatic events which Cook et al. (2011) relayed, such as the terrorist attacks of September 11th, the war in Iraq and Afghanistan, devastating natural disasters, and sociopolitical climates of unrest (Collins & Collins, 2005; Cook & Newman, 2014; Sommers, 2005) which carry with them potential adverse physical and psychological health factors.

The potential physical and mental health risks associated with the effects of trauma exposure, exorbitant costs associated with treatment, and prevalence of trauma exposure in our society speak to the need for the inclusion of trauma training in graduate programs (Beck & Sloan, 2012). Exposure to trauma and the resulting potential negative consequences (e.g., anxiety disorders, dissociative disorders, depression, substance abuse/dependence, PTSD, and other anxiety disorders) have been recognized as a major public health concern (Beck & Sloan, 2012; Brown et al., 2009) as knowledge has grown concerning the broad reaching societal effects, financial costs, and the potentially lasting negative effects of traumatic events (Green et al., 2010; McLaughlin et al., 2010; U.S. Department of Health and Human Services, 2003). Kilpatrick et al. (2013) stated in a comprehensive quantitative study that a representative sample of 89.7% of United States residents have experienced at least one posttraumatic stress-disorder level event as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013), and most had experienced multiple traumatic exposures. Alongside this exposure, data suggests that PTSD may be one of the costliest mental health disorders, with estimated annual productivity losses in excess of \$3 billion dollars (Brunello, Davidson, & Deahl, 2001; Brunello et al., 2001; Greenberg et al., 1999; Kessler, 2000).

A seminal study impacting trauma education and training in all allied mental health fields is the Adverse Childhood Experiences Study (ACEs), known as the ACEs Study, which was born out of Dr. Vincent Felitti's concerns when more than half of the clients in his obesity clinic dropped out of treatment (Anda et al., 2006). Dr. Felitti, chief physician of the Department of Preventative Medicine, could not figure out why his patients dropped out so and with the scientific resources of the preventative medicine department, he began to investigate the problem. Dr. Robert Anda, with the Centers for Disease Control and Prevention, joined Dr. Felitti in 1992 and the two collaborated on the largest scale study to date of the incidence and effects of childhood trauma, the (ACE) Study (Anda et al., 2006). From 1995 to 1997, every person who came through the Department of Preventative medicine filled out a biopsychosocial (biomedical, psychological, and social) questionnaire and 17, 337 participants filled out this questionnaire which included questions pertaining to childhood trauma (Anda et al., 2006). Dr. Felitti and his team reviewed the research literature and included eight types of trauma including sexual abuse, verbal abuse, physical abuse and five types of family dysfunction being a parent who's mentally ill or alcoholic, a mother who's a domestic violence victim, a family member who's been incarcerated, and a loss of a parent through divorce or abandonment (2006). Later emotional and physical neglect were added, for a total of 10 types of adverse childhood experiences, or ACEs. This groundbreaking study was unique in that it was the first study to look at the effects of several types of trauma, instead of the consequences of just one (2006). The study revealed data directly linking childhood trauma with adult disease, mental illness, incarceration, and work issues

(2006). Nearly two-thirds of the participants experienced one or more types of adverse childhood experiences and more experiences resulted in higher risk (2006). This study changed the landscape of understanding human development in that it revealed the pervasiveness of expensive public health problems, depression, substance abuse, STD's, cancer, heart disease, lung disease, and diabetes associated with early exposure to trauma. According to data collected from the over 17,000 Kaiser patients, adverse childhood experiences are unexpectedly common, and may have a profound negative effect on adult health a half century later (Anda et al., 2006). ACEs are found to be a prime determinant of adult health status in the United States (Anda et al., 2006). There are many implications for counselor education and trauma training but two emerge from the literature are especially relevant. First, the ACEs study shows the importance of rigor in research methods and the benefits of assessments and screenings linked to client narratives and client outcomes. Science aids in offering an important part of the explanation as to the biological impact of trauma and why symptomology may be present (Anda et al., 2006). This speaks to the benefits of incorporating the neurobiological dimensions of trauma in trauma education. Secondly, counselor educators would be well-served to identify how to best teach counselors-in-training to recognize what trauma is and how to approach first contact with a trauma-exposed individual including training related to competent intake procedures, focusing on the interview, assessment, and screening process. Proper recognition and awareness of trauma symptomology holds significance because trauma has historically been viewed as an issue only prevalent among veterans or individuals who experience catastrophic events such as rape, war, or

abuse (Courtois & Gold, 2009). Additionally, many trauma assessments and inventories do not account for cultural aspects or the subjective nature of individuals' trauma responses. Results from the ACES study show a positive correlation between the experience of adverse childhood experiences and adverse physical and psychological health conditions (Anda et al., 2006).

Even with this growing body of scientific research, most mental health providers have only a cursory knowledge of the impact of trauma and its treatment (Cook et al., 2011; Courtois, 2002; Courtois & Gold, 2009; DePrince & Newman, 2001). Despite the ubiquity of trauma (Beck & Sloan, 2012; Brown et al., 2009), growing scientific literature (Beck & Sloan, 2012; American Psychological Association, 2013; Kilpatrick et al., 2013), societal awareness, financial cost, and potential adverse health conditions (Lupien, McEwen, Gunnar, & Heim, 2009; Solomon & Johnson, 2002), trauma training has yet to be solidly incorporated within the core curriculum of graduate training (Courtois, 2002; Courtois & Gold, 2009; DePrince & Newman; 2011; Miller, 2001; Newman, 2011; Turkus; 2013).

Many factors converge out of the existing literature to provide a logical explanation for the lack of trauma-related training in counselor education programs. For instance, CACREP changed the standards from 2009 to 2016 and this posed a challenge to educators in general, nevertheless to the development of trauma education training competencies. Correspondingly, the semantics of trauma in counselor education standards has grouped crisis, trauma, and disaster together as a cluster making them difficult to differentiate. The topic of trauma specifically identified in the standards is a more recent

development (see CACREP Standards, 2009, 2016). As aforementioned the rapid developments and advancements in the field of traumatology and the developing pedagogical approaches in education make it difficult to stay abreast of what is the current and most efficacious research to integrate. Methodologies for describing and evaluating particular educational approaches are still developing (DePrince & Newman, 2011). A barrier to developing trauma education is the challenge educators face in including all the required information into their curricula. Counselor educators have voiced concern regarding how much training they can realistically provide students within the current model of counselor education (Murphy, 2007). Counselor educators must include educational components and experiences in counseling programs that teach students how to do counseling at a basic level. Additionally, researchers have related the non-inclusion of trauma in curriculum with societal ambivalence and discomfort. This lack of acknowledgement of trauma, forces us to face the ugly side of humanity (Courtois & Gold, 2009). Trauma has historically been associated with only a few factors, war, rape, and sexual abuse; it has been viewed as a specialty area (Cook & Newman, 2011) so recent expansion of the understanding and definition of trauma holds complexities as well. Multiple challenges and complexities surround the approach to trauma education, but as the counseling field advances promising developments provide support for the further development of trauma education in counselor education.

### **Challenges in Trauma Education**

There are considerable challenges facing the inclusion of trauma education in counselor education and some are similar to challenges faced in most courses in

counselor education, but others indicate the need for a different approach when teaching about trauma. Simon, Rosenberg, and Eppert (2000) built upon the existence of considerable pedagogical challenges and difficulties in teaching matters associated with trauma in that not one standard definition of trauma exists. With multiple disciplines defining what is meant by trauma and using the relatively new terminology of trauma-informed, trauma-informed systems, and trauma-informed approaches, etc., it becomes important to survey the principles, definitions, and terms counselor educators use to consider what is fundamental and consistent in an effort to promote continuity among research (Courtois & Gold, 2009).

Another issue faced by counselor education is whether to infuse trauma throughout courses or to provide a stand-alone course. The research related to crisis preparation provides many implications for trauma preparation (Morris & Minton, 2012). In their study that examined the curriculum in crisis preparation in counselor education, Morris and Minton (2012) relayed important considerations and gaps in the literature, with surveying and comparing the benefit of the inclusion of crisis education as infused throughout a curriculum or as a stand-alone course. While Morris and Minton's (2012) study was specific to 'crisis,' the results may indicate that, since crisis, trauma, and natural disaster have historically been grouped together in our standards, these findings may provide insights related to the inclusion of trauma education as well. First, research findings revealed a third of the participants in the study reported zero hours of classroom attention to crisis, which indicated that there is a need to increase the coverage of and enhance this type of preparation in graduate programs in general (Morris & Minton,

2012). Another interesting finding was that most participants indicated they responded to high-risk crisis during their master's-level practicum and/or internship (Morris & Minton, 2012). It is possible students may be facing issues pertaining to crisis and trauma without adequate preparation in graduate counseling programs. Preparation given to counselors-in-training in the classroom needs to advance to meet the expectations and issues these students are facing in their field experiences, so they may develop the necessary skills from a standpoint of knowledge and efficacious practice (Morris & Minton, 2012). Without a knowledge of what and how counselor educators are preparing counselors-in-training to encounter and care for trauma-exposed individuals, no baseline exists to examine curricular gaps or get a sense of how counselor education can enhance this coverage throughout the curriculum. With the change in CACREP standards from 2009 to 2016, along with the pervasiveness of trauma exposure in our society, it is imperative to understand what counselor educators are doing to integrate trauma training into their curricula in an effort to meet accreditation standards and prepare counselors-in-training.

**Risks.** An absence of guidelines for trauma education poses a risk for the profession on various levels. Without guidelines, there is a lack of assurance that counselor educators are prepared to perform a core aspect of their professional responsibility to students. Although the CACREP standards for trauma training in counselor education are somewhat vague, the literature from counseling (e.g., AMHCA, ACA Trauma Interest Network, etc.) and allied professional fields (APA, SAMHSA, ISTSS, CCTF, etc.) have provided direction regarding the approach and content that should be included in terms of knowledge, skills, and beliefs and attitudes (Sue et al.,

1994; Myers, 1992). Nevertheless, there is a dearth of empirical research related to trauma training in counselor education and how educators are embedding trauma training in the curriculum (Courtois & Gold, 2009; Levers, 2012; Turkus, 2013). Just as trauma education has challenges and risks that are unique to trauma training, these challenges afford opportunities to carefully consider how to best teach this subject matter.

**Vicarious trauma.** Trauma education is unique as this is sensitive subject matter that may be triggering for students exposed to the course content, therefore the ethical considerations of safety and the possibility of vicarious trauma must be accounted for. Vicarious trauma and safety in the classroom will be discussed later; however, many factors converge to make creating a safe frame for learning a priority (Black & Weinreich, 2000; Cunningham, 2004; Figley, 1999; McCann & Pearlman, 1990; Miller, 2001; Sommer, 2008). For example, Collins and Collins (2005) noted several events that speak to the likelihood of counselors-in-training encountering individuals with trauma-related issues, such as September 11, 2001, terrorist attacks, the Colorado shootings in Littlejohn, frequent reports of sexual abuse within religious organizations, Hurricane Katrina in 2005, and, in addition to these, it is imperative to consider the current socio-political climate of the United States in which refugees and certain populations who are deemed racial-ethnic minorities experience fear, horror, and persecution from the very environment they live in, to say nothing of the historical basis for trauma and intergenerational trauma that is ever-present (Trippany, White Kress, & Wilcoxon, 2004). Specific approaches to trauma education should be developed given the conditions that exacerbate the impact of trauma require sensitivity and responsiveness to social, political,

cross-cultural issues because the conditions that promote the effects of trauma. The very conditions that create trauma can make it difficult for an individual to participate in treatment, such as fear of persecution, difficulties with trust, and emotional regulation.

Education would be well-served to consider how to train counselors to recognize and address unique client characteristics (complex, vulnerable trauma-exposed populations).

### **Advances in Trauma Training in Counselor Education**

The field of counselor education has experience advances in the inclusion of trauma education and training in the core curriculum. Research journals are providing additional outlets for scholarship surrounding the topic of trauma and pedagogy, which, in turn provides the space for research dialogue to flourish. Webber, Kitzinger, Runte, Smith, and Mascari (2014) conducted a content analysis on traumatology trends in three journals spanning from 1994 to 2014 and found that the frequency of trauma related articles was low. Webber et al. (2014) recommended adoption of more consistent nomenclature, more empirical research articles on trauma education, and the development of trauma-specific journals to advance the profession of counselor education. In their content analysis, the researchers found that most of the published articles related to trauma education were conceptual in nature, describing models, theories, or curricula structure, and that a few works offered anecdotal experience of educators who taught a trauma course (Webber et al., 2014; McCammon, 1994). An early conceptual article on trauma pedagogy written by McCammon (1995) described her experiences teaching trauma in a university setting. She reflected on her observations of this “painful pedagogy” (p. 107) as she relayed her feelings of responsibility for learning more about

trauma and how her teaching impacted students' learning. McCammon offered ten suggestions for faculty to alleviate undue stress on students in a trauma class, including the following: faculty offering an accepting tone for the classroom, but not a tone that establishes a confessional session of processing personal traumas; providing students with clear classroom topics and objectives for the classroom; considering the emotional intensity of the course materials; informing the class and oneself of support and counseling resources; speaking privately with students who may disclose trauma in the classroom; relating any personal disclosures in class back to the course content; discussing trauma treatments; including a stress debriefing activity following an intense classroom discussion, and considering one's potential for vicarious trauma (McCammon, 1995). The observations and suggestions from her personal experiences of teaching about trauma in a university setting offer valuable insight into this type of painful pedagogy she was observing. Although McCammon's observations have face validity, these suggestions were not based on systematic research.

Black (2008) implemented a model based on the principles of trauma treatment including resourcing, titrated exposure, and reciprocal inhibition, and applied the model to the classroom for teaching graduate counseling psychology students about trauma. Although the research methods used relied on students' self-report, the authors' recommendations of the usefulness of employing Rogerian principles and trauma-sensitive approaches in the teaching of trauma mirrored the trauma-informed movement (Black, 2006). Black's recommendations are consistent with Harris and Fallot's (2002) trauma-informed care principles and many staged/phased treatments of trauma (e.g.,

Judith Herman's tri-phasic model and Peter Levine's staged model). Influenced by the work of McCann and Pearlman (1990) and Saakvitne, Pearlman, and Abrahamson (1996) on vicarious trauma and by Charles Figley's (2002) work on compassion fatigue, Black's (2008) pilot study provided an empirical foundation for additional research to be conducted.

To date, there have been no studies in which counseling researchers have solicited and compiled the opinions of counselor educators who teach trauma in their courses, nor have there been empirical articles on trauma education and training in counseling programs (Minton et al., 2014). Black (2006, 2008) stated the need for future research conducting qualitative and quantitative studies to solicit the opinions of students and counselor educators to identify relevant areas for potential inquiry (2008). Black's pilot study (2008) provided a starting point for more research to be conducted. While the research methods used relied on students' self-report, the authors' recommendations of the usefulness of employing Rogerian principles and trauma-sensitive approaches in the teaching of trauma mirror the trauma-informed approach and provide a starting point for future research (Black, 2006).

### **Call to Action**

In 2002, Courtois issued a call to action imploring counselor educators to integrate trauma into the clinical training curriculum (Carello & Butler, 2008; Courtois, 2002; Courtois & Gold, 2009). Since then, response to this challenge has been mixed. While the implementation of trauma education and training remains a work in progress (Minton, Morris, & Yaites, 2013; Courtois & Gold, 2009; DePrince & Newman, 2011;

Mattar, 2011), recently there has been an emergence of research into the importance of trauma education and how to best implement this curricular inclusion into counselor education (Black, 2006; Courtois & Gold, 2009; Newman, 2011). Trauma courses and training are gradually being integrated into the core curriculum of graduate programs in counselor education and other mental health professions (Black, 2006; Courtois & Gold 2009; Turkus, 2013), and while a review of the literature on the history of trauma education yielded only a few sources that explicitly addressed the teaching of trauma in counselor education (Black, 2008; Cook et al., 2011; Courtois, 2002; Courtois & Gold, 2009; Greene, Williams, Harris, Travis, & Kim, 2016; Sommer, 2008), there are promising advances in trauma education in the field of counseling. Webber et al. (2006) identified nine trauma counseling related components and provided the motivation for the American Counseling Association (ACA) Trauma Interest Network. Webber et al. (2006) argued that the most important component to address was “a call for standards to inform crisis and trauma training in counselor education and practice programs as well as trauma training models and related curricula” (p. 126). The development of trauma education and training guidelines in the counseling field to aid in increasing and enhancing the quality of training is a critical first step.

Despite the considerable progress made toward competent trauma education and inclusion of trauma in the core counseling curriculum (CACREP, 2009, 2015), little is known about what key content, skills, and attitudes counselor educators are implementing in their classrooms (Bryant-Davis, 2010, Mattar, 2010; Newman, 2011; Weine et al., 2002). Standardized trauma curriculum used to inform the education of counselors-in-

training have yet to be included into graduate counseling programs, despite the fact that researchers report high trauma-exposure rates among U.S. residents (Courtois & Gold, 2009). Professional counselors will encounter trauma survivors in the various mental health settings in which they work, regardless of setting, so it is imperative they develop a level of trauma competency (Courtois & Gold; Layne et al., 2014). Nevertheless, there remains a lack of education about trauma in graduate education in the counseling profession (Black, 2006; Courtois & Gold, 2009; Layne et al., 2014; Litz & Salters-Pedneault, 2008; Logeran et al., 2004; Newman, 2011). Therefore, a critical need for established trauma guidelines for training to inform and support counselor educators, and in turn, counselors-in-training exists. More specifically, “the dissemination of a comprehensive model of trauma-focused, empirically informed guidelines (knowledge, skills, and attitudes) is currently required to provide the foundational training for a ‘trauma informed mental health workforce’” (Cook & Newman, 2014, p. 300). At this point in the field of counselor education, what we know about trauma education is mostly conjecture, conceptual, and anecdotal information from counselor educators’ personal experience or pilot studies (Black, 2008; Courtois & Gold, 2009; McCammon, 1995). Missing from the research have been the voices of the counselor educators who provide trauma education to counselors-in-training. The next obvious step is to gather experts together to determine what knowledge, skills, and attitudes counselors need to hold and what teaching practices counselor educators need to employ to prepare counselors-in-training for competent counseling work with trauma-exposed individuals.

## Conclusion

In summation, the key concepts drawn from this review of the extant literature included the importance of educating counselors using a comprehensive framework which included the biomedical model, cultural considerations, and relational components. Unfortunately, these concepts have not yet been integrated into a system of trauma education and are generally addressed, separately in the literature. Trauma training and education in counseling requires a multi-faceted approach (Bala & Kramer, 2007; Cook et al., 2011; Courtois & Gold, 2009; DePrince & Newman, 2011; Mattar, 2010). It is important to preserve the humanistic roots of counseling and include cultural considerations, as well as biological factors in trauma education. Further, by fusing key concepts from the research literature, the profession may acknowledge more fully investigate the therapeutics of education (pedagogy) while teaching trauma through a multi-dimensional lens that embraces purposes and processes in addition to learning outcomes. This study explored the collective opinion of counselor educators with expertise in trauma asking what they deemed as the foundational knowledge, skills, and attitudes necessary to prepare counselors-in-training to provide trauma-informed counseling.

This study drew from a culturally responsive research framework (Hood et al., 2005) and the trauma-informed approach (SAMHSA, 2014). It builds on the existing and emerging research in both discipline-general and discipline-specific trauma educational practices. The research focused on the identification of trauma training guidelines that are central to education in the field of counseling. This study contributed to the empirical

knowledge base by adding the collective expert opinions of a panel of counselor educators who iteratively delineated the educational components they believed were foundational for the effective trauma education of counselors-in-training. Further, through multiple rounds of narrowing experts' statements, the results intended to move beyond the sometimes-ambiguous language, towards explicitly identifying foundational guidelines for trauma education in counseling.

In Chapter III the author provides a detailed discussion of the research methodology. The chapter includes detailed information about the Delphi methodology, rationale, the research questions, participant selection, data collection and analysis, researcher bias and positionality, and results from the pilot study.

### **CHAPTER III**

### **METHODOLOGY**

In Chapter I, the researcher explored the lack of clarity surrounding trauma training in graduate counseling programs (ACA, 2009; CACREP, 2015) and the need for more guidance about what specific content and useful pedagogical practices teachers should employ to best prepare master's-level counselors-in-training to a level of competence for work with trauma survivors. In Chapter II the researcher explored the relevant literature and illustrated that as the counseling field responds to advances in the field of traumatology and education, there is a call to incorporate more sophisticated education specifically related to trauma. However, there is a need to add to the empirical research to better understand the complexities unique to trauma education and training as counselor educators approach this teaching endeavor. Therefore, the central topic of this study explored what counselor educators with expertise in trauma identified as the knowledge, skills, attitudes, and teaching practices deemed as foundational to prepare master's counseling students to an entry-level of competence for trauma work. The purpose of the current chapter is to provide a detailed description of the research methods implemented in the study beginning with an elaboration of the research question, survey questionnaire, procedures, and data analysis. The following research question guided the study:

What do a group of counselor educators with clinical expertise in trauma deem as the foundational knowledge, skills, and attitudes necessary to prepare counselors-in-training in masters counseling programs to provide trauma-informed counseling?

### **Round 1 Survey Questionnaire**

The study asked the panelists to respond to the following open-ended survey questions based on the construct of competence (i.e., knowledge, skills, and attitudes, as well as supplemental questions regarding teaching practices to be utilized in a future study):

1. How would you describe the best practices in trauma-informed counseling?
2. What would a newly graduated counselor need to be aware of to be able to work with a client who had experienced a traumatic event?
3. What specific things would they need to understand about trauma?
4. What trauma-specific skills might they need to have developed?
5. What other abilities might they need to demonstrate?
6. How should counselors-in-training approach clients when they suspect a history of trauma?
7. What should counselor educators consider when they set up course content or curricular tasks focused on trauma?
8. What classroom or workshop activities have you seen that have helped counselors-in-training learn about how to work with clients who have experienced trauma?

9. What challenges specifically related to teaching about trauma might counselor educators need to consider?
10. What do you believe is lacking within trauma training in counselor education?
11. Related to the topic of trauma training and education in counselor education, would you like to add any additional comments, opinions, or ideas that you did not include in the above responses?

To pursue this goal, the study utilized the Delphi method, a widely used survey method, for building consensus among experts (Clayton, 1997; Fletcher-Johnston, Marshall, & Straatman, 2011; Hsu & Sandford, 2007). Hypotheses were not developed in advance of the study due to the inability to predict how a group of experts would come to consensus.

### **Rationale for the Delphi Method**

When competencies or guidelines are lacking within a certain research area, consensus opinion from relevant experts helps provide a framework for effective practice and development (Powell, 2003). Upon consideration of the many conceptual articles but scant empirical literature that exists in the profession of counselor education related to trauma training, it became clear that the nature of this research process would need to be one capable of marrying the diverse opinions of experts in a transparent fashion that captured the consensus, dissention, and various rationales, while permitting emergent themes. The Delphi methodology is best utilized when the collection of informed judgments on issues are mostly unexplored, difficult to define, highly contextual, and

expertise-specific information is deemed as necessary (Helmer, 1968; Adler & Ziglio, 1996). This method aligned with the exploratory state of research related to trauma education, since there was a dearth of empirical studies in the field of counselor education.

The Delphi method was not the only way to identify a core set of trauma competencies; however, it provides a highly structured means to distill key information and lessons learned from counselor educators with expertise in the area of trauma across a range of settings (Bowling, 2005; Duncan, 2006). Although competencies or guidelines for trauma education could be identified deductively using an existing theory of teaching and then studied in-depth or by utilizing other methods of inquiry (e.g., Consensual Qualitative Research, Case Study, or a Phenomenological design, survey instruments, qualitative interviews, etc.), the unique nature of the Delphi method provided the structure to move beyond identifying “what is,” to also address “what could be or what should be” (Miller, 2006). The Delphi method aligns well with a culturally responsive research framework (Hood et al., 2005) as the results are based on the iterative communication among a diverse group of expert panelists who work with a wide variety of trauma-exposed populations as well as teaching a variety of graduate student populations. This method facilitated the integration of combined experiences, worldviews, cultures, and opinions (Nielsen & Thangadurai, 2007).

The Delphi method was well suited for this study because it allowed the researcher to expand on the previous trauma education literature in allied professions, as well as in the field of counselor education, to generate expert consensus surrounding the

knowledge, skills, and attitudes that are foundational for trauma education in counseling. The Delphi method lent itself to this rigorous exploration, while highlighting the commonalities and differences of expert opinions (Black, 2008; Courtois & Gold, 2009; Linstone & Turoff, 2002).

### **Purpose**

The purpose of this study is to contribute to the emerging body of research and literature on trauma pedagogy by using a panel of counselor educators with expertise in trauma to develop consensus opinion. In doing so, the results will serve the following purposes. First, this study seeks to highlight the need to identify the knowledge, skills, attitudes, and teaching practices that counselor educators deem as necessary to build competence in entry-level masters counseling students for trauma work. Second, by drawing from the collective opinions of counselor educators, the study seeks to prioritize the development of a set of core competencies for trauma education that align with the belief system of the profession of counseling. These competencies may serve as an initial framework to support the development and training of counselor educators by providing an empirically derived set of trauma education competencies specific to the counseling field, which in turn may aid in counseling programs further implementation of trauma training and curriculum development.

### **History and Application of the Delphi Method**

Since the introduction of the Delphi method, it has been used in many forms (McKenna, 1994; Hasson et al., 2000) adopted by many disciplines (e.g., medicine, education, nursing and public health services research (Young & Jamieson, 2001), and

used in situations where contradictory or insufficient information exists in order to make effective decisions (Williams & Webb, 1994). The Delphi method has been used for various research purposes including needs assessment, resource utilization, program planning, and policy determination, to name a few (Linstone & Turoff, 2002). Originally developed by Dalkey and Helmer (1963) at the Rand Corporation in the 1950's for technological forecasting, it is now a widely accepted method for achieving the consensus of opinion concerning knowledge solicited from experts within a certain topic area (Hsu & Sandford, 2007).

This method is especially useful in circumstances where new trends are emerging (Toohey, 1999), complex problems are addressed, expert opinions may vary greatly, and/or there is a paucity of research in a particular area (Linstone & Turoff, 1975, 2002; Rowe & Wright, 1999; Stone Fish & Busby, 2005) such as the dearth of empirical research related to trauma training in counselor education. Stewart (2001), asserted the value of the Delphi method for the field of education was in its ability to represent areas of collective knowledge that held within a profession but not often explicitly expressed, making this method extremely useful in education.

Specifically related to the field of mental health research, the Delphi method has been used for making estimations where there is incomplete evidence, making predictions, determining collective values, and defining foundational concepts (Linstone & Turoff, 2002). For example, the Delphi method has recently been used in mental health research to improve professional practice (Goodyear et al., 2015), to improve professional training (2015); to improve mental health systems (Lauriks et al., 2014); to

develop the content of interventions (Ross, Hart, Jorm, Kelly, & Kitchener, 2012); to provide improved standards (Berk, Jorm, & Kelly, 2011); to improve public action on prevention or early intervention (Yap, Pilkington, Ryan, Kelly, & Jorm, 2014); to improve cultural competence (Chalmers et al., 2014); develop policy (2014), to develop a concept (San, Serrano, & Canas, 2015); for scale development (Xie et al., 2015); and to determine research priorities (Forsman et al., 2015).

### **The Delphi Methodology**

The Delphi method utilizes an expert panel's responses to reach consensus (Dawson & Brucker, 2001; Hsu & Sandford, 2007; Skulmoski, Harman, & Karahn, 2007; von der Gracht, 2012). Delbecq, Van de Ven, and Gustafson (1975) indicated that the Delphi method may be used to achieve the following objectives:

1. To develop a range of possible program alternatives;
2. To explore/expose underlying assumptions or information leading to different judgements;
3. To seek out information which may generate a consensus on the part of the panelists;
4. To educate the group of panelists as to the diverse and interrelated aspects of the topic (p. 11).

Although the procedures and foci of various Delphi studies may differ, four distinct features of the classical Delphi usually remain the same (Rowe & Wright, 1999). These key features include anonymity, iteration, controlled feedback, and statistical group response (Rowe & Wright, 1999).

The experts, referred to as ‘panelists,’ have several opportunities to communicate their knowledge anonymously, examine how their opinions align with other panelists, and possibly amend their opinions after considering the findings of the group (Hsu & Sandford, 2007). In this sense, the method can be viewed as a constructive effort in the collective building of knowledge by the group of panelists who share in this process to effectively address the complex problem at hand (Linstone & Turoff, 1975). The panelists have access to one another’s collective judgements and ratings of agreement on all the statements as the process to reach consensus progresses. This iterative process of communication, referred to as ‘rounds,’ allows for the pooling of judgments to discover an appropriate course of action (Delbecq, Van de Ven, & Gustafson, 1975). As the rounds progress and the participants’ opinions are narrowed into more specific statements, the levels of consensus and dissent within the sample are allowed to emerge (Fletcher-Johnston, Marshall, & Straatman, 2011). The group opinions of divergence and convergence may be represented statistically throughout the rounds (Hsu & Sandford, 2007).

Group opinion is defined by using the predominant statistics used in Delphi studies, which are measures of central tendency (median, mean, and mode), levels of dispersion (interquartile ranges and standard deviations), and sometimes frequency distributions (histograms or frequency polygons) to represent expert panelists’ opinions (Linstone & Turoff, 1975; Skulmoski, Hartman, & Krahn, 2007). These statistics are used to present the information of the collective judgments of panelists. Typically, the use of the median and mode are favored over the mean to measure panelists’ responses (Hasson,

Keeney, & McKenna, 2000). The use of the Linstone and Turoff median score based on a Likert-scale is highly favored in the literature, as Jacobs (1996) discussed, since the consensus of opinions may differ greatly resulting in skewed responses, so the median may be the best measure to capture the results of the convergence of opinion. However, because the Delphi process tends to create convergence, usually to a single point, there is the possibility of the clustering of results around two or more points, in which case the mean or median could be misleading (Ludwig, 1997).

This method allows for the statistical analysis of responses by providing both quantitative and qualitative data for interpretation, while allowing for controlled feedback to the group (Murray & Hammons, 1995; Rowe & Wright, 1999). Controlled feedback consists of an organized summary of the competency statements generated by the panelists from the prior round, as well as the panelists' ranking of agreement on each of these statements. This information is intentionally provided to the panelists, allowing them to generate additional insights, and this aids in clarifying the statements and data from previous rounds. Through the rounds the panelists are expected to offer their opinions more insightfully, thus minimizing the effects of noise (Dalkey, 1972; Hsu & Sandford, 2007).

### **Ending the Iteration Process**

Rules must be established prior to commencing the study to organize the judgments provided by the panelists. Consensus and stability measurement are key components of the organization of the study, contributing to the determination of when to end the iteration process of the Delphi method (Miller, 2006). The iteration process, used

to reach consensus, is one in which participants receive and review the group's feedback and have an opportunity to revise their answers. The kind and type of criteria used to determine consensus in the Delphi method is subject to interpretation (Hsu & Sandford, 2007; Keeney, Hasson, & McKenna, 2011; Maxwell, 2013). The rounds can be administered for any number of iterations and the criteria for stopping differs from one study to the next, as the types of data collected in Delphi studies all differ (Armstrong, 2001).

Von der Gracht (2012) presented examples of criteria used in previously published Delphi studies which all ended the process when a degree of *consensus* (i.e., levels of agreement and disagreement) set by the researcher was reached. Essentially, consensus can be decided if a certain percentage of votes falls within a specified range (Miller, 2006). Examples of criteria used to measure consensus include the following: measures of central tendency and dispersion (e.g., when ratings are within the range of a set mean, or standard deviation), when the interquartile range is 1 or below on a 7-point Likert scale, an arbitrarily determined level of agreement (e.g., 70% or 80% in the top measures, for example, *agree* and *strongly agree* on a Likert scale), cutoff rates, and inter-rater agreement measures (e.g., kappa statistics and Kendall's *W* coefficient).

Careful consideration must be given to data analysis parameters and the level of consensus employed. Ulschak (1983) recommended the criteria for consensus to be achieved if 80% of panelists' votes fell within two categories on a 7-point Likert scale. Green (1982) suggested 70% of panelists needed to reach three or higher on a 4-point Likert scale and the median should be set at 3.25 or higher to determine consensus

(Keeney et al., 2002). While there is not one required or agreed upon method to determine consensus (Miller, 2006), using the median and the interquartile range are common (Duncan, 2006; Hsu & Sanford, 2007).

Many Delphi studies have stopped the iterations when a predetermined level of consensus was achieved. However, other researchers assert that the *stability*, referring to “the consistency of responses between the rounds of a study” (Dajani, Sincoff, & Talley, 1979, p. 84; Scheibe, Skutsch, & Schofer, 1975), should be considered heavily as the criterion for ending the iteration process. Research indicated that measuring the stability of panelists’ responses over the iterative rounds is a more reliable alternative over the use of percentage measures (Scheibe, Skutsch, & Schofer, 1975). The level of consensus is viewed as meaningless when the responses between rounds are unstable and disagreement may remain stable, indicating meaningful divergence of opinions is present (Dajani et al., 1979; Scheibe et al., 1975). The absence of consensus, from the perspective of data analysis, is just as important as the existence of it (von der Gracht, 2012).

Much like consensus criteria, stability criteria vary widely as well (Rowe & Wright, 1999). Schiebe et al. (1975) suggested that less than a 15% change in the responses between the rounds (i.e., total number of net changes in response distributions between two rounds divided by the number of participants) should be considered as the criteria for stability being reached. Schiebe et al. (1975), in line with Dajani et al. (1979), suggested testing for group stability instead of individual stability given the Delphi method is interested in the opinions of the group, rather than the individual. In like manner, statistical measures such as the McNemar test, the Wilcoxon signed-rank test

(von der Gracht, 2012), Pearson product-moment correlation coefficient, Spearman's rank correlation coefficient, as well as parametric tests may also be used as stability criterion (2012).

Theoretically, the Delphi process can continue with iterations until consensus is achieved. Ludwig (1997), and Duncan (2006) pointed out that three iterations are usually sufficient to collect the needed information to reach consensus. However, based upon the literature, this study was tentatively set to include four rounds (Linstone & Turoff, 2002). Consensus parameters were determined a priori for this study. Guidelines for identifying the importance of items utilizing the Delphi methodology indicates that only items that receive a consensus median rating of 6 or higher (on a 1-7 scale) should be kept (Stone, Fish, & Busby, 2005). Therefore, an interquartile range of 1.00 or less will indicate consensus being reached. A cutoff score of a median of 6 or higher on a 7-point Likert scale (i.e., on a 7-point Likert scale with 1 = *strongly disagree* and 7 = *strongly agree*) will be used to determine whether panelists agreed that an item was necessary to be included in the list of competencies (Keeney et al., 2011). Items where a consensus agreement is not reached will be included in the final list to be reviewed in the discussion. The stability of responses between rounds and the level of consensus will be reported (see Holey, Feeley, Dixon, & Whittaker, 2007).

### **Strengths of the Delphi Method**

The Delphi method is designed to combine the opinions of experts into group consensus, while minimizing logistical and personal constraints in the process (Clayton, 1997; Rowe & Wright, 1999). As it pertains to the current study, expert counselor

educators working at various institutions of higher education across the nation will be able to express their views and opinions, access the opinions expressed by others, react to the views of others, consider and amend their own responses, and possibly reassess their own views in light of the wider group feedback (Rowe & Wright, 1999). All of this may be done via electronic survey without asking panelists to attend time-consuming and costly face-to-face group meetings (Linstone & Turoff, 2002). This method holds the benefit of recreating the cross-fertilization of views and opinions that would occur if the expert panel had been brought together in face-to-face groups (Ager, Stark, Akeeson, & Boothby, 2010), while allowing panelists to retain their anonymity (Hsu & Sandford, 2007). The feature of anonymity allows panelists to participate without the possible pressures to conform to popular opinion (Rowe & Wright, 1999). Another strength of this method is that it aids in providing informed collective group judgments that are thought to be more reliable than the judgment of one individual (Adler & Ziglio, 1996; Dalkey, 1972, p. 15). This method allows research to be conducted in a manner that minimizes issues of bias, group-think, or dominance because of the anonymous cycles of ongoing expert reconsideration (Linstone & Turoff, 1975). Panelists are able to consider their own responses without the pressure of immediate time limits, prior to reviewing others' feedback (Hasson et al., 2000; Linsonte & Turoff, 1975). This allows panelists a flexible timeframe to offer higher quality responses than if the group was meeting face-to-face in real time (Skulmoski et al., 2007). Furthermore, the Delphi method provides a means to control for the political and social processes that may distort the distillation of knowledge in developing consensus in mediating the under- or overweighting of specific elements of

evidence (Jones, 1975). The process serves as a learning and communication tool for the panelists, while maintaining anonymity potentially avoids the pitfall of group-think or the undue influence of an influential panelist (Murray & Hammons, 1995).

### **Limitations of the Delphi Method**

Research in any form has its limitations and the Delphi is no exception. Low response rates, attrition, time requirements, and the potential molding of opinions pose challenges (Witkin & Altschuld, 1995). As such, Witkin and Altschuld (1995) indicated that when using the Delphi method, low response rates are exaggerated four times over because a maximum of four surveys may be sent to the same participants. Accounting for attrition on the front end of a Delphi study is critical to ensure there are enough participants to provide a representative pooling of judgements regarding the topic at hand (Ludwig, 1997). If panelists discontinue participation at various rounds, the information obtained could be critically scrutinized or discredited (Hsu & Sandford, 2007).

Additionally, it can be difficult to complete the study if respondents do not participate in a timely fashion (Ludwig, 1997), so this method requires the participants to be motivated and responsive (Delbecq, Van de Ven, & Gustafson, 1975). Also, use of the Delphi method can be time-consuming for both participants and researchers, particularly if there are a large number of statements generated (Delbecq et al., 1975). Ludwig (1997) discussed a drawback to the Delphi method in that the use of a questionnaire, versus utilizing a live Delphi which captures all the information in one round, may significantly slow down the process over the multiple days or weeks that pass in between the rounds. Developing the survey instrument, collecting the data, and administering the

questionnaires are all interconnected components between the rounds, so ensuring the panelists respond in a timely fashion promotes the ability of the researcher to analyze the data, develop new survey instruments based upon the prior responses, and distribute the amended questionnaires in a timely manner (Hsu & Sandford, 2007).

Another issue to consider, the iterative rounds of the Delphi method could enable researchers to mold the opinions (Witkin & Altschuld, 1995). For example, there is always the risk of unintentionally guiding the feedback from a group through the information selected to form the consecutive sets of questionnaires based upon the panelists' answers, and so the researcher's views may dominate the analysis (Hsu & Sandford, 2007). The second round could be completely guided by the researcher, or the second set of questions could be solely based on the literal responses to the first set, or it may be a combination of summarizing the statements through a particular lens (Hsu & Sandford, 2007). Dalkey and Helmer (1968) asserted that 'some leading' by the researchers was inevitable and that it resulted from the choice of information supplied (p. 467). Even when consensus is reached, it could stem from a subtle pressure to conform to the panel's majority group opinions (Goodman, 1987; Witkin & Altschuld, 1995). There is always the risk that different opinions may not be thoroughly investigated or may be inadvertently misconstrued (Hasson et al., 2000). Researchers should exercise caution and make a conscious effort to implement safeguards against the potential molding of opinions (Hsu & Sandford, 2007).

The many possibilities of utilizing both qualitative and quantitative components within this method give rise to a wide variety of ways to execute a study. This is both a

strength and a limitation, but with so many variations of the method, it can be difficult to distinguish a lack of methodological rigor from the fact that the Delphi methodology appears in different forms; among its many qualities are a variety of methodological interpretations and changes (Keeney et al., 2001). Some positivists have critiqued it as a soft method, that strays from the scientific approach (Murray, 1995). Generalizability poses an issue as the Delphi method does not attempt to produce generalizable results, however it has been found to be an acceptable method of use for exploratory studies (Toohey, 1999).

To address these limitations, the researcher evaluated the design choices that would directly impact the rigor and relevance of the results prior to administering the Delphi method. The pairing of this research method and approach was carefully considered, as the choice of research question guides the development of the research through supporting the formulation of the theoretical perspective of a culturally responsive model and the trauma-informed approach, as well as the methodology used to explore the problem (Creswell, 2009; Hood et al., 2005). The researcher addressed the limitations by considering elemental items such as refinement of the appropriate research question(s) by implementing feedback from the pilot study and modifications suggested by the dissertation committee; by thoroughly assessing the research design to ensure it accurately answered the question; by allotting the appropriate time in between the rounds to provide a timely turnaround of feedback, but also, to provide the panel with enough time to provide their answers; through careful consideration of the expert inclusion criteria and panel composition by consulting the research literature, by checking in with

the additional coder, keeping a reflexive journal to safeguard the potential molding of opinions, implementing the dissertation committee recommendations; and by reviewing the means of analyses and how they are used for reliable, trustworthy interpretation. Additionally, the cutoff scores for keeping items after each round and the statistics used to determine consensus, were explicitly stated prior to the study.

As referenced earlier, the Delphi method is appropriate for exploratory study where little research is available. Face validity in this study referred to whether the Delphi questionnaire measured the appropriate concepts (Hung, Altshuld, & Lee, 2008). This is a subjective judgment that the questionnaire measures what it intends to measure in terms of the presentation and relevance of the questions (Babbie, 2001). It included the questionnaire being readable, clear, and presenting comprehensible content (Beech, 1999). An assumption of this study was that the content validity was enhanced by judgements, group-based decisions, and the logical and structured communication process between experts (Hasson et al., 2000). Content validity refers to the judgments of the experts about the extent to which the Delphi questionnaire comprehensively and logically included the appropriate characteristics of the topic being investigated (Goodman, 1987). To improve content validity, the researcher developed the Delphi questionnaire by incorporating the research literature, then amended the questionnaire to include the feedback of the expert counselor educators from the pilot study to ensure the questionnaire logically and comprehensively included the components relevant to the topic. The data from the first round were carefully analyzed and the researcher included expert panelists who were knowledgeable about trauma. Rounds 2, 3, and 4 confirmed

the validity of the content and components by providing the panelists an opportunity to review their responses and the responses of others. These steps were taken to ensure the final results met an appropriate standard of content validity. To begin the study, the rigorous process of the selection of the panel was first considered.

### **Population and Sample Procedures**

The panel of experts is the most important element of a Delphi study, and the literature describes many important components to the panel selection (Linstone & Turoff, 2002; Powell, 2003). The panel selection is crucial to the validity and strength of the Delphi method (Clayton, 1997). Purposeful sampling was used to identify counselor educators based on specific criteria to control for unnecessary variance and to identify potential participants who most likely possess trauma expertise (Powell, 2003).

Additionally, a snowball sampling approach was used. Panelists who the researcher purposefully identified were asked to nominate a colleague with significant practice with trauma and teaching in the field (Goetz & LeCompte, 1984; Powell, 2003), as using this approach may strengthen panelist retention (Rowe & Wright, 1999).

The size of the panel is directly related to the topic of inquiry, design selected, complexity of the problem, range of expertise required, and the resources available (Hsu & Sanford, 2007; Powell, 2003). There is not one sample size recommended for Delphi studies (Clayton, 2007; Keeney, Hasson, & McKenna, 2006). For instance, Novakowski and Wellar (2008) indicated that a panel size of ten was sufficient to provide diversity of expert opinion. On the other hand, as referenced in Keeney et al. (2006), Jones and Twiss (1978) recommended 10-15 participants. Patton (2002) directed researchers to identify

the minimum number of participants based on “expected reasonable coverage of the phenomenon” (p. 246). Research supported the use of a small sample size, indicating that the careful selection of a panel can still yield valuable answers for the research questions (Keeney et al., 2002). As meta-studies of the Delphi method utilized panels ranging from 3 to 98 experts (Rowe & Wright, 1999), the goal of this study was to recruit up to 20 and retain a minimum of 10 panelists (Powell, 2003). This range is congruent with other Delphi studies within the counseling field (Herlihy & Dufrene, 2011).

Another consideration in terms of the panel selection pertains to heterogeneity or homogeneity of the sample. Most Delphi studies call for a homogenous sample so that the researcher can identify the strict inclusion criteria and ensure an expert panel is represented (Novakowski & Weller, 2008). Conversely, heterogeneity is favorable when a researcher wants to identify very broad sampling criteria so that almost anyone willing may participate (Keeney et al., 2011). It is advantageous for participants’ different perspectives, cultures, experiences, and skills to be brought to bear upon this area of study to generate more comprehensive results (Keeny et al., 2011). For this study, guided by a culturally responsive research framework (Hood et al., 2005) a diverse group of counselor educators with clinical trauma expertise were purposefully selected to reflect the diversity found within student populations, as well as that of trauma-exposed populations.

Also vital to the soundness of a Delphi study is the expertise of the panel. The purposeful formation and expertise of the panel, over and above numbers, is most desirable (Delbecq et al., 1975; Murray & Hammons, 1995) because the validity and

trustworthiness of the study is directly linked to the members forming the panel. Thus, the expert inclusion criteria used was critical (Linstone & Turoff, 2002). Controversy abounds over the use of the term 'expert' and how to aptly identify individuals (Strauss & Zeigler, 1975). The researcher consulted the research literature, a culturally responsive research framework (Chouinard & Cousins, 2009), as well as three academicians, and her dissertation committee about the parameters of the inclusion criteria used to specify who would be considered 'experts.' The intention of this consultation was to aid in determining the level of content validity. Powell (2003) noted, having specific criteria aids in limiting the variance of the sample and assists in participant selection for the panel. The purposeful selection of counselor educators will ensure they meet the inclusion criteria to be considered experts with knowledge, experience, and interest in the field. As Patton (2002) relayed, the trustworthiness of the qualitative portion of a study is associated more with the relevancy of the cases, rather than the sample size.

### **Expert Inclusion Criteria**

In keeping with a culturally responsive framework, to establish a culturally diverse representative panel of experts, with a variety of ethnicities, orientations, perspectives, and clinical trauma experience, the following criteria were stipulated: (a) An individual must have current or significant professional teaching experience within the field of counselor education and (b) have years of clinical trauma expertise in trauma counseling and/or trauma supervision experience. Panelists were also purposefully sampled based on their diverse settings, publications related to trauma and/or trauma education, history of engagement in continuing education, professional presentations, or

training credentials or certifications related to trauma, experience in diverse settings with various trauma-exposed populations, and teaching experience with diverse student populations, from various locations throughout the United States.

This investigation involved two phases. Phase 1 consisted of a pilot study used to develop the preliminary open-ended questions that make up the Delphi questionnaire. Phase 2, constituted the main study. The main Delphi study consisted of recruiting panelists and nominees, and then, four rounds of data collection and analysis. The first round was the brainstorming round where panelists generated competency statements. Content analysis was utilized after Round 1 to identify categories that emerged from their statements. Rounds 2 and 3 conveyed the panelists' categorized competency statements, ratings of agreement, and provided an opportunity for panelists to add, edit, and/or provide a rationale for any statements. Round 4 was tentatively set as the last round, as the number of rounds in the Delphi method is not pre-determined and was used to relay the results and gain feedback from panelists regarding their interpretations of the results, barring evidence that further iterations were necessary.

### **Phase 1: Pilot Study**

The pilot study was launched in September of 2017. It explored the relevance of the open-ended questions to be used in the initial round of the actual Delphi method. The pilot study sought to gain feedback from counselor educators on the two forms that will be used in Round 1 of the main study, enacting the Delphi method. The forms included a one-page synopsis providing directions and the context for the study (see Appendix A), as well as the Delphi questionnaire (see Appendix B), including brief demographic

questions (see Appendix C). Skulmoski et al. (2007) discussed the important role of pilot studies in Delphi research because it helps reveal problems in the survey instrument and improve the comprehension of the survey. The results from the pilot study will be used to further refine the Delphi questionnaire, instruction page, and ensure comprehensibility.

### **Sampling Procedures**

The pilot study was used to gain feedback on the Delphi questionnaire and instruction page to be used in the first round of the main Delphi study. The individuals were chosen based on a culturally diverse representative sample of individuals that fit the inclusion criterion for the expert panel. A recruitment e-mail (see Appendix D) including the one-page introduction, and the Delphi questionnaire was sent out. The counselor educators were asked to provide specific feedback evaluating the two forms. Feedback was requested specifically regarding the clarity and comprehensibility of the forms and questions, as well as suggestions or edits for either form.

The pilot study consisted of gaining feedback on the Delphi questionnaire and the instruction page from six counselor educators who met the inclusion criteria to be considered as “experts” in the field of trauma. All participants had earned doctoral degrees in counselor education and were counselor educators with expertise in trauma. Additional demographic information can be found in Table 1.

Table 1

Pilot Study Demographic Data ( $N=6$ )

Characteristics	Value	Percentage
Gender		
Male	3	50.00%
Female	3	50.00%
Age		
20-29		
30-39	2	33.33%
40-49	2	33.33%
50-59	1	16.66%
60-69+	1	16.66%
Ethnicity		
Pacific Islander	1	16.66%
Caucasian	4	66.66%
Multiracial	1	16.66%
Work Role		
Professional Counselor	6	100.00%
Counselor Educator	6	100.00%
Supervisor	6	100.00%
Personal Counseling Track		
Clinical Mental Health	4	66.66%
School Counseling	1	16.66%
Couples and Family Counseling	1	16.66%

**Procedures**

A request to complete the study was approved by the Institutional Review Board at The University of North Carolina at Greensboro. The pilot study was deemed as a low risk to participants and therefore received exempt status from the Institutional Review Board. A recruitment e-mail was sent out and included a request for participation and feedback, a description of the pilot study, an instruction page providing the protocol and

context for the study, and the Delphi questionnaire. If the individual wished to participate, they were asked to provide their feedback on the two forms. Participants were asked to review the overall research question to analyze its congruence within the topic area as well as the appropriateness and clarity of the open-ended questions on the Delphi questionnaire, and contextual information provided on the instruction page. They were asked to critique the forms and provide feedback regarding clarity and comprehension, and then forward their responses and/or suggestions back to the researcher via e-mail. Six counselor educators, considered experts in the field of trauma, provided their judgments, suggestions, and editorial comments on the Delphi-questionnaire and instruction page. Table 2 illustrates the definition of terms the participants were provided.

Table 2

## Category Definitions

<b>Term</b>	<b>Definition</b>
<b>Educator Teaching Practices</b>	Any theory, method, and/or pedagogical approach (e.g., any instructional method, activity, case study, framework, lecture style, setup, teaching strategy), that you employ in the classroom to prepare counselor-in-training in the area of trauma.
<b>Trauma-related competency</b>	The minimal knowledge, skills, and attitudes an entry-level counselor (i.e., a novice entry-level counselor-in-training) working with trauma-exposed populations ought to possess. working with trauma-exposed populations ought to possess.
<b>Student Knowledge</b>	Trauma specific content (e.g., concepts, theories, facts, foundational information, and theoretical or practical understanding) acquired through education.
<b>Student Skills</b>	Ability, facility, or specific learned activity that is developed through training to be able to perform a task; the observable application of theory and knowledge that a student can demonstrate.
<b>Student Attitudes</b>	A view or perspective; the way a person views or behaves toward something; a predisposition or tendency to respond positively or negatively towards a certain idea, object, person, or situation.

## **Data Analysis and Results**

As Powell (2003) discussed, the open-ended questions must be carefully considered and directly focus on the research problem. The six participants were asked to review the Delphi-questionnaire, suggest amendments, and provide any comments they have regarding the forms. Specifically, the participants were asked to provide feedback on the form's clarity, the instruction page, the questions comprehensibility, understanding of how to respond to the questions, and any questions that they would change or add. The feedback from the participants was categorized and reviewed by the researcher and the dissertation chairs. All participants responded that the questions were clear. From the feedback received, instructions on the introduction form were clarified and enumerated. As for comprehensibility of the questions, three participants commented that examples under the definition of teaching practices were important to either include or leave broadly open, so examples were added under teaching practices to elaborate on what practical teaching activities and practices may include. All participants felt the questions were clear and understandable. One participant advised that an example response under each question to guide the respondent may be helpful. They suggested providing an answer from a different area of counseling so that the answer wouldn't be leading. Counter to this opinion, two participants advised just the opposite, that they felt an example would be detracting and that it was not necessary as it could be potentially leading. Also, a suggestion was made to add a word or phrase under the definition of 'attitudes' to speak to the development of certain dispositions or propensities so this definition was expounded upon.

## **Discussion**

Data and suggestions collected from this focus group, from the dissertation committee, and the dissertation proposal will be integrated into the structure of the study and discussed in the modifications section. The feedback from the critique of the forms in the pilot study was very helpful and aided in clarifying definitions, streamlining the instruction page, and adding in specific words for greater clarity and comprehension. Some limitations of the pilot study included researcher bias in that the researcher knew and selected each of the participants which could've unduly influenced the study. The pilot feedback was reviewed by another colleague, thereby limiting the influence of researcher bias. Another limitation may be the size of the pilot and geographic location of the participants. 6 out of 10 participants who were recruited responded and all six of the pilot study participants lived in the southeast, so different geographic regions were not represented.

### **Delphi Questionnaire Development**

The Delphi method permits researchers to utilize previous research and theory to formulate the questionnaires (Linstone & Turoff, 2002; Powell, 2003). There has been a burgeoning interest in competency-based education in professional counseling and psychology (Kaslow, 2004), and in the trauma-informed movement (Harris & Fallot, 2001). The researcher focused on the identification and delineation of foundational and core categories emerging from the research literature to inform the open-ended questions. The key components of the questions for the Delphi questionnaire were structured around the competency model (i.e., the knowledge, skills, and attitudes necessary for trauma

education), and also, influenced by the trauma-informed approach (i.e., the category of necessary pedagogical practices unique to trauma education; Harris & Fallot, 2001; SAMHSA, 2014). Attention was paid to context (i.e., higher education, ethical principles, standards, guidelines, and values of the profession) and developmentally informed and innovative approaches to training and thus the question related to teaching practices was included (Black, 2008; Harris & Fallot, 2002; Rogers, 1959, SAMHSA, 2014). The Delphi questionnaire design was informed by the research literature, data collected from the pilot study regarding feedback the questionnaire itself, as well as the recommendations of the dissertation committee.

### **Modifications**

Based on the pilot study, the proposal seminar, and consultation with the dissertation committee members, several modifications will be applied to this study and integrated into its structure. First, given the demographics of trauma-exposed populations, and diverse student populations, a diverse sample of counselor educators will be purposefully sampled to incorporate a culturally responsive research framework and represent a variety of cultures, perspectives, and trauma work with a variety of populations in different settings. Given the demographics of trauma-exposed populations, the researcher will ask how the teachers address diversity in their classrooms. The open-ended survey questions were amended from asking five questions to asking eleven questions to produce even more open-ended questions and to allow additional categories to emerge. Demographic questions were added to explicitly address culture, diversity, trauma specializations, and the course names educators infused trauma education in.

Researcher positionality was further expounded upon in the methods section, and the term ‘foundational’ replaced the term ‘critical.’ A culturally responsive research framework (Hood et al., 2005) was infused throughout Chapters I-III, making clearer the links between theory and execution of the study.

## **Phase 2: Main Study**

### **Population and Sampling Procedures**

Upon IRB approval, 10 potential participants were identified and contacted via e-mail. These 10 individuals were asked if they were willing to participate in the study (see Appendix E) and, if so, would they nominate additional individuals who met the specified inclusion criterion and whom they believed were experts. The nomination e-mail to potential participants can be found in Appendix F. Ludwig (1994) stated that solicitation of nominations of known and respected members from within the target group of experts was acceptable. The goal of this study was to recruit up to 20 and retain a minimum of 10 panelists throughout the rounds (Powell, 2003). Counseling research utilizing the Delphi method indicated the possible risk of high attrition rates ranging anywhere from 26% to 70% (Doughtry, 2009; Mellin & Pertuit, 2009; Powell, 2003). Considering the possibility of high attrition rates, each individual who was nominated by the experts was contacted and asked to participate. The initial recruitment e-mail included the informed consent form (Appendix G). Receipt of participants’ consent forms signaled their agreement to participate. Upon receipt of their consent to participate, an e-mail with the link to the Delphi questionnaire, which included a brief demographic questionnaire, was sent to the panelists who agreed to proceed with participation in Round 1. The

panelists completed the link via the online Qualtrics survey. All data collection utilized the Qualtrics online survey interface to capture the panelists responses and ensure the anonymity of their responses and scores.

### **Data Collection and Analysis of Data Procedures**

Data collection included four rounds over a period of two months. All rounds were conducted electronically, via e-mail and utilized Qualtrics to capture the data. Panelists were e-mailed instructions with the link to the Qualtrics survey prior to each round. For Round 1, individuals who consented to participate were e-mailed the instruction page that provided the context and protocol for the study, along with the Qualtrics link to the survey, including demographic questions and the Delphi questionnaire. Round 1 facilitated exploration of the inquiry at hand and allowed panelists to provide their expert opinions as they answered the open-ended questions with as many statements as they wished. Panelists were also able to add any important components they thought should be included that were not listed. The panelists were provided with a definition of a trauma-informed approach and trauma competency on the instruction page. Content analysis was utilized after Round 1 to analyze the results and form the different categories and subcategories (Krippendorff, 2013). An additional coder aided the researcher in identifying the categories. Round 2 was used to determine areas where the panelists agreed and disagreed. The goal of Round 2 was to move towards consensus on the items panelists generated from Round 1 (Powell, 2003). Round 3 provided the panelists an opportunity to re-rate items that did not meet the consensus cutoff from Round 2 (Fletcher-Johnston et al., 2011). Panelists were given the

opportunity to respond to any items that changed, to add, edit, and/or provide their rationale for items that did not meet consensus as per the median score (greater than or equal to 6 on a 7-point Likert scale) and the IQR (maximum IRQ of less than or equal to 1). Round 4 was meant to provide panelists with the final items of the study that reached consensus and another chance to review one another's ratings and responses. This final round asked panelists to provide their interpretation of the results, provide any questions they were left with, and the opportunity to relay any final comments or thoughts about trauma education. The Qualtrics surveys remained open for two weeks so panelists could review one another's comments and ratings and respond to the survey in light of other panelists' responses. Data analysis with statistics (interquartile ranges and median scores) and reflections including the participants rationales were provided to participants via e-mail after each round (Duncan, 2006; Green, Jones, Hughes, & Williams, 1999; Hasson et al., 2000).

### **Round 1**

The first round of the Delphi process began with the open-ended Delphi questionnaire that captured extensive demographic information. One variation made during this brainstorming round, was to insert a seed, meaning, the researcher(s) eluded to *a priori* categories from key emergent themes (i.e., knowledge, skills, and attitudes) identified in the relevant literature and pilot studies (Greenstein & Hamilton, 1995; Skumolski et al., 2007). The purpose was to account for factors that were relevant to the inquiry at hand and to align with a constructivist framework considering multiple voices for knowledge construction. Use of *a priori* categories from the literature served as the

starting point for narrowing alternatives, but did not eliminate the brainstorming phase, rather inspired the eleven open-ended questions with information derived from the research literature to guide the responses, while allowing additional categories to emerge. The Delphi questionnaire functioned as the cornerstone for soliciting information about the content area from the expert panelists (Custer, Scarcella, & Steward, 1999), then, content analysis was used to analyze all the responses to the open-ended questions (Powell, 2003). The researcher utilized the assistance of an additional coder to analyze panelists' responses to formulate the categories and subcategories including the list of statements for Round 2. This questionnaire was utilized as the survey instrument for Round 2 and included a 7-point Likert scale, with 1 being *strongly disagree*, and 7 being *strongly agree*, next to each item so the panelists could rate each item with their level of agreement. A space was provided so panelists could also comment, add to, or edit their responses.

### **Content Analysis**

Content analysis was used in this study as part of the methodology to provide a systematic means for analyzing and coding the text gained from the experts' answers to Round 1 of the Delphi questionnaire. Content analysis is commonly used to analyze data from Phase 1 (Powell, 2003) and then code the data into themes or categories (Krippendorff, 2013). The methodology of content analysis is appropriate for both quantitative and qualitative means for analysis of the text (Neuendorf, 2017). This study utilized *a priori* categories derived from the literature and based on a competency framework (i.e., skills, knowledge, and attitudes) to deductively code the experts' text-

based responses. Content analysis also permitted categories to emerge from the data received from the expert panelists. So, in addition to examining existing categories, this study employed an inductive approach to allow for emergent categories (Krippendorff, 2013). This allowed for the examination of existing and emergent categories, in addition to examining the relationships between both the existing and emergent categories (Powell, 2003). Categories and subcategories were formed constructively from the research literature, and the researchers' interpretations of expert opinion statements. The researcher used an additional coder who aided in the content analysis, due to its centrality within the Delphi method which added another layer of trustworthiness (Powell, 2003).

**Coding scheme.** Content analysis uses the text gained from asking questions, as the units of data analysis (Neuendorf, 2017; Perrin, 2002), and in this case, the researcher and the additional coder served as the coders of this data. The coding involved each of the researchers using a coding scheme that included the set of *a priori* nominal categories (i.e., knowledge, skills, attitudes) and their definitions in a codebook for the text analysis. The codebook corresponded to a coding form which provided space for the researchers to record and categorize the data. The coding form included space to note new emergent categories or subcategories. Each researcher reviewed and coded the content based on their objective analyses and then *a priori* categories (Neuendorf, 2017). To aid in intercoder reliability, detailed definitions of the *a priori* categories were established beforehand and the coders independently and then collectively analyzed and discuss the text to reach consensus. Prior to coding all the data, the coders reviewed and analyzed two of the participants' responses, then came together and reviewed and discussed their

interpretations to reach consensus. They documented this process regarding their interpretation in journals logging their independent and collective analysis. Then, the coders reviewed all the responses from the open-ended questions, first inductively to assess what categories emerged and then, deductively and coded the data that matched the *a priori* categories.

**Criteria of reliability and validity.** Mays and Pope (1995) used the term reliability and claimed this significant criterion to assess the value of research. They stated qualitative research can be enhanced by employing an independent assessment of transcripts by additional coders and then comparing the agreement between raters (1995). One way to determine whether two coders are consistent in evaluating the characteristics of the text is to measure consistency through an indicator of measurement such as inter-rater reliability. Even though intercoder reliability does not ensure validity, it is an important element in content analysis (Krippendorff, 2013; Powell, 2003). It is important to establish inter-rater reliability to ensure that the process for information collecting is consistent enough that the same results may be obtained repeatedly. Having a good measure of inter-rater reliability, along with sound survey construction, allows the researcher to be confident that the information has been collected in a consistent manner (Neunedorf, 2017). The goal of content analysis is to objectively identify characteristics of text. Therefore, it is critical to establish inter-rater reliability because without it the coding schemes are useless (Neunedorf, 2017). For estimating the inter-coder reliability used in qualitative content analysis it is recommended that researchers select one or more indices based on the characteristics of the study, such as a percentage of agreement or

Cohen's Kappa (Hayes & Krippendorff, 2013; Neuendorf, 2017). Cohen's kappa is considered to be an improved measure over using the percentage of agreement to evaluate interrater (Neuendorf, 2017).

***Inter-rater reliability.*** Cohen's kappa is a widely cited method for estimating reliability for nominal data (Cohen, 1960; Hayes & Krippendorff, 2007; Krippendorff, 2013; Neuendorf, 2017). Cohen's kappa attempts to measure agreement between two coders accounting for their chance agreement. Thus, the calculation specifies how much agreement to expect by chance, how much agreement over and above chance was achieved, and computes the ratio of these values to find how much agreement is actually observed over and above what would be expected by chance (Neuendorf, 2017). Cohen's kappa has a value from -1 to 1; a value of 0 depicts purely incidental agreement; values below 0 indicate agreement worse than chance; a value between 0 and 1 indicates some degree of agreement (Cohen, 1960). The closer the score is to 1 the better the agreement which has been reached. However, one agreed upon set of conclusive criteria for a kappa value that denotes sufficient agreement has not been agreed upon (Cohen, 1960). Burla, Knierim, and Barth (2008) noted that kappa values of 0.40–0.60 are considered satisfactory agreement and values above 0.80 suggest perfect agreement. On the other hand, Lombard, Snyder, and Bracken (2002) suggested that 0.90 is acceptable, despite values over 0.70 being consistently used in exploratory research. For the purposes of this study values of .70 or above were considered satisfactory and the intended purpose of the statistic was to estimate the reliability of the mean ratings from multiple coders.

## **Round 2**

In the second round, each panelist received a recruitment e-mail (see Appendix H) to participate, including instructions and the Qualtrics link to complete the study questionnaire which was formulated from their responses from Round 1 (Appendix I). The panelists were asked to review the items summarized based on the information provided from the first round. Delphi panelists were asked to rate each item to establish the priorities among the items, in this case, on a 7-point Likert scale, with 1 being *strongly disagree* and 7 being *strongly agree*. Panelists will be provided room under each statement to provide the rationale for their rating. Panelists were encouraged to make any comments, edits, or add new items they felt were missing from the list provided. As a result of round 2, areas of disagreement and consensus were identified. Consensus began to form.

## **Round 3**

In the third round, each panelist received a recruitment e-mail (Appendix J) inviting them to continue participation. This e-mail included the instructions and the Qualtrics link needed to complete the study questionnaire (Appendix K) which included the items and ratings, as well as the comments summarized by the researcher from the previous round (see Appendix L). Panelists were asked to revise their judgements or specify the reasons for remaining outside consensus (Linstone & Turoff, 2002). This third round provided panelists with an opportunity to further clarify their positions regarding the items and their judgements surrounding the importance of items. Compared to the

previous round, only a slight increase in levels of consensus was expected (Dalkey & Rourke, 1972; Linstone & Turoff, 2002).

#### **Round 4**

In the fourth and final round, a recruitment e-mail (see Appendix M) to continue participation was sent that included the Qualtrics link to complete the study questionnaire (Appendix N). The list of comments from Round 3 (see Appendix O), the remaining items that achieved consensus with the ratings, and minority opinions and ratings on items that did not reach consensus were e-mailed to the panelists for review only. The panelists were provided with one last opportunity to survey their judgments and see one another's opinions. No changes or edits were made to these items from round 3. In this final round, an e-mail with a link to the last Qualtrics survey, along with the document summarizing the results was e-mailed to the panelists (Appendix P). Panelists could access the survey for two weeks. Panelists were asked to review the results, comment on their interpretation of the results, relay any questions they were left with, and provide any take-away's or comments they had not already included regarding trauma training and education in counselor education.

**Data analysis.** The analysis of the Delphi questionnaire included establishing if consensus was reached by analyzing the experts' ratings of agreement and their levels of agreement as to what they perceived the necessity of the items to be. Between each round the median, mode, and interquartile range (IQR) were calculated. The median indicated the middle of the distribution and was used because it was less sensitive to extreme scores. The median score is the number that divided the distribution in half. The IQR was

calculated by dividing the distribution into four equal parts using quartiles. The IQR is the distance between the first and third quartile and it provided a measure of dispersion describing the middle 50% of the scores and it is not influenced by extreme scores (Gravetter & Wallnau, 2000). Only statements with an IQR of 1.0 or less were included in Rounds 2 and 3. Descriptive statistics and measures of dispersion for each item were reported to panelists in Rounds 2, 3, and 4.

Only items that received a median rating of 6 or higher, on a Likert-scale from 1–7, were included in the final list of foundational components of trauma education (Stone Fish & Busby, 2005). Items rated a 6 or greater indicated consensus agreement and a high necessity. Additionally, an IQR of 1.0 or less indicated consensus had been reached. Items that met the cutoff scores were included in further rounds as part of the list of foundational knowledge, skills, and attitudes panelists agreed upon. Items that did not reach consensus due to low importance or inability to agree, were included along with comments, for panelists to review and were attached in a document e-mailed to them, along with final list of items that reached consensus.

### **Researcher Bias and Positionality**

The researcher's understanding of the literature and topic was inevitably a unique construction, rather than a completely objective perception of reality. No construction posited in this work claimed absolute truth. The researcher's beliefs were shaped by her assumptions and prior experiences, as well as by the realities interacted within. This study was influenced by the researcher's belief in interdisciplinary scholarship and a culturally responsive research framework (Frierson, Hood, & Hughes, 2005), as well as

the historical development of the field which offered a critical lens to understand the current omissions, tensions, assumptions, and approaches in the field of trauma education. In terms of the practical role of the researcher, the execution of the Delphi methodology must be carried out. The Delphi method is a complex undertaking in that the amount of organization involved in its planning, implementation and management was considerable (Fletcher-Johnston et al., 2011). It was the role of the researcher to develop the questionnaires, analyze the data, and prepare the feedback for each round while ensuring that there was an appropriate ranking system in place in the later rounds of the process as the iterative rounds took place (Gordon & Helmer, 1964). In preparing the demographic questions and eleven open-ended questions that made up the Round 1 survey, the researcher considered the history and culture of the current trauma population in the United States, as well as the diverse student populations. Additionally, the historic, political, and social factors salient were considered and thus, the purposeful selection of a trauma-informed approach that is based off of a socioecological frame (Bronfenbrenner & Ceci, 1994). A culturally responsive research framework guided the selection of a trauma-informed approach, and while the individual voices of trauma survivors are not directly represented, a trauma-informed approach is made up of the weaving together of trauma research, trauma practitioners' voices, and the voices of trauma survivors. The panelists also had extensive experience with many different populations in various settings and sectors of practice and teaching. The researcher's role was to delineate the bounds of the study, identify the expert inclusion criteria, set up the Delphi questionnaire, invite participants and receive consent, collect, transcribe, and analyze the data, and

finally, report the results in a transparent fashion. Throughout the study the researcher(s) kept a reflexive journal to incorporate critical subjectivity and to document the experience and possible influences on data interpretation. The journal kept track of personal reflections, reactions, and insights. Part of the bracketing process involved journaling as well as ongoing conversations with the dissertation committee and the additional coder. While the researcher worked towards complete transparency and forthrightness regarding her own subjectivity and the procedures utilized so that the study could be replicated, there is also the acknowledgment that the conceptual framework and research lens were mediated through a human instrument.

My dual role as a researcher and trauma counselor impacted the design, allowing my tacit knowledge of trauma and counselor education to be incorporated as an asset, rather than a liability (Lincoln & Guba, 1985). Several core assumptions aligned with the framework of this study which are congruent with its purposes, such as the belief that various realities are constructed collaboratively by individuals drawing from current and historical experiences (Lincoln & Guba, 1985). The researcher was heavily influenced by a culturally responsive research framework (Hood et al., 2005) which accounted for the use of a trauma-informed approach (SAMHSA, 2014) which is based upon a socioecological framework (Bronfenbrenner & Ceci, 1994). The research questions aimed to collect data from a diverse population to represent various perspectives and experiences to further develop categories from the literature, pilot study, and the main study. As the categories emerged, I discussed them with my dissertation committee and met with the additional coder, as well as using the last round of the Delphi study to relay

and discuss the themes with the participants through member checks and follow-up questions.

### **Summary**

Chapter III reviewed the purpose statement, research question, Delphi methodology, research design, and procedures in the current study. The Delphi method was selected and explored foundational components panelists deemed as foundational for the preparation of counselors-in-training in counselor education. The researcher expounded on her own personal bias and positionality. In Chapter IV, a summary of the results of the study are provided. Lastly, Chapter V includes a discussion, summary of the findings, conclusions, and the recommendations for future research.

## CHAPTER IV

### RESULTS

The purpose of this Delphi study was to answer and reach consensus on the following research question:

**Research Question 1:** What do a group of counselor educators with clinical expertise in trauma deem as the foundational knowledge, skills, attitudes necessary to prepare counselors-in-training in masters counseling programs to provide trauma-informed counseling?

A secondary aim was to investigate and collect data but not seek consensus, on the following question below which will be used for future research:

What teaching practices do counselor educators identify as important to consider in the preparation of counselors-in-training to provide trauma-informed counseling?

To address the first research question and collect data to explore the secondary inquiry related to trauma teaching practices, the study began with an open-ended survey which served as the cornerstone for soliciting specific information about the content area from the Delphi panelists. Panelists were asked to brainstorm and relay their expert opinions regarding eleven open ended questions that addressed the knowledge, skills, and attitudes they deemed as foundational to prepare entry-level masters counseling students to provide trauma-informed care and counseling. The open-ended questionnaire also included questions regarding trauma pedagogy to collect data for future research.

This chapter is divided into five sections. The first section will present the results of Delphi Round 1, in which counselor educators with expertise in trauma, referred to as panelists, responded to an online questionnaire asking them to first brainstorm and then provide their opinion statements in response to eleven open-ended questions. The eleven open-ended questions explored the components the panelists deemed as foundational for masters-level trauma education. The second section presents the results of Delphi Round 2, in which the panelists were asked to evaluate and rate the representative statements generated from Round 1 to provide their level of agreement (*1 – Strongly Disagree to 7 – Strongly Agree*) as to the necessity of each item for the training of master students to provide trauma-informed counseling. Panelists were asked to provide justifications for their rating if they rated an item anything other than a 6 or 7 indicating strong agreement (Gall et al., as cited in Doughty, 2009), and they were also given the opportunity to add, edit, or provide comments on any items. Section 3 will present the results from Delphi Round 3, in which panelists were asked to re-evaluate their responses to items that consensus was not reached ( $IQR \geq 1.0$ ) given the median and IQR for each item calculated from Round 2. Panelists were asked to provide justification for their ratings regardless of whether they rated the item as anything other than the median score from Round 1 (Doughty, 2009; Wester & Borders, 2014). They were also given the opportunity to view all comments and to provide any additional rationales, edits, or comments. Section 4 presents all items originating out of Rounds 1, 2, and 3 from the Delphi study upon which the panelists reached consensus, as well as the items that did not reach consensus, and any final comments or questions that panelists offered in Round

4 (Wester & Borders, 2014). The items that reached consensus were categorized to provide a meaningful framework for presenting the 99 foundational components of trauma education that reached consensus. This process resulted in 4 competency domains and several subcategories.

### **Delphi Round 1 Results**

Delphi Round 1 addressed Research Question 1: What do a group of counselor educators with trauma expertise deem as the foundational components for trauma education to prepare counselors-in-training to an entry-level of competence to provide trauma-informed counseling? The Round 1 questionnaire (Appendix B) was formulated electronically using the online survey instrument, Qualtrics. Potential participants received an email explaining their selection or nomination as a counselor educator with expertise in trauma and were provided with the Qualtrics link to the online questionnaire (Appendix E) and the Consent to Participate Form (Appendix G). The online questionnaire for Delphi Round 1 also included open-ended questions addressing Research Question 2 exploring effective trauma pedagogy. The responses related to trauma pedagogy were captured as part of an exploratory inquiry only, and these questions were intentionally excluded from the iterative Delphi rounds as there was no intention to reach consensus.

### **Response Rate**

Of the 30 e-mails sent to experts, 17 responded and agreed to participate, as well as nominating 3 additional individuals who they believed to be experts. The 3 individuals who were nominated also agreed to participate. A total of 20 panelists agreed to

participate in Round 1. One individual started the questionnaire, but only completed the demographic questions and was not included in the response rate for the rounds of the Delphi study ( $N=19$ , Response rate = 63%). Nineteen panelists responded to all 11 open-ended questions for Round 1. Results in the form of opinion statements were compiled by the researcher, and anonymous study ID's were assigned to each participant's set of data. Each study ID was connected to the participant's e-mail address in a password-protected file separated from the study data. All panelists responses were captured through the online survey website, Qualtrics, which allowed for individual responses and anonymity of responses.

### **Demographics**

Twenty (100%) panelists completed the demographic questions, but 19 panelists (95%) completed all the open-ended survey questions included in the Round 1 questionnaire. Fourteen panelists participated in Round 2, and ten panelists continued to participate in Rounds 3 and 4. There is no power analysis in the Delphi method; rather, representativeness of the results is based upon the quality of the expert panel, rather than on its size (Powell, 2003). The following demographic questions were asked to ascertain the expertise of the panel, as well as provide a description of their primary work roles, culture, perspectives related to trauma, and trauma-exposed populations they have served (Chouinard & Cousins, 2009; Friere, Hood, & Hughes, 2005). Influenced by a culturally responsive research framework, a diverse panel was purposefully selected to represent a variety of participants in an effort to represent various cultural contexts of the trauma

exposed-populations, and diverse student populations counselor educators interact with (Friere, Hood, & Hughes, 2005).

**Gender.** All 20 panelists (100%) completed the gender question. For Round 1, of the 20,  $n=4$  were male (20%) and  $n=16$  were female (80%) (Table 2). By Round 4, the composition of panelists who completed rounds was made up of  $n=8$  females (80%) and  $n=2$  males (20%) (Table 3).

Table 3

Rounds 1-4—Gender

Gender	<i>n</i>	%
Round 1 ( <i>N</i> =20)		
Male	4	20%
Female	16	80%
Round 2 ( <i>N</i> =14)		
Male	4	29%
Female	10	71%
Rounds 3 and 4 ( <i>N</i> =10)		
Male	2	20%
Female	8	80%

**Age.** Twenty (100%) of the panelists completed the question about their age. Of the 20, two panelists (10%) fell within the range of 20-29, 10 panelists (50%) were between the ages of 30 and 39, one panelist (5%) was within the age range of 40–49, two (10%) were between 50 and 59, four (20%) were between the ages of 50 and 59, and one panelist was between the ages of 70 and 79 (Table 3). The most prevalent age range

throughout the study was 30-39, with over 60% of participants falling within this bracket (Table 4).

Table 4

## Rounds 1-4—Age

Age	<i>n</i>	%
Round 1 ( <i>N</i> =20)		
20-29	2	10.00%
30-39	10	50.00%
40-49	1	5.00%
50-59	2	10.00%
60-69	4	20.00%
70-79	1	5.00%
80-89	0	0.00%
Round 2 ( <i>N</i> =14)		
20-29	1	7.14%
30-39	9	64.29%
40-49	0	0.00%
50-59	1	7.14%
60-69	2	14.29%
70-79	1	7.14%
80-89	0	0.00%
Rounds 3 and 4 ( <i>N</i> =10)		
20-29	0	0.00%
30-39	7	70.00%
40-49	0	0.00%
50-59	1	10.00%
60-69	2	20.00%
70-79	0	0.00%
80-89	0	0.00%

**Ethnicity.** Twenty (100%) panelists responded to the question addressing ethnicity. Of the 20, 14 (70%) responded as Caucasian/White, 2 (10%) responded as

Asian American/Pacific Islander, 2 (10%) responded as African American/Black, 1 (5%) responded as Multiracial, 1 (5%) responded as Other, and was provided with space to clarify if they chose to and clarified with Taiwanese American (Table 12). The composition of the panelists who generated the items versus the ending composition was very similar. In Round 4, of the 10 panelists who completed all rounds 1 (10%) responded as Multiracial, 1 (10%) responded as African American/Black, (1 (19%) responded as Asian American/Pacific Islander, and 7 (70%) responded as Caucasian/White (Table 5).

Table 5

## Rounds 1-4—Ethnicity

Ethnicity	<i>n</i>	%
Round 1 ( <i>N</i> =20)		
African American/Black	2	10.00%
Asian American/Pacific Islander	2	10.00%
Caucasian/White	14	70.00%
Multiracial	1	5.00%
Other*	1	5.00%
Round 2 ( <i>N</i> =14)		
African American/Black	2	14.28%
Asian American/Pacific Islander	1	7.14%
Caucasian/White	10	71.43%
Multiracial	1	7.14%
Other	0	0.00%
Rounds 3 and 4 ( <i>N</i> =10)		
African American/Black	1	10.00%
Asian American/Pacific Islander	1	10.00%
Caucasian/White	7	70.00%
Multiracial	1	10.00%
Other	0	0.00%

Note. \*Other response = Taiwanese American

**Years of teaching experience.** Twenty (100%) experts responded to the question addressing how many years of experience they held as a counselor educator (Table 5). They were then asked the number of years of experience as counselor educators in which they had specifically included trauma related content in their curriculum (Table 6 and Table 7). By Round 4, 90% of the panelists who completed all iterations had specifically incorporated trauma into their curriculum for three or more years.

Table 6

Round 1—Years of Teaching Experience as a Counselor Educator ( $N=20$ )

Years of Teaching Experience	<i>n</i>	%
6 months – 1 year	2	10.00%
1-4 years	9	45.00%
5-10 years	1	5.00%
11-15 years	1	5.00%
16-20 years	2	10.00%
21-30 years	4	20.00%
31+ years	1	5.00%

Table 7

Rounds 1-4—Years of Teaching Experience Integrating Trauma-Related Content

Years of Teaching Experience	<i>n</i>	%
Round 1 ( $N=20$ )		
0-6 months	3	15.00%
1-3 years	8	40.00%
4-6 years	2	10.00%
7-10 years	3	15.00%
16-20 years	0	0.00%
21-25 years	1	5.00%
26+ years	3	15.00%

Table 7

Cont.

Years of Teaching Experience	<i>n</i>	%
Round 2 ( <i>N</i> =14)		
0-6 months	2	14.29%
1-3 years	6	42.86%
4-6 years	3	21.43%
7-10 years	1	7.14%
16-20 years	0	0.00%
21-25 years	1	7.14%
26+ years	1	7.14%
Rounds 3 and 4 ( <i>N</i> =10)		
0-6 months	1	10.00%
1-3 years	5	50.00%
4-6 years	2	20.00%
7-10 years	1	10.00%
16-20 years	0	0.00%
21-25 years	0	0.00%
26+ years	1	10.00%

**Course offerings integrating trauma.** Twenty (100%) panelists were asked to list the course names of the primary classes in which they integrated trauma-related material (Table 8).

Table 8

Rounds 1-4—Courses in which Counselor Educators Integrate Trauma-Related Material

(N=20)

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Sexual Abuse Counseling
Counseling the Addicted Person
The Addictive Process
Substance Abuse and the Family System
Practicum in Individual Counseling
Internship in School Counseling and
Guidance Orientation to Clinical Counseling
Legal and Ethical Issues in Counseling
Psychology
Psychological Trauma and Intervention for Individuals, Families and Communities
Appraisal and Assessment in Counseling
Internship in Clinical Counseling
Counseling Survivors of Trauma
Integrating Somatic Interventions in Trauma Treatment
Addictions/Substance Use
Dialectical Behavior Therapy
Crisis Intervention
Diagnosis and Treatment Planning;
Human Development
Treatment in Trauma Recovery
Death and Grief Counseling
Ecology of Domestic Violence
Counseling Victims, Perpetrators, and Children of Domestic Violence
Psychophysiology of Trauma
Advanced Trauma Techniques
Trauma and Suffering
Counseling Culturally Diverse Clients
Career and Life Planning; Stress Management
Counseling Diverse Populations
Human Growth and Development
Diagnosis and Treatment Planning Developmental Issues and Strategies
Stand-alone course on trauma
Internship class
Crisis Counseling
Trauma Counseling
Professional Issues and Ethics
Psychopharmacology
Mental Health Counseling

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Table 8

Cont.

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Crisis, Trauma, and Loss
Trauma Counseling
Counseling for Grief and Loss
Advanced Treatment Planning
Advanced Skills and Practicum Supervision
Crisis Counseling
Legal and Ethical Issues in Counseling
Counseling the Sexually Abused Client
Sexuality and Healthy Relationships

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**Description of primary work role.** Twenty (100%) of the panelists responded to the question addressing their current primary work roles. Respondents could indicate more than one role, if they considered more than one as primary. When asked to respond to what best described the role(s) in which they presently worked,  $n=15$  (44.12%) chose Counselor Educator,  $n=9$  (26.47%) chose Supervisor,  $n=8$  (23.54%) chose Professional Counselor,  $n=1$  (2.94%) chose Counselor Administrator, and  $n=1$  (2.94%) was currently teaching mental health to undergraduates (Table 16). The majority, 78% in Round 2 and 80% in Round 4, indicated their primary work role as counselor educators. Of the 10 panelists who responded to Round 4,  $n=8$  (80%) indicated Counselor Educator as their primary work role,  $n=1$  (10%) selected Supervisor, and  $n=1$  (10%) indicated Counselor Supervisor/Counselor Administrator as their primary role. Six (60%) of the 10 panelists in the final round also indicated that they are actively engaging in providing trauma counseling (Table 9).

Table 9

## Rounds 1-4—Description of Primary Work Role(s)

Work Role(s)	<i>n</i>	%
Round 1 ( <i>N</i> =20)		
Counselor Educator	15	44.12%
Supervisor	9	26.47%
Professional Counselor	8	23.53%
Counselor Administrator	1	2.94%
Agency Director	0	0.00%
Other*	1	2.94%
Round 2 ( <i>N</i> =14)		
Counselor Educator	11	78.57%
Supervisor	6	42.86%
Professional Counselor	6	42.86%
Counselor Administrator	1	7.14%
Agency Director	0	0.00%
Other	0	0.00%
Rounds 3 and 4 ( <i>N</i> =10)		
Counselor Educator	8	80.00%
Supervisor	5	50.00%
Professional Counselor	6	60.00%
Counselor Administrator	1	10.00%
Agency Director	0	0.00%
Other	0	0.00%

*Note.* \*Other responses = Undergraduate Professor currently teaching mental health.

**Description of institution CACREP accreditation.** Twenty (100%) panelists responded to the question addressing whether they currently taught at a CACREP accredited institution. Of the 20 respondents, *n*=13 (65%) indicated their graduate counseling programs were CACREP accredited, *n*=5 (25%) indicated their programs were not CACREP accredited, *n*=1 (5%) indicated their institution's CACREP

accreditation was pending, and  $n=1$  (5%) response indicated their current work was at residential institution. In Round 2,  $n=9$  (64.29%) of the 14 panelists indicated their university held the accreditation, and in Rounds 3 and 4,  $n=7$  (70%) of the 10 panelists indicated their graduate counseling programs were CACREP accredited (Table 10).

Table 10

## Rounds 1-4—CACREP Accredited Institution

CACREP Accreditation	<i>n</i>	%
Round 1 ( $N=20$ )		
Yes	13	65.00%
No	5	25.00%
Accreditation Pending	1	5.00%
Other*	1	5.00%
Round 2 ( $N=14$ )		
Yes	9	14.28%
No	3	7.14%
Accreditation Pending	1	71.43%
Other*	1	7.14%
Rounds 3 and 4 ( $N=10$ )		
Yes	7	70.00%
No	2	20.00%
Accreditation Pending	1	10.00%
Other	0	0.00%

Note. \* Other responses = Female Residential Faculty.

**Counseling track.** Twenty (100%) experts responded to the question addressing their personal professional counseling track. Of the 20 respondents,  $n=18$  (90%) chose Clinical Mental Health,  $n=1$  (5%) chose School, and  $n=1$  (5%) chose Couple and Family

(Table 11). The Clinical Mental Health Track was also prevalent throughout Rounds 2, 3, and 4 including 80% or more of participants.

Table 11

## Rounds 1-4—Personal Professional Counseling Track

Counseling Track	<i>n</i>	%
Round 1 ( <i>N</i> =20)		
Clinical Mental Health	18	90.00%
School Counseling	1	5.00%
Couple & Family	1	5.00%
Round 2 ( <i>N</i> =14)		
Clinical Mental Health	12	85.71%
School Counseling	1	7.14%
Couple & Family	1	7.14%
Rounds 3 and 4 ( <i>N</i> =10)		
Clinical Mental Health	8	80.00%
School Counseling	1	10.00%
Couple & Family	1	10.00%

**Description of the diversity of the graduate counseling student population.**

Twenty panelists responded to the question asking them to describe the diversity of the graduate counseling student population that they teach. This was an open response question. Of the 20 responses, eight panelists indicated their student populations were predominantly made up of Caucasian females with limited diversity; nine panelists described their student populations as moderately to highly diverse; one panelist described the diversity of their student population as whoever was admitted to the university program; one explained their student population included some ethnic

diversity, but mostly diversity among gender, class, and spirituality; and finally, one panelist described their students as new interns or professionals in the field (Table 12).

The panelists who continued through Rounds 2, 3, and 4 indicated the majority of student populations were made up of Caucasian females or males, ages 20-30.

Table 12

Rounds 1-4—Description of the Diversity of Student Population Taught

Description
<p>Round 1 (N=19)</p> <ul style="list-style-type: none"> <li>• Gender, Class, Religious/Spiritual Diversity is common among my students. There is <i>some</i> ethnic diversity and disability diversity among the graduate student population I teach.</li> <li>• Currently, the masters level students I teach are diverse in age, sex, gender, cultural background, ethnicity, culture, spirituality, and ability. They are also quite diverse in their theoretical orientations and future career goals. Previously I have worked with both master's and doctoral level trainees, as diverse as my current group in noted areas.</li> <li>• Licensed professionals, interns in the field, new therapists to the field</li> <li>• Predominately White, heterosexual, age 21-31, women.</li> <li>• We teach all graduate students who are admitted to the University.</li> <li>• Majority of white students</li> <li>• limited diversity</li> <li>• I teach at a minority-serving public university in the southeast. Approximately 40% of my students identify as minority students.</li> <li>• The majority of my students are white, including both males and female. A small percentage of students identify as transgender. A small percentage of students are Black/African American.</li> <li>• I currently teach master's and doctoral students who are attending graduate school full-time in a mid-sized city surrounded by rural areas. Our master's students are about 80% female, white, and Christian; they often come from southeast region. Our doctoral students tend to be more diverse in gender, ethnicity, and regionality.</li> <li>• Highly diverse</li> <li>• male and female—all ethnicity, disabilities, etc.</li> <li>• International visa students, Latin American, African American</li> <li>• Students are from the United States and multiple foreign countries.</li> </ul>

Table 12

Cont.

Description
<p>Round 1 (cont.)</p> <ul style="list-style-type: none"> <li>• 90% women, 70% identify as Christian, 10% as agnostic, 10% as Jewish or Buddhist 15% African American, 10% Latin-X, 5% Asian, MENA, International, 20% LGBT, 60% first generation in graduate programs, 15% with a disability requiring accommodations.</li> <li>• The student population is not very diverse. Most of the students are white females/ males.</li> <li>• The majority of our students are white females, age 23 to 28. Most specialize in clinical mental health counseling.</li> <li>• primarily white females</li> <li>• There exists racial, sexual orientation, age, and counseling track diversity.</li> <li>• Extremely diverse. I teach in an urban setting.</li> </ul>
<p>Round 2 (N=14)</p> <ul style="list-style-type: none"> <li>• There exists racial, sexual orientation, age and counseling track diversity.</li> <li>• Primarily white females</li> <li>• The majority of our students are white females, age 23 -28. Most specialize in clinical mental health counseling.</li> <li>• The student population is not very diverse. Most of the students are white females or males</li> <li>• Students are from the United States and multiple foreign countries.</li> <li>• International visa students, Latin American, African American</li> <li>• Male and female - all ethnicity, disabilities, etc.</li> <li>• I currently teach master's and doctoral students who are attending graduate school full-time in a mid-sized city surrounded by rural areas. Our master's students are about 80% female, white, and Christian; they often come from the southeast region. Our doctoral students tend to be more diverse in gender, ethnicity, and regionality.</li> <li>• The majority of my students are white, including both males and female. A small percentage of students identify as transgender. A small percentage of students are Black/African American.</li> <li>• I teach at a minority-serving public university in the southeast. Approximately 40% of my students identify as minority students.</li> <li>• Predominately White, heterosexual, age 21-31, women.</li> </ul>

Table 12

Cont.

Description
Round 2 (cont.)
<ul style="list-style-type: none"> <li>Licensed professionals, interns in the field, new therapists to the field. Currently I am teaching masters level students - diverse in age, sex, gender, cultural background, ethnicity, culture, spirituality, and ability. They are also quite diverse in their theoretical orientations and future career goals. Previously I have worked with both master's and doctoral level trainees, as diverse as my current group in noted areas.</li> </ul>
Rounds 3 and 4 (N=10)
<ul style="list-style-type: none"> <li>Primarily white females</li> <li>The majority of our students are white females, age 23 to 28. Most specialize in clinical mental health counseling.</li> <li>The student population is not very diverse. Most of the students are white females or males.</li> <li>International visa students, Latin American, African American</li> <li>male and female - all ethnicity, disabilities, etc.</li> <li>I currently teach master's and doctoral students who are attending graduate school full-time in a mid-sized city surrounded by rural suburbs. Our master's students are about 80% female, white, and Christian; they often come from the southeast region. Our doctoral students tend to be more diverse in gender, ethnicity, and regionality.</li> <li>The majority of my students are white, including both males and female. A small percentage of students identify as transgender. A small percentage of students are Black/African American.</li> <li>I teach at a minority-serving public university in the southeast. Approximately 40% of my students identify as minority students.</li> <li>Predominately White, heterosexual, age 21-31, women.</li> <li>Licensed professionals, interns in the field, new therapists to the field</li> </ul>

**Area of trauma specialization.** Twenty (100%) panelists responded to the question addressing their professional area(s) of specialization within trauma. Two (10%) indicated Addictions as their primary specialization,  $n=1$  panelist (5%) indicated Intimate Partner Violence,  $n=4$  (20%) responded with Sexual Abuse,  $n=2$  (10%) panelists

indicated Emotional Abuse, and  $n=2$  (10%) selected Complex Trauma as their area of specialization within trauma. Through Rounds 2, 3, and 4 almost half of the panelists (45%) continued to indicate “Other” and specified their own trauma specialties (Table 13).

Table 13

## Rounds 1-4—Description of Area of Specialization Within Trauma

Area of Trauma Specialization	<i>n</i>	%
Round 1 ( $N=20$ )		
Addictions	2	10.00%
Natural Disaster	0	0.00%
First Responders	0	0.00%
Intimate Partner Violence	1	5.00%
Sexual Abuse	4	20.00%
Emotional Abuse	2	10.00%
Complex Trauma	2	10.00%
Intergenerational Trauma	0	0.00%
Historical/Oppression-based Trauma	0	0.00%
Veterans	0	0.00%
Other, please specify:	9	45.00%

*Note.* Other responses:

- Addictions, Sexual Abuse, IPV, and Natural Disaster are all my areas of expertise. Interpersonal Trauma broadly (sexual and partner violence), sex trafficking, child maltreatment), and Neuroscience of Trauma
- Addictions, Natural Disasters, Intimate Partner Violence, Sexual Abuse, Emotional Abuse, Physical Abuse, Foster Care, Complex Trauma, Intergenerational Trauma, Historical Trauma, Neuroscience of Trauma
- Trauma related to career and related to diversity considerations (i.e., cultural trauma)
- I would categorize my area of specialization regarding development and age
- Children and adolescents who have experienced trauma. My experience regarding trauma is within this age range as opposed to a specific type of trauma as it has varied
- Complex trauma, emotional abuse, and sexual abuse with children and adolescents
- Crisis, severe-persistent mental illness, complex trauma, sexual abuse, addictions
- General
- Substance abuse

Table 13

Cont.

Area of Trauma Specialization	<i>n</i>	%
<b>Round 2 (N=14)</b>		
Addictions	1	7.14%
Natural Disaster	0	0.00%
First Responders	0	0.00%
Intimate Partner Violence	0	0.00%
Sexual Abuse	4	28.57%
Emotional Abuse	2	14.29%
Complex Trauma	1	7.14%
Intergenerational Trauma	0	0.00%
Historical/Oppression-based Trauma	0	0.00%
Veterans	0	0.00%
Other, please specify:	6	42.86%

*Note.* Other responses:

- I currently work as a Professional that specializes in substance abuse.
  - General
  - Crisis, severe-persistent mental illness (which often includes all of the above)
  - I would categorize my area of specialization more regarding development and age. Specifically, children and adolescents who have experienced trauma.
  - trauma related to career and trauma related to diversity considerations (i.e., cultural trauma)
  - Interpersonal Trauma broadly (sexual and partner violence; sex trafficking; child maltreatment)
- Neuroscience of Trauma

<b>Rounds 3 and 4 (N=10)</b>		
Addictions	1	10.00%
Natural Disaster	0	0.00%
First Responders	0	0.00%
Intimate Partner Violence	1	10.00%
Sexual Abuse	4	40.00%
Emotional Abuse	1	10.00%
Complex Trauma	1	10.00%
Intergenerational Trauma	0	0.00%
Historical/Oppression-based Trauma	0	0.00%
Veterans	0	0.00%
Other, please specify:	4	40.00%

*Note.* Other responses:

- General
- Crisis, severe-persistent mental illness (which often includes all of the above)
- I would categorize my area of specialization more regarding development and age. Specifically, children and adolescents who have experienced trauma. My experience is more with trauma within this age range as opposed to a specific type of trauma as it has varied mostly across complex trauma, emotional abuse, and sexual abuse with children and adolescents.
- Trauma related to career and trauma related to diversity considerations (i.e., cultural trauma)

**Years of trauma counseling experience.** Twenty (100%) participants responded to the question addressing how many years of professional counseling experience they had specifically working with trauma-exposed populations, so this number represents the years of trauma counseling experience, rather than total counseling experience. In Round 1, of the 20 participants,  $n=2$  (10%) had between 2 and 3 years,  $n=9$  (45%) indicated between 4 and 6 years,  $n=1$  (5%) indicated between 7 and 10 years,  $n=2$  (10%) indicated between 11 and 15 years,  $n=1$  (5%) indicated between 16 and 19 years,  $n=2$  (10%) indicated between 30 and 39 years, and  $n=3$  (15%) indicated more than 40 years of trauma counseling experience (Table 14). In Round 2, 13 of the 14 panelists had 4 or more years trauma counseling experience, and in Rounds 3 and 4, 9 out of 10 who continued through all rounds indicated they had 4 or more years of trauma counseling experience (Table 14).

Table 14

## Rounds 1-4—Years of Professional Trauma Counseling Experience

Years of Trauma Counseling Experience	<i>n</i>	%
Round 1 ( $N=20$ )		
2-3	2	10.00%
4-6	9	45.00%
7-10	1	5.00%
11-15	2	10.00%
16-19	1	5.00%
20-29	0	0.00%
30-39	2	10.00%
40-45	3	15.00%

Table 14

Cont.

Years of Trauma Counseling Experience	<i>n</i>	%
Round 2 ( <i>N</i> =14)		
2-3	1	7.14%
4-6	7	50.00%
7-10	1	7.14%
11-15	2	14.29%
16-19	0	0.00%
20-29	0	0.00%
30-39	2	14.29%
40-45	1	7.14%
Rounds 3 and 4 ( <i>N</i> =10)		
2-3	1	10.00%
4-6	6	60.00%
7-10	1	0.00%
11-15	0	0.00%
16-19	0	0.00%
20-29	0	0.00%
30-39	1	10.00%
40-45	1	10.00%

**Description of populations served as trauma counselor.** Twenty (100%) of the panelists responded to the question asking them to describe the population(s) with whom they have the most experience working as a trauma counselor. This question was an open, free response question. The panelists descriptions of the varied trauma-exposed populations they have served are detailed in Table 15.

Table 15

## Rounds 1-4—Trauma Populations Served

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Trauma Populations Served ( <i>N</i> =20)
<ul style="list-style-type: none"> <li>• Women in recovery from addictions—all ages and ethnicity co-occurring PTSD and eating disorders College students who have been recently assaulted</li> <li>• Female population, ranging in ages 12 - 65+. Mostly clients struggling with eating disorders, mood disorders, issues related to substance abuse, and co-occurring disorders</li> <li>• Victims of child abuse- physical, sexual, and emotional</li> <li>• Urban adolescents (middle and high school) from low SES households and Mexican Immigrants</li> <li>• Survivors of intimate partner violence including women and children, perpetrators of intimate partner violence</li> <li>• Refugees from Cambodia, Bosnia, Iraq, Sudan, Karen LGBT individuals who have experienced childhood trauma and abuse Women who are survivors of child sexual abuse and violence</li> <li>• Individual adult males and females</li> <li>• In-patient and outpatient private practice with hundreds of adult survivors of child abuse suffering from complex trauma</li> <li>• I have provided substance abuse counseling in a Level One trauma center, in which approximately 50% of our patients in trauma are 50 years of age or older, and approximately 1/3 or more identify as African-American, Latino/Hispanic, or other non-Caucasian racial categories. The majority of patients were of lower SES with many arriving to our medical center without insurance or on government-subsidized coverage. I have also worked in a clinic specializing in the counseling needs of adults living with dementia as well as their caregivers. Of this population, almost all were Caucasian and middle-to upper-income</li> <li>• Females at a residential treatment center for eating disorders, mood disorders, substance abuse, and trauma. children and adolescent wards of the state in residential treatment adult and adolescent females and males with emotional, physical, sexual trauma history</li> <li>• Female survivors of interpersonal violence (sexual violence, partner violence, sex trafficking, child maltreatment)</li> <li>• Female Average ages ranging 18-28 years co-occurring (Eating Disorders, Substance Abuse, &amp; Mood)</li> <li>• Ethnically diverse youth and young adults who live in poverty in mid-sized city</li> <li>• Culturally diverse females in a residential treatment center College males and females</li> <li>• LGBT (ages 18 and up) -Substance Abuse (Inner city and Rural populations with variation in Race and Gender) -Eating disorders in residential (Women between the ages of 18-65) -Schizophrenia (Not guilty by reason of insanity population; High functioning individuals) -Hispanic population (Psychotherapy, inner-city, ages 7-65)</li> <li>• Male clients in residential facilities diagnosed with a chronic axis I diagnosis (e.g., schizophrenia) as well as a substance abuse issue. Most crisis situations were associated with psychological decompensation.</li> </ul>

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**Description of primary trauma counseling setting.** Twenty (100%) of the panelists responded to the question addressing the primary setting in which they have counseling experience. Of the 20,  $n=7$  (35%) indicated working with in a mostly urban counseling setting,  $n=4$  (20%) indicated working in a suburban area,  $n=5$  (25%) worked in both urban and suburban contexts, and  $n=2$  (10%) specified that they worked in a hospital and residential treatment center serving a wide variety of individuals, both from urban and suburban areas (Table 23). For Round 2,  $n=6$  (43%) of the panelists indicated serving in urban settings, and  $n=4$  (28.57%) in suburban or rural areas, and  $n=4$  (28.57%) in both urban and rural contexts. In Rounds 3 and 4,  $n=6$  (60%) of the panelists indicated that they served in an urban setting, and 4 (40%) responded that they served in both urban and rural contexts (Table 16).

Table 16

## Rounds 1-4—Primary Trauma Counseling Setting

Type of Setting	<i>n</i>	%
Round 1 ( <i>N</i> =20)		
Urban	7	35.00%
Residential Mental Health/Substance Abuse (2)		
Private Practice (1)		
University Setting (1)		
Inpatient/Outpatient Private Practice (1)		
Youth/Adolescent Mental Health Clinic (2)		
Suburban	5	25.00%
Residential Facility for Eating Disorders (1)		
University Counseling Clinic (1)		
Non-profit Agency/Juvenile Correction Center (1)		
Private Practice (2)		
Urban and Suburban	8	40.00%
Residential Treatment Center (3)		
Inpatient-Hospital (1)		
Medical Center (2)		
Community Counseling (2)		

Table 16

Cont.

Type of Setting	<i>n</i>	%
Round 2 ( <i>N</i> =14)		
Urban Residential Mental Health/Substance Abuse (2) University Setting (1) Inpatient/Outpatient Private Practice (1) Youth/Adolescent Mental Health Clinic (2)	6	42.86%
Sub-urban Residential Facility for Eating Disorders (1) Non-profit Agency/Juvenile Correction Center (1) Private Practice (2)	4	28.57%
Urban & Suburban Residential Treatment Center (1) Medical Center (1) Community Counseling (2)	4	28.57%
Rounds 3 and 4 ( <i>N</i> =10)		
Urban Residential Mental Health/Substance Abuse (2) Private Practice (1) University Setting (1) Youth/Adolescent Mental Health Clinic (2)	6	60.00%
Suburban	0	0.00%
Urban & Suburban Residential Treatment Center (1) Inpatient-Hospital (1) Medical Center (1) Community Counseling (1)	4	40.00%

**Description of type of trauma counseling.** Twenty (100%) of the panelists responded to the question addressing the primary type of trauma counseling they engaged in and all (100%) indicated that they engaged in face-to-face individual counseling. Three panelists indicated they engaged in face-to-face group counseling as well. One panelist also engaged in counseling via the telephone, and another indicated they provided online trauma counseling as well. Across all four rounds all panelists primarily engaged in face-to-face counseling (Table 17).

Table 17

Rounds 1-4—Primary Type of Trauma Counseling ( $N=20$ )

Type of Counseling	<i>n</i>	%
Face-to-face Individual	20	100.00%
Additional Means of Counseling:		
Group	3	
Telephone	1	
Online	1	

**Description of trauma supervision experience.** Twenty (100%) of panelists answered the question that addressed how many years of supervision experience they had supervising counselors who work with trauma-exposed populations. One panelist (5%) relayed they had no supervision experience working with counselors who worked with trauma-exposed populations,  $n=7$  (35%) had 1 to 2 years of supervision experience,  $n=5$  (25%) indicated 3 to 5 years of supervision experience,  $n=1$  (5%) indicated 6 to 10 years,  $n=1$  (5%) indicated 11 to 15 years, and  $n=4$  (20%) indicated 16 or more years of supervision experience working specifically with counselors who worked with trauma-exposed populations (Table 25). In Round 2,  $n=1$  (7.14%) panelist responded they had no trauma supervision experience,  $n=10$  (71.43%) of the panelists indicated they had between 1 and 5 years,  $n=1$  (7.14%) responded with 11-15 years, and  $n=2$  (14.79%) indicated they had 16 or more years of trauma supervision experience. Of the 10 participants who responded in Rounds 3 and 4,  $n=1$  (10%) indicated no experience,  $n=7$  (70%) indicated between 1 and 5 years of experience,  $n=1$  (10%) responded they had 10-

15 years, and  $n=1$  (10%) indicated they had 16 or more years of trauma supervision experience (Table 18).

Table 18

## Rounds 1-4—Number of Years of Trauma Supervision Experience

Number of Years of Experience	<i>n</i>	%
Round 1 ( $N=20$ )		
0	1	5.00%
1-5	7	35.00%
6-10	5	25.00%
11-15	1	5.00%
16+	4	20.00%
Round 2 ( $N=14$ )		
0	1	7.14%
1-5	10	71.43%
6-10	0	0.00%
11-15	1	7.14%
16+	2	14.29%
Rounds 3 and 4 ( $N=10$ )		
0	1	10.00%
1-5	7	70.00%
6-10	0	0.00%
11-15	1	10.00%
16+	1	10.00%

**Description of trauma trainings and continuing education.** When asked the number of training sessions related to trauma the panelists had attended over the last five years, twenty (100%) of panelists responded. All panelists had attended trauma trainings and continuing education regarding trauma. Of the 20 panelists,  $n=10$  panelists (50%) indicated they had attended from 1 to 5 trauma trainings,  $n=5$  (25%) indicated they had attended 6 to 10,  $n=2$  (10%) attended 11 to 15 trainings,  $n=1$  (5%) panelist indicated

attendance of 16 to 20 sessions, and  $n=2$  (10%) panelists indicated they had attended 20 or more training and education sessions (Table 19).

Table 19

Rounds 1-4—Number of Trauma Trainings Attended in the Past 5 Years ( $N=20$ )

Number of Trauma Trainings	<i>n</i>	%
1-5	10	50.00%
6-10	5	25.00%
11-15	2	10.00%
16-20	1	5.00%
20+	2	10.00%

**Description of trauma certifications.** Twenty (100%) of the panelists responded to the question of what certificates or designations they held that were specifically related to trauma. This question was a free response question (Table 20).

Table 20

Rounds 1-4—Trauma Certifications and Licenses Held

Licenses or Certifications Held Related to Trauma
LCAS
Certified Clinical Trauma Professional
A-TIP
TF-CBT
Trauma and Crisis Management Specialist
Certified Compassion Fatigue Therapist
EMDR-Levels 1 & 2
Somatosensory Psychotherapist
ISTSS & ISSTD Trainer

**Trauma-related publications.** All 20 (100%) panelists responded to the question about whether they had published a peer-reviewed journal article related to trauma. A majority of the panel indicated they had published at least one or more peer-reviewed journal articles on or related to the topic of trauma. Nine panelists (45%) had not published any peer-review articles specifically related to trauma,  $n=8$  panelists (40%) had published 1-5 articles, and  $n=3$  panelists (15%) had published ten or more peer-reviewed journal articles related to or on the topic area of trauma. Eleven of panelists (55%) had published an article related to the area of trauma. In Round 2,  $n=8$  participants (57.14%) had not published peer reviewed articles,  $n=5$  (35.71%) responded they had published 1-5 articles, and  $n=1$  (7.14%) panelist responded they had published over 10 journal articles related to or specifically on trauma. Of the  $n=10$  (100%) participants who continued through Rounds 3 and 4,  $n=5$  (50%) indicated they had not published any journal articles related to trauma,  $n=4$  (40%) responded they had published 1-5 articles, and  $n=1$  panelist (10%) indicated he or she had published 10 or more peer-reviewed journal articles directly related to trauma (Table 21).

Table 21

Rounds 1-4—Trauma-related Published in a Peer-reviewed Journal

Number of Articles	<i>n</i>	%
Round 1 ( $N=20$ )		
0	9	45.00%
1-5	8	40.00%
6-9	0	0.00%
10 or more	3	15.00%

Table 21

Cont.

Number of Articles	<i>n</i>	%
Round 2 ( <i>N</i> =14)		
0	8	57.14%
1-5	5	35.71%
6-9	0	0.00%
10 or more	1	7.14%
Rounds 3 and 4 ( <i>N</i> =10)		
0	5	50.00%
1-5	4	40.00%
6-9	0	0.00%
10 or more	1	10.00%

**Professional trauma-related presentations.** Twenty panelists (100%) responded to the question that addressed how many trauma-focused professional presentations they had offered over the past five years, whether at state, regional, or national-level conferences. Five panelists (25%) indicated no trauma-related professional presentations,  $n=8$  (40%) panelists indicated they had presented 1-5 times,  $n=1$  (5%) panelist indicated 6-9 times,  $n=2$  (10%) indicated they had 10-15 presentations, and  $n=3$  panelists (15%) indicated they had presented 16 or more professional presentations specifically related to trauma (Table 21). In Round 2,  $n=4$  (28.57%) panelists indicated they had none,  $n=7$  (50%) responded with 1-5 presentations, and  $n=1$  (7.14%) panelist indicated he or she had engaged in 10-15 professional presentations on trauma. For Rounds 3 and 4, 10 panelists (100%) responded and out of 10,  $n=1$  (10%) had no trauma-related presentations,  $n=8$  (80%) indicated they had presented 1-5 times, and  $n=1$  (10%)

responded he or she had presented 10 -15 times on trauma at professional conferences over the past 5 years (Table 22).

Table 22

## Rounds 1-4—Trauma-related Professional Presentations

Number of Trauma Presentations	<i>n</i>	%
Round 1 ( <i>N</i> =20)		
0	5	25.00%
1-5	8	40.00%
6-9	1	5.00%
10-15	2	10.00%
16+	3	15.00%
Round 2 ( <i>N</i> =14)		
0	4	28.57%
1-5	7	50.00%
6-9	1	4.14%
10-15	1	7.14%
16+	0	0.00%
Rounds 3 and 4 ( <i>N</i> =10)		
0	1	10.00%
1-5	8	80.00%
6-9	0	0.00%
10-15	1	10.00%
16+	0	0.00%

**Licensure.** Twenty of the panelists (100%) responded to the question of what professional counseling licenses they currently held. This was an open-response question and participants were allowed to respond with more than one answer, if applicable. Of the 20 panelists, *n*=11 (29.73%) are licensed professional counselors, *n*=3 (8.11%) are Licensed Professional Counseling Associates, *n*=9 (24.32%) are Nationally Certified Counselors, *n*=4 (10.81%) are Licensed Clinical Addiction Specialists, and *n*=10

(27.03%) reported other types of licensure (Table 23). All participants held professional licensure.

Table 23

Rounds 1-4—Common Counseling Licenses Held ( $N=20$ )

Type of License	<i>n</i>	%
LPC	11	29.73%
LPCA	3	8.11%
NCC	9	24.32%
LCAS	4	10.81%
Other	10	27.03%

*Note.* Other responses = Professional School Counselor, Approved Clinical Supervisor, Licensed Psychologist, Licensed Clinical Professional Counselor, and Board-Certified Dance/Movement Therapist (BC-DMT, LCASA, CMHC).

### Round 1 Questionnaire Results

The Delphi Round 1 Questionnaire included 11 open-ended questions addressing the foundational components that counselor educators with expertise in trauma deemed as foundational for trauma training and education in graduate counselor education programs (See Appendix B). Based on the literature review, the first six open-ended questions were formulated to address research question 1 and the following domains: knowledge, skills, attitudes. Open-ended questions 6-11 addressed the second inquiry capturing information related to trauma pedagogy to be used for future research. These open-ended survey questions were based on *a priori* categories of knowledge, skills, attitudes, and teaching practices drawn from the extensive literature review. The questions were intentionally designed to allow for additional categories to emerge from panelists' responses. Panelists could respond to these 11 open-ended questions with as many opinion statements as they

wished. There were no length limits placed on the responses panelists could enter in the text boxes. The following 11 open-ended questions were included in the Round 1 questionnaire:

1. How would you describe the best practices in trauma-informed counseling?
2. What would a newly graduated counselor need to be aware of to be able to work with a client who had experienced a traumatic event?
3. What specific things would they need to understand about trauma?
4. What trauma-specific skills might they need to have developed?
5. What other abilities might they need to demonstrate?
6. How should newly-graduated counselors approach clients when they suspect a history of trauma?
7. What should counselor educators consider when they set up course content or curricular tasks focused on trauma?
8. What classroom or workshop activities have you seen that have helped counselors-in-training learn about how to work with clients who have experienced trauma?
9. What challenges specifically related to teaching about trauma might counselor educators need to consider?
10. What do you believe is lacking within trauma training and education in counselor education?

11. Related to the topic of trauma training and education in counselor education, would you like to add any additional comments, opinions, or ideas that you did not include in the above responses?

Utilizing content analysis (Krippendorff, 2013), the researcher and an additional coder worked to analyze all the panelists' responses collected from the Round 1 questionnaire and then formulated nominal categories and subcategories. The researcher used a set of categories that were determined *a priori* (i.e., knowledge, skills, attitudes), drawn from the extensive literature review, and based on the construct of competency (McIlvried & Bent, as cited in Rodolfa et al., 2005). The fourth category that emerged was that of professional characteristics. Several sub-categories emerged under the knowledge and skills domains.

The three categories served to structure the eleven open-ended questions, while still allowing other categories to emerge (Powell, 2003). The researcher and coder utilized a codebook consisting of the nominal categories, their definitions, and space to record, categorize, and note new emergent categories or sub-categories. To establish interrater reliability, the coders independently analyzed two of the panelists' responses then came together to review the coding schemes and discuss interpretations to reach consensus. Then, the researcher and coder went through all the responses from the open-ended questions first inductively, and assessed what categories emerged and then, deductively to code the data that fit into the *a priori* categories.

Cohen's kappa is a widely cited method for estimating reliability for nominal data (Cohen, 1960; Hayes & Krippendorff, 2007, 2013; Neuendorf, 2017). Cohen's kappa was

used to measure the agreement between the two coders accounting for chance agreement. Thus, the calculation specifies how much agreement to expect by chance, how much agreement over and above chance was achieved, and computes the ratio of these values to find how much agreement was observed (Neuendorf, 2017). Cohen's kappa has a value from -1 to 1; a value of 0 depicts incidental agreement; values below 0 indicate agreement worse than chance; a value between 0 and 1 indicates some degree of agreement (Cohen, 1960). The closer the score is to 1 the better the agreement reached. For the purposes of this study values of .70 or above were considered satisfactory and the intended purpose of the statistic will be to estimate the reliability of the mean ratings from multiple coders. Some panelists' responses elicited high agreement between the researcher and coder (e.g., where panelists commented briefly and directly elicited higher agreement), while others elicited less agreement (e.g., where panelists responses were longer and contained more nuanced or vague language elicited less agreement; Table 24).

For Round 1, panelists were instructed to brainstorm, and then answer the eleven open-ended questions in the form of sentences. They could provide as many statements as they wished. Some panelists responded with one sentence, multiple sentences, and/or paragraphs. There were a few one-word responses to questions regarding attitudes or professional characteristics. Additionally, within the knowledge category, some panelists' responses included actionable language referring to an ability or skill, rather than a component of knowledge, awareness, or understanding. Panelists categorized opinion statements were then used to format the questionnaire for Round 2. The 135

representative statements are listed in in categorical order with their respective subcategories (Table 25).

Table 24

Round 1—Trustworthiness of Categories and Subcategories (N=19)

Individual Participant Responses	Kappa
1	0.827
2	0.907
3	1.000
4	0.871
5	0.727
6	1.000
7	0.821
8	0.668
9	1.000
10	0.834
11	0.927
12	1.000
13	0.873
14	0.786
15	1.000
16	0.813
17	0.679
18	1.000
19	0.879

*Note.* Overall kappa=0.874.

Table 25

Round 1—Representative Statements from Participants (*N*=14)

<p>Category: Knowledge Subcategory: Process</p> <hr/> <ul style="list-style-type: none"> <li>• Clients are learning to “hold” something cognitively and physically that has been entirely overwhelming or oppressive to them in the past, that they have pushed away.</li> <li>• Be aware of the existential issues of safety, meaning, loss, suffering, identity, and death and that these cannot all be resolved at once.</li> <li>• Patience and pacing are important as this one area of trauma counseling where counselors can actually do damage.</li> <li>• Trauma work is not like other counseling.</li> <li>• Trauma work is a process, sometimes a long one that should not be rushed.</li> <li>• Rogers’s core conditions are first and foremost—the relationship is the most powerful “tool” any counselor brings into the room.</li> </ul> <hr/>
<p>Category: Knowledge Subcategory: Trauma Definition, Prevalence, and Nature</p> <hr/> <ul style="list-style-type: none"> <li>• Have basic knowledge about the various definitions of trauma and the variability of what trauma can be/mean (or potentially traumatic for the individual), and how such an experience might relate to a client's mental health, relational, and physical health.</li> <li>• Have knowledge of specific trauma interventions.</li> <li>• Be aware of the prevalence of trauma exposure and incidence of PTSD in a general sense in everyday life, as well as population specific (e.g. sexual abuse among children, both male and female etc.).</li> </ul> <hr/>
<p>Category: Knowledge Subcategory: Client Responses to Trauma</p> <hr/> <ul style="list-style-type: none"> <li>• Understand how trauma may influence the counseling relationship</li> <li>• Know the physical manifestations of psychological trauma, as well as the psychological manifestations of physical trauma.</li> <li>• Know the potential and various effects that trauma can have on an individual, specifically neurobiology, as well as developmental, relational, emotional, and behavioral effects.</li> <li>• Demonstrate a basic understanding of the various types of trauma (e.g. complex, emotional abuse, intergenerational, IPV) and the potential connection between trauma and what the client experiences (emotionally, behaviorally, relationally etc.).</li> </ul> <hr/>

Table 25

Cont.

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 Category: Knowledge

 Subcategory: Client Responses to Trauma (cont.)
 

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- Acknowledge the relational importance of trauma counseling and the focus on integration and self-regulation versus focusing on a client “telling their story.”
  - Recognize the high rates of addiction, self-harm, and ongoing relationship dysfunction for those who have been traumatized.
  - Understand addiction and differential diagnosis for addiction and other mental health concerns.
  - Recognize and understand the signs, symptoms, impact, and common responses of trauma, as well as the adaptive responses to trauma and opportunities for recovery.
  - Possess a working understanding of causation of trauma and the mechanisms behind trauma response.
  - Trauma is often at the core and symptoms are a way that clients are trying to control the effects/impact of their trauma.
  - Trauma changes the brain; therefore, counselors-in-training must understand the neurological- and brain-based aspect of trauma and effects on the autoimmune system and physical health.
  - Be aware that traumatized clients talk about death but that does not mean they are suicidal. “I want this to end is a common statement,” but they are talking about ending the suffering, not necessarily life. (Take clients’ statements seriously but not literally, so that they do not overreact).
  - Some experiences can be traumatizing to a person even if the situation does not appear extreme or dangerous so understanding how objective and subjective factors related to trauma interact is important. What one might deem a “small t” trauma could for someone else be a “big T” trauma.
  - Know how to differentiate the reactions and needs of a client immediately following a traumatic event, and in long term trauma specific care.
  - There is not one approach to trauma care, as individuals may experience or react to traumatic events in different ways.
  - Know the impact of trauma on individuals who are peripheral to the client and the potential for peripheral trauma reactions.
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Category: Knowledge

 Subcategory: Culture
 

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- Trauma is especially shaped by racial ethnic perceptions and responses to violence.
  - Understand cultural, historical, and gender issues related to trauma and ways in which culture, development, and power/systems intersect with trauma experiences (events and responses).
-

Table 25

Cont.

<p>Category: Knowledge Subcategory: Culture (cont.)</p>
<ul style="list-style-type: none"> <li>• Acknowledge integrated knowledge about trauma policies, procedures, and systems, cultural, historical and gender issues.</li> <li>• Know the trauma-informed approach which calls for more training regarding socio-economic, political, neurobiological, relational, and cross-cultural issues related to trauma for the sake of students' well-being, as well their clients.</li> </ul>
<p>Category: Knowledge Subcategory: Counselor Self-awareness</p>
<ul style="list-style-type: none"> <li>• Understand self-care (not in a cliché sense, but genuinely take care of yourself in part by seeking supervision/consultation, have your own counselor, do your own work surrounding personal trauma narratives and trauma reactions, continue to develop self-awareness, know how to identify and watch for signs of vicarious trauma/burnout, etc.).</li> </ul>
<p>Category: Knowledge Subcategory: Research</p>
<ul style="list-style-type: none"> <li>• Staying current in trauma research is essential.</li> <li>• CBT is important, but only one dimension of efficacious care.</li> <li>• Acknowledge the competencies published by Social Work Education and APA Division 56 of the American Psychological Association that are organized around core competencies for different levels of expertise and they may serve as best practices (Cook, Newman, et al., 2012)</li> </ul>
<p>Category: Knowledge Subcategory: Supervision</p>
<ul style="list-style-type: none"> <li>• Audio tape sessions for supervision of the counseling session with client permission.</li> <li>• Engagement in ongoing supervision, beyond that which is required for licensure, for all counselors regardless of client narratives or experience is important.</li> <li>• Be aware of referral resources, a mentor, or supervisor that may provide guidance and support in the event you aren't equipped to help the individual because of the delicate nature of traumatized clients and seek support from these supervisors, mentors, or colleagues.</li> </ul>

Table 25

Cont.

<p>Category: Knowledge Subcategory: Re-traumatization</p>
<ul style="list-style-type: none"> <li>• Understand how to work with a client to avoid re-traumatization of the client by knowing best practices, trauma-sensitive practices and policies and conversely, know how counselors may retraumatize clients.</li> <li>• Know the appropriateness of gathering content from a client versus processing trauma prematurely.</li> </ul>
<p>Category: Knowledge Subcategory: Attachment</p>
<ul style="list-style-type: none"> <li>• Possess and understanding of attachment and trauma and that clients' secure attachments may be torn and they need to have time to attach to the counselor and be able to address issues of "abandonment" at termination of treatment.</li> </ul>
<p>Category: Knowledge Subcategory: Ethics</p>
<ul style="list-style-type: none"> <li>• Possess a thorough understanding of ethics.</li> </ul>
<p>Category: Knowledge Subcategory: Safety</p>
<ul style="list-style-type: none"> <li>• Understand the client's need for safety and security and recognize basic needs for survival that have not been met.</li> <li>• Know standard safety procedures and how to promote emotional safety and integration.</li> </ul>
<p>Category: Knowledge Subcategory: Resources &amp; Referrals</p>
<ul style="list-style-type: none"> <li>• Have a good understanding of the ethical assessment of personal competence to be able to address trauma specific client concerns; know when to refer a client.</li> <li>• Know referral sources for outside services that may be helpful for client's self-regulation (i.e., trauma-informed yoga practitioners, biofeedback practitioners, etc.) as well as resources of the local community, including trauma-focused groups and medical providers skilled at assessing for ongoing trauma and somatic effects of trauma.</li> <li>• It is necessary to provide resource building for a client before any trauma work is to be initiated.</li> </ul>

Table 25

Cont.

<p>Category: Knowledge Subcategory: Resilience &amp; Post-traumatic Growth</p> <hr/> <ul style="list-style-type: none"> <li>• Counselors-in-training need information on posttraumatic growth, resilience, and recovery.</li> <li>• Acknowledge the strength and resiliency in the client's coping skills even if you disagree with how they are coping - remember they are trying to move forward with life.</li> <li>• Do not make assumptions about trauma survivors' reactions or assume that all individuals who have experienced trauma will be negatively impacted. (With over approximately 300,000 different symptoms combinations for PTSD in the DSM, there is a lot of room for individuality in this process).</li> </ul> <hr/> <p>Category: Knowledge Subcategory: Assessment</p> <hr/> <ul style="list-style-type: none"> <li>• Understand the unique nature of assessing safety, progress, and stage in the cycle of trauma reactions.</li> <li>• Be familiar with the appropriate assessments to screen for a history of trauma and the impact of trauma on everyday life. There are many different ways of assessing for trauma—formally, informally, verbally, self-assessments, etc.</li> <li>• PTSD assessment and treatment may be helpful as a paradigm to use.</li> <li>• Know the trigger warnings and signs of dissociation and what dissociation can look like.</li> </ul> <hr/> <p>Category: Knowledge Subcategory: Intervention, Treatment, Approach, &amp; Models</p> <hr/> <ul style="list-style-type: none"> <li>• Understand basic competencies, best practices, and best approaches to working with clients exposed to trauma.</li> <li>• A semi-structured protocol with empirically-validated interventions/approaches</li> <li>• culture, systems, context, empowerment (voice and choice)</li> <li>• individualized intervention based on the type/timing of trauma.</li> <li>• distinctives of trauma interventions (trauma specific or trauma-sensitive counseling approaches and interventions (e.g., TF-CBT) as opposed to regular traditional interventions, or crisis interventions.</li> <li>• Integrate holistic (mind and body) approaches</li> <li>• policy and social justice issues associated with trauma work.</li> <li>• ecological perspective in trauma work.</li> </ul> <hr/>
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Table 25

Cont.

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Category: Knowledge
Subcategory: Intervention, Treatment, Approach, & Models (cont.)

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- adapt core counseling theories to suit the needs of a trauma victim.
- meta model or staged approach that informs trauma treatment in three stages (though not necessarily linear) including safety and stabilization; mourning and remembrance; and finally, reconnection and reintegration.
- wellness model
- Understand a variety of trauma focused treatment modalities including somatic and creative arts therapy, and the staples like EMDR.
- Motivational Interviewing
- Be familiar with trauma-informed care and interventions and understand a trauma-informed approach which “1) realizes the prevalence and influence of trauma; 2) recognizes how trauma affects all individuals involved in the program, organization, or system; 3) responds with trauma-sensitive practices and policies; and 4) works against re-traumatization” (SAMHSA, 2012, p. 4). A counselor must be vigilant in taking a 'trauma-informed lens' and continuously assess how a traumatic experience(s) are potentially impacting the client to create appropriate and beneficial treatment plans, interventions, and approaches for the client's well-being.

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Category: Skills
Subcategory: Assessment

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- Be able to identify traumatic symptoms in a client.
- Ability to assess and respond with appropriate corresponding trauma-based interventions
- Possess skills for identifying and addressing beliefs and patterns related to trauma.
- Assessment of trauma, client safety, and personal safety (ability to ask questions to appropriately assess for the potential experience of a traumatic event)
- Articulate the importance of understanding history for helping with presenting issue and ask for permission to discuss history.
- Skills at assessing for self-harm, suicidality, and substance misuse/abuse
- Be able to directly inquire about past or current trauma in a sensitive and gentle manner to assess for trauma history and/or their suspicions of a trauma history rather than ignoring it or shying away from discussing its possible relationship to symptoms.
- Let the client’s narrative lay the foundation and organization of trauma assessment.

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Table 25

Cont.

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 Category: Skills

 Subcategory: Assessment (cont.)
 

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- Recognize and be acutely aware of clients' nonverbals and paralinguistic cues. Counselors-in-training need to pay attention to nonverbal and paralinguistic cues when with a client because they provide so much information (e.g., a break in the voice, the subtle shift in tone or facial expression, the shift in gaze, the shift in breathing, patterns of breaths, the clenching of the chair, etc.) These all become very useful information about knowing how activated (physiological arousal) your client is becoming).
  - CIT's must be skilled at assessing for ongoing trauma, post-trauma dynamics, and somatic effects of trauma.
  - Approach clients when you suspect a history of trauma as you would every other client, since 8 out of 10 clients will probably have experienced trauma.
  - Ask in general terms if the client feels like anything from their past is impacting their present, or if they have ever felt unsafe.
  - Identify, address, and manage potential barriers to counseling and working with clients with trauma such as trust issues and recognizing potential barriers (e.g., a client's possible self-sabotage/self-injury, trauma reenactments, transference, and countertransference, etc.).
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## Category: Skills

 Subcategory: Collaboration
 

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- Collaborate with the client to choose which treatment option is best for trauma processing (i.e., CPT, TF-CBT, EMDR) and mutually develop skills and strategies to address trauma responses.
  - Let the client define what is traumatic, lead you into the trauma processing, and dictate the speed work.
  - Do not collude with learned helplessness/hopelessness while not giving up on clients
  - Collaboration with family and peer support systems.
  - Recognize ruptures in the counseling relationship and initiate repair
  - Facilitate the reintegration and consolidation of client gains.
  - CIT's should demonstrate the ability to consult and ask for help in treatment of those living with trauma and appropriately use supervision; do not try to do this work alone—have a team backing you up and a team for supporting the client.
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Table 25

Cont.

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<p>Category: Skills</p> <p>Subcategory: Counselors-in-training Self-Care Skills</p>
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- The counselor-in-training must maintain very strong clinical and personal boundaries, which includes not telling the victim how they should feel or what they should do (in re, reporting assaults), being mindful of self-disclosure, and possessing the ability to maintain a healthy distance.
- Counselors must demonstrate the ability to manage a relational treatment and possible personal vicarious traumatization by monitoring self-care (awareness of signs of burnout/compassion fatigue), having a personal self-care plan (counseling/supervision/support), and engaging in personal self-care to reduce possibility of vicarious traumatization.

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<p>Category: Skills</p> <p>Subcategory: Grounding &amp; Emotional Regulation</p>
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- Counselors-in-training must prepare themselves to hear things they never thought would be possible from clients' trauma narratives and be mindful of their reaction when listening to the client.
- CIT's should have the ability to hold the space for a client's story, be with others in their trauma responses, stay emotionally engaged, and emotionally regulated to manage reactivity in response to the client, practicing an ongoing mindfulness of language used, attend to their physical presence in the counseling relationship, and energetic relationality.
- Some skills are classic counseling skills and others are unique to trauma work (although some could argue they would be beneficial to all). A solid set of foundational counseling skills (reflections, active listening, immediacy, etc.) and person-centered and relationship building skills are essential—empathy, unconditional positive regard, affective and cognitive reflections, etc. In that, knowing what safety means for the client and working to build that in the room and outside if needed, on an ongoing basis.
- CIT should know a range of grounding and autonomic regulation (body and sensory awareness) skills and how to facilitate those (i.e., contraindications, speed of language, pacing, etc.) in session to maintain one's own grounding and self-care and to teach these to help the clients develop skills for affective regulation. This means having a considerable knowledge of many different kinds of techniques/skills.
- CITs should possess a fair degree of desensitization and the ability to approach rather than avoid a trauma history.

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Table 25

Cont.

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Category: Skills
Subcategory: Grounding & Emotional Regulation (cont.)

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- Identifying warning signs of what dissociation can look like and have the ability to intervene to help ground a client presenting with dissociative symptoms while regulating yourself.
- Ability to notice micro-shifts and hyper/hypo arousal responses

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Category: Skills
Subcategory: Techniques & Training

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- Have the ability to provide and deliver psychoeducation to the client in a way that is most appropriate to them (e.g., kids, teens, combat trauma survivors, etc.)
- Relaxation training, breathing exercises, and emotional regulation training for themselves and their clients.
- Crisis intervention techniques
- Desensitization techniques
- EMDR Exposure therapies such as Prolonged exposure, Cognitive Processing therapy, Mindfulness based therapies such as ACT, Skills Training for Affective and Interpersonal Regulation/Narrative Story Telling, Brain spotting, Somatic integration
- Understand basic medical first aid
- Psychological first aid
- Reality testing
- Unique utilization of core counseling skills as appropriate when related to the precipitating event (e.g., excessive eye contact with an individual diagnosed with schizophrenia during a psychological decompensation may elicit paranoia).
- Have the ability to implement phasic treatment
- Possess the ability to employ holistic integrative treatment.
- Be able to employ specific strategies, trauma interventions, and trauma treatment to help clients work through traumatic experiences.
- Ask permission to provide psycho-education, don't just start lecturing about trauma responses
- Practice with supervisor/colleagues how to respond and work with clients without asking questions or giving advice.
- Avoid over-questioning the client or asking intrusive questions the client may not be willing or comfortable initially sharing and that the counselor may not know how to respond to. Allow the client to share their history first and what they feel is important as this can set the tone for disclosure over time (i.e., avoid asking "Do you have a history of trauma?")

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Table 25

Cont.

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 Category: Skills

 Subcategory: Techniques & Training (cont.)
 

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- Use the clients' own language, language they prefer when discussing their trauma, or the appropriate person-first language, for example, instead of calling someone an "abused spouse" or a "victim of war," shifting to person-first monikers such as "a spouse who experienced abuse" or "someone who experienced war."
  - CITs should be able to use validation skills (validate the trauma, worth of the client, and difficulty of discussing history) and confirm that there is a way through and that they (the counselor) know the way through, and that they (the counselor) are willing to walk with the client through to conclusion of treatment.
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## Category: Skills

 Subcategory: Establishing Safety
 

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- Ability to create safety plans (e.g., IPV survivors) and/or understand duty to warn and make appropriate reports if needed (e.g., child abuse reporting, elder abuse reporting, etc.).
  - Ensuring the safety of the client and peripheral parties by bringing the client back to a state of equilibrium comparable to that prior to the onset of the crisis, while also setting the stage for future, long term care that can focus on more specific issues, provide more depth in services, and work toward "post traumatic growth."
  - Know how to establish and sustain safety which means addressing the physical, emotional, social, mental, and spiritual needs of the client both outside of counseling and inside the counseling setting by creating an atmosphere of safety including asking the client what they would prefer (e.g., curtains open or drawn, where to sit in the room, temperature, handshake or not).
  - Be able to build rapport in a compromised environment immediately following a crisis.
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 Category: Attitudes
 

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- Enter into the counseling relationship as an authentic helper, humble, empathetic, and focused on the client in order to set the counselor-client relationship in the proper and most helpful tone.
  - A willingness to continue reading, learning, growing, and seeking supervision and ongoing education within the trauma field.
  - Openness—Always remain open to learning from every client.
  - Presuming nothing and be open to anything, as difficult as that can be for beginning and more experienced counselors, is essential.
-

Table 25

Cont.

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Category: Attitudes (cont.)

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- Have a healthy level of caring and a non-judgmental curiosity. Truly caring about understanding how they are experiencing their symptoms, how their life has changed as a result, how they experience their body (if they are in a place to go there), etc. This is from a place of wanting to facilitate the client’s own awareness around how they are experiencing their lives and symptoms now and help the counselor work with the client to determine windows of autonomic arousal and affective tolerance.
- Flexibility—even if working with manualized treatments.
- Respect—have and demonstrate respect for all persons.
- Belief in recovery—resilience trumps trauma. Trauma is not a life sentence.

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Category: Professional Characteristics

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- Trustworthiness and transparency
- Be compassionate, kind, and gentle
- Recognize the limits to one’s own empathy and being able to pull back in empathy a bit when needed.
- Optimistic
- Self-control and composure—maintaining one’s “cool” under pressure
- peaceful/calm
- persistent and possess initiative
- Relentless pursuit of resilience.
- Creative
- Courageous
- Objective and consistent

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### **Delphi Round 2 Results**

The Round 2 the questionnaire was created from the 135 items, or representative opinion statements, formulated from the content analysis of all panelists’ responses from Round 1. Their responses, in the form of statements, included items addressing the knowledge, skills, attitudes, and professional characteristics the panelists deemed as foundational for counselors-in-training trauma education. For Round 2, the panelists were

asked to review each of the 135 items and to indicate their level of agreement by rating each item on a Likert scale of 1 (*strongly disagree*) to 7 (*strongly agree*). They were asked to provide a rationale if they did not agree that an item was necessary, and were also provided the option to comment, add, or edit any item in a text box provided below each item.

Results from Round 2 were compiled into a descriptive analysis table that included the mean, median, and interquartile range (IQR). The median and IQR were utilized to indicate the level of agreement and consensus for each item. The mean provided a representative value of the necessity of each item according to the expert panel. The median indicates the score that is at the 50th percentile and is utilized because it is unaffected by extreme scores. The median is found to be most appropriate for Delphi studies because of the tendency to have skewed data (Stone Fish & Busby, 2005). Therefore, in the current study, only items with a median score of 6 or greater were included. This indicated that the item was strongly agreed upon as a foundational component of trauma education for masters counseling students. The IQR is an indication of the variability of scores and it is utilized to establish consensus. The distribution is divided into four equal parts, or quartiles and the IQR is the distance between the first and the third quartile. The IQR provides a measure of dispersion describing the middle 50% of scores and it is not influenced by extreme scores (Gravetter & Wallnau, 2000). Items with an IQR of 1.0 or less were deemed as reaching consensus and were included in the final list. The cutoff scores established a priori included items with a median score of 6 or greater and also an IQR of 1.0 or less.

**Response Rate**

Fourteen (70%) of 20 participants responded to the Round 2 Questionnaire. Mean scores for the items varied between 4.57 and 6.92. Median scores varied between 5 and 7. No items received a median score lower than 5. IQR scores varied between 0 and 3.5.

**Round 2 Questionnaire Results**

The Delphi Round 2 Questionnaire was formulated from the 135 opinion statements from panelists' responses to the 11 open-ended questions from Round 1. The Round 2 questionnaire asked participants to review all responses and indicate their level of agreement on each item as a foundational component of counselors-in-training trauma education on a Likert Scale of 1 (strongly disagree) to 7 (strongly agree). In addition, if they chose to rate an item less than 6, panelists were asked to provide their rationale or a justification for their rating. Panelists could also comment, add to, or edit any item. Results were compiled into a descriptive analysis table that includes the mean, median, and interquartile range (Table 26). All comments made by the panelists may be found in Appendix L.

In Round 2, panelists rated the 135 items and came to consensus on 98 items (73% of the items). Of the 135 total representative statements, 37 items did not reach consensus and were used to formulate the questionnaire for Round 3. Of the 98 items for which consensus was reached, three items had a median score of less than 6, but an IQR of 1 or below, so the panelists reached consensus that these 3 items were not foundational components. The three items are as follows: "Trauma work is unique; not like other counseling," and, counselors-in-training should "possess the ability to employ holistic

integrative treatment,” and last, counselors-in-training should “understand a variety of trauma-focused treatment modalities including somatic and creative arts therapy, and staples like EMDR.” Of the 98 items for which consensus was reached, panelists determined that 95 were foundational for trauma education. Ninety-five items had a median rating of 6 or greater and an IQR of less than or equal to 1 and were included in the final list. Table 26 presents the mean, median, and IQR for each item on the Round 2 questionnaire. This information is provided in the same order as was presented to the participants in the questionnaire.

Table 26

Round 2—Mean, Median, and IQR for Knowledge, Skills, Attitudes, and Professional Characteristics for Trauma Education Survey Responses

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Process			
• Clients are learning to “hold” something cognitively and physically that has been entirely overwhelming or oppressive to them in the past, that they have pushed away.	5.71	6	1
• Be aware of the existential issues of safety, meaning, loss, suffering, identity, and death and that these cannot all be resolved at once.	6.71	7	0
• Patience and pacing are important as this one area of trauma counseling where counselors can actually do damage.	6.50	6.5	1
• Trauma work is not like other counseling.	5.50	5.5	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Process (cont.)			
• Trauma work is a process, sometimes a long one that should not be rushed.	6.36	6.5	1
• Rogers’s core conditions are first and foremost—the relationship is the most powerful “tool” any counselor brings into the room.	6.29	6.5	1
Category: Knowledge Subcategory: Trauma Definition, Prevalence, and Nature			
• Have basic knowledge about the various definitions of trauma and the variability of what trauma can be/mean (or potentially traumatic for the individual), and how such an experience might relate to a client's mental health, relational, and physical health.	6.64	7	1
• Have knowledge of specific trauma interventions.	6.50	7	1
• Be aware of the prevalence of trauma exposure and incidence of PTSD in a general sense in everyday life, as well as population specific (e.g. sexual abuse among children, both male and female, etc.)	6.14	6.5	1
Category: Knowledge Subcategory: Client Responses to Trauma			
• Understand how trauma may influence the counseling relationship	6.93	7	0
• Know the physical manifestations of psychological trauma, as well as the psychological manifestations of physical trauma.	6.79	7	0
• Know the potential and various effects that trauma can have on an individual, specifically neurobiology, as well as developmental, relational, emotional, and behavioral effects.	6.57	7	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Client Responses to Trauma (cont.)			
• Demonstrate a basic understanding of the various types of trauma (e.g. complex, emotional abuse, intergenerational, IPV) and the potential connection between trauma and what the client experiences (emotionally, behaviorally, relationally etc.).	6.29	6	1
• Acknowledge the relational importance of trauma counseling and the focus on integration and self-regulation versus focusing on a client “telling their story.”	6.21	6	1
• Recognize the high rates of addiction, self-harm, and ongoing relationship dysfunction for those who have been traumatized.	6.43	7	1
• Understand addiction and differential diagnosis for addiction and other mental health concerns.	6.36	7	1
• Recognize and understand the signs, symptoms, impact, and common responses of trauma, as well as the adaptive responses to trauma and opportunities for recovery.	6.57	7	1
• Possess a working understanding of causation of trauma and the mechanisms behind trauma response.	6.21	6	1
• Trauma is often at the core and symptoms are a way that clients are trying to control the effects/impact of their trauma.	<b>5.86</b>	<b>6</b>	<b>2</b>
• Trauma changes the brain; therefore, counselors-in-training must understand the neurological and brain-based aspect of trauma and effects on the autoimmune system, physical health.	6.50	7	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Client Responses to Trauma (cont.)			
• Be aware that traumatized clients talk about death but that does not mean they are suicidal. “I want this to end is a common statement,” but they are talking about ending the suffering, not necessarily life. (Take clients' statements seriously but not literally, so that they do not over-react).	5.57	6	1
• Some experiences can be traumatizing to a person even if the situation does not appear extreme or dangerous, so understanding how objective and subjective factors related to trauma interact is important. What one might deem a “small t” trauma could for someone else be a “big T” trauma.	6.64	7	0.75
• Know how to differentiate the reactions and needs of a client immediately following a traumatic event, and in long term trauma specific care.	<b>5.93</b>	<b>6</b>	<b>1.75</b>
• There is not one approach to trauma care, as individuals may experience or react to traumatic events in different ways.	6.43	7	1
• Know the impact of trauma on individuals who are peripheral to the client and the potential for peripheral trauma reactions.	5.79	6	0.75
Category: Knowledge Subcategory: Culture			
• Trauma is especially shaped by racial-ethnic perceptions and responses to violence.	<b>5.79</b>	<b>6</b>	<b>2</b>
• Understand cultural, historical, and gender issues related to trauma and ways in which culture, development, and power/systems intersect with trauma experiences (events and responses).	6.50	7	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Culture (cont.)			
• Acknowledge integrated knowledge about trauma policies, procedures, and systems, cultural, historical and gender issues.	6.07	6	1
• Know the trauma-informed approach which calls for more training regarding socioeconomic, political, neurobiological, relational, and cross-cultural issues related to trauma for the sake of students' well-being, as well their clients.	5.93	6	1
Category: Knowledge Subcategory: Counselor Self-awareness			
• Understand self-care (not in a cliché sense, but genuinely take care of yourself in part by seeking supervision/consultation, have your own counselor, do your own work surrounding personal trauma narratives and trauma reactions, continue to develop self-awareness, know how to identify and watch for signs of vicarious trauma/burnout, etc.).	6.64	7	0.75
Category: Knowledge Subcategory: Research			
• Staying current in trauma research is essential.	6.14	6	1
• CBT is important, but only 1 dimension of efficacious care.	<b>5.57</b>	<b>6</b>	<b>2.5</b>
• Acknowledge the competencies published by Social Work Education and APA Division 56 of the American Psychological Association that are organized around core competencies for different levels of expertise and they may serve as best practices (Cook, Newman, et al., 2012).	<b>5.29</b>	<b>6</b>	<b>2.5</b>

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Supervision			
• Audio tape sessions for supervision of the counseling session with client permission.	<b>5.57</b>	<b>6</b>	<b>1.25</b>
• Engagement in ongoing supervision, beyond that which is required for licensure, for all counselors regardless of client narratives or experience is important.	6.00	6.5	1
• Be aware of referral resources, a mentor, or supervisor that may provide guidance and support in the event you aren't equipped to help the individual because of the delicate nature of traumatized clients and seek support from these supervisors, mentors, or colleagues.	6.07	6	1
Category: Knowledge Subcategory: Re-traumatization			
• Understand how to work with a client to avoid re-traumatization of the client by knowing best practices, trauma-sensitive practices and policies and conversely, know how counselors may retraumatize clients.	6.79	7	0
• Know the appropriateness of gathering content from a client versus processing trauma prematurely.	<b>6.00</b>	<b>6</b>	<b>1.75</b>
Category: Knowledge Subcategory: Attachment			
• Possess and understanding of attachment and trauma and that clients' secure attachments may be torn and they need to have time to attach to the counselor, and be able to address issues of "abandonment" at termination of treatment.	5.93	6	0.75
Category: Knowledge Subcategory: Attachment			
• Possess a thorough understanding of ethics.	6.21	6.5	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge			
Subcategory: Safety			
• Understand the client’s need for safety and security and recognize basic needs for survival that have not been met.	6.21	6.5	1
• Know standard safety procedures and how to promote emotional safety and integration.	6.21	6.5	1
Category: Knowledge			
Subcategory: Resources & Referrals			
• Have a good understanding of the ethical assessment of personal competence to be able to address trauma specific client concerns; know when to refer a client.	6.43	7	1
• Know referral sources for outside services that may be helpful for client’s self-regulation (i.e., trauma-informed yoga practitioners, biofeedback practitioners, etc.) as well as resources of the local community, including trauma-focused groups and medical providers skilled at assessing for ongoing trauma and somatic effects of trauma.	6.21	6	1
• It is necessary to provide resource building for a client before any trauma work is to be initiated.	<b>5.86</b>	<b>6</b>	<b>1.75</b>
Category: Knowledge			
Subcategory: Resilience & Post-traumatic Growth			
• Counselors-in-training need information on posttraumatic growth, resilience, and recovery.	6.21	6	1
• Acknowledge the strength and resiliency in the client’s coping skills even if you disagree with how they are coping—remember they are trying to move forward with life.	<b>5.86</b>	<b>6</b>	<b>1.75</b>

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Resilience & Post-traumatic Growth (cont.)			
<ul style="list-style-type: none"> <li>Do not make assumptions about trauma survivors' reactions or assume that all individuals who have experienced trauma will be negatively impacted. (With over ~300,000 different symptoms combinations for PTSD in the DSM, there is a lot of room for individuality in this process).</li> </ul>	6.29	7	1
Category: Knowledge Subcategory: Assessment			
<ul style="list-style-type: none"> <li>Understand the unique nature of assessing safety, progress, and stage in the cycle of trauma reactions.</li> </ul>	6.50	7	1
<ul style="list-style-type: none"> <li>Be familiar with the appropriate assessments to screen for a history of trauma and the impact of trauma on everyday life. There are many different ways of assessing for trauma—formally, informally, verbally, self-assessments, etc.</li> </ul>	6.50	6.5	1
<ul style="list-style-type: none"> <li>PTSD assessment and treatment may be helpful as a paradigm to use.</li> </ul>	<b>6.07</b>	<b>6</b>	<b>1.75</b>
<ul style="list-style-type: none"> <li>Know the trigger warnings and signs of dissociation and what dissociation can look like.</li> </ul>	6.50	6.5	1
Category: Knowledge Subcategory: Intervention, Treatment, Approach, & Models			
<ul style="list-style-type: none"> <li>Understand basic competencies, best practices, and best approaches to working with clients exposed to trauma.</li> </ul>	6.15	7	1
<ul style="list-style-type: none"> <li>A semi-structured protocol with empirically-validated interventions/approaches</li> </ul>	5.23	6	1
<ul style="list-style-type: none"> <li>Culture, systems, context, empowerment (voice and choice)</li> </ul>	<b>5.71</b>	<b>6</b>	<b>2</b>
<ul style="list-style-type: none"> <li>individualized intervention based on the type/timing of trauma.</li> </ul>	5.86	6	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Intervention, Treatment, Approach, & Models (cont.)			
• distinctives of trauma interventions (trauma specific or trauma-sensitive counseling approaches and interventions (e.g., TF-CBT) as opposed to regular traditional interventions, or crisis interventions.	<b>5.36</b>	<b>6</b>	<b>2.75</b>
• Integrate holistic (mind and body) approaches	5.64	6	1
• policy and social justice issues associated with trauma work.	<b>5.29</b>	<b>5.5</b>	<b>2</b>
• ecological perspective in trauma work.	5.50	6	1
• adapt core counseling theories to suit the needs of a trauma victim.	<b>5.64</b>	<b>6</b>	<b>1.75</b>
• meta model or staged approach that informs trauma treatment in three stages (though not necessarily linear) including safety and stabilization; mourning and remembrance; and finally, reconnection and reintegration.	5.86	6	0.75
• wellness model	<b>5.57</b>	<b>6</b>	<b>1.75</b>
• Understand a variety of trauma focused treatment modalities including somatic and creative arts therapy, and the staples like EMDR.	5.43	5.5	1
• Motivational Interviewing	<b>5.57</b>	<b>6</b>	<b>2.75</b>
• Be familiar with trauma-informed care and interventions and understand a trauma-informed approach which “1) realizes the prevalence and influence of trauma; 2) recognizes how trauma affects all individuals involved in the program, organization, or system; 3) responds with trauma-sensitive practices and policies; and 4) works against re-traumatization” (SAMHSA, 2012, p. 4). A counselor must be vigilant in taking a ‘trauma-informed lens’ and continuously assess how a traumatic experience(s) are potentially impacting the client to create appropriate and beneficial	6.21	6.5	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Intervention, Treatment, Approach, & Models (cont.)			
• treatment plans, interventions, and approaches for the client's well-being.			
Category: Skills Subcategory: Assessment			
• Be able to identify traumatic symptoms in a client.	6.71	7	0.75
• Ability to assess and respond with appropriate corresponding trauma-based interventions	6.29	6	1
• Possess skills for identifying and addressing beliefs and patterns related to trauma.	6.00	6	0.75
• Assessment of trauma, client safety, and personal safety (ability to ask questions to appropriately assess for the potential experience of a traumatic event)	6.50	6.5	1
• Articulate the importance of understanding history for helping with presenting issue and ask for permission to discuss history.	5.86	6	1
• Skills at assessing for self-harm, suicidality, and substance misuse/abuse	6.71	7	0.75
• Be able to directly inquire about past or current trauma in a sensitive and gentle manner to assess for trauma history and/or their suspicions of a trauma history rather than ignoring it or shying away from discussing its possible relationship to symptoms.	5.93	6	1
• Let the client's narrative lay the foundation and organization of trauma assessment.	5.79	6	2
• Recognize and be acutely aware of clients' nonverbals and paralinguistic cues. Counselors-in-training need to pay attention to nonverbal and paralinguistic cues when with a client because they provide so much information (e.g., a break in the voice, the subtle shift in tone or facial expression, the shift in gaze, the shift in	6.57	7	0.75

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Assessment (cont.)			
breathing, patterns of breaths, the clenching of the chair, etc.) These all become very useful information about knowing how activated (physiological arousal) your client is becoming.			
• CIT's must be skilled at assessing for ongoing trauma, post-trauma dynamics, and somatic effects of trauma.	6.36	6.5	1
• Approach clients when you suspect a history of trauma as you would every other client, since 8 out of 10 clients will probably have experienced trauma.	4.57	5	3.5
• Ask in general terms if the client feels like anything from their past is impacting their present, or if they have ever felt unsafe. Identify, address, and manage potential barriers to counseling and working with clients with trauma such as trust issues and recognizing potential barriers (e.g., a client's possible self-sabotage/self-injury, trauma reenactments, transference, and countertransference, etc.)	5.79	6	0.75
Category: Skills Subcategory: Collaboration			
• Collaborate with the client to choose which treatment option is best for trauma processing (i.e., CPT, TF-CBT, EMDR) and mutually develop skills and strategies to address trauma responses.	<b>6.36</b>	<b>7</b>	<b>7.75</b>
• Let the client define what is traumatic, lead you into the trauma processing, and dictate the speed work.	5.79	7	2
• Do not collude with learned helplessness/hopelessness while not giving up on clients	5.71	7	1.75
• Collaboration with family and peer support systems.	5.71	5.5	2
• Recognize ruptures in the counseling relationship and initiate repair.	6.57	7	0.75

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Knowledge Subcategory: Collaboration (cont.)			
• Facilitate the reintegration and consolidation of client gains.	6.29	6.5	1
• CIT's should demonstrate the ability to consult and ask for help in treatment of those living with trauma and appropriately use supervision; do not try to do this work alone—have a team backing you up and a team for supporting the client.	6.57	7	0.75
Category: Skills Subcategory: Counselors-in-training Self-Care Skills			
• The counselor-in-training must maintain very strong clinical and personal boundaries, which includes not telling the victim how they should feel or what they should do (in re, reporting assaults), being mindful of self-disclosure, and possessing the ability to maintain a healthy distance.	6.43	7	1
• Counselors must demonstrate the ability to manage a relational treatment and possible personal vicarious traumatization by monitoring self-care (awareness of signs of burnout/compassion fatigue), having a personal self-care plan (counseling/supervision/support), and engaging in personal self-care to reduce possibility of vicarious traumatization.	6.64	7	0.75
Category: Skills Subcategory: Grounding & Emotional Regulation			
• Counselors in-training must prepare themselves to hear things they never thought would be possible from clients' trauma narratives and be mindful of their reaction when listening to the client.	6.43	7	1
• CITs should have the ability to hold the space for a client's story, be with others in their trauma responses, stay emotionally engaged, and emotionally regulated to	6.64	7	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Skills Subcategory: Grounding & Emotional Regulation (cont.)			
manage reactivity in response to the client, practicing an ongoing mindfulness of language used, attend to their physical presence in the counseling relationship, and energetic relationality.			
<ul style="list-style-type: none"> <li>Some skills are classic counseling skills and others are unique to trauma work (although some could argue they would be beneficial to all). A solid set of foundational counseling skills (reflections, active listening, immediacy, etc.) and person-centered and relationship building skills are essential—empathy, unconditional positive regard, affective and cognitive reflections, etc. In that, knowing what safety means for the client and working to build that in the room and outside if needed, on an ongoing basis.</li> </ul>	6.43	6.5	1
<ul style="list-style-type: none"> <li>CIT should know a range of grounding and autonomic regulation (body and sensory awareness) skills and how to facilitate those (i.e., contraindications, speed of language, pacing, etc.) in session to maintain one’s own grounding and self-care and to teach these to help the clients develop skills for affective regulation. This means having a considerable knowledge of many different kinds of techniques/skills.</li> </ul>	6.36	6	1
<ul style="list-style-type: none"> <li>CITs should possess a fair degree of desensitization and the ability to approach rather than avoid a trauma history.</li> </ul>	6.07	6	1
<ul style="list-style-type: none"> <li>Identifying warning signs of what dissociation can look</li> </ul>	6.29	6	1
<ul style="list-style-type: none"> <li>Ability to notice micro-shifts and hyper/hypo arousal responses</li> </ul>	6.21	6	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.			
	Mean	Median	IQR
Category: Skills			
Subcategory: Techniques & Training			
• Have the ability to provide and deliver psychoeducation	6.50	7	1
• Relaxation training, breathing exercises, and emotional regulation training for themselves and their clients.	6.50	7	1
• Crisis intervention techniques	6.57	7	1
• Desensitization techniques	<b>5.64</b>	<b>6</b>	<b>2</b>
• EMDR Exposure therapies such as Prolonged exposure, Cognitive Processing therapy, Mindfulness based therapies such as ACT, Skills Training for Affective and Interpersonal Regulation/Narrative Story Telling, Brain spotting, Somatic integration	<b>5.07</b>	<b>5.5</b>	<b>2.5</b>
• Understand basic medical first aid	5.14	5	2
• Psychological first aid	6.00	6.5	1.75
• Reality testing	<b>5.36</b>	<b>6</b>	<b>3</b>
• Unique utilization of core counseling skills as appropriate when related to the precipitating event (e.g., excessive eye contact with an individual diagnosed with schizophrenia during a psychological decompensation may elicit paranoia).	<b>5.79</b>	<b>6</b>	<b>1.5</b>
• Have the ability to implement phasic treatment	<b>5.29</b>	<b>5.5</b>	<b>1.8</b>
• Possess the ability to employ holistic integrative treatment.	<b>5.64</b>	<b>5</b>	<b>1</b>
• Be able to employ specific strategies, trauma interventions, and trauma treatment to help clients work through traumatic experiences.	<b>6.00</b>	<b>6</b>	<b>1.75</b>
• Ask permission to provide psycho-education, don't just start lecturing about trauma responses	<b>6.00</b>	<b>6</b>	<b>1.75</b>
• Practice with supervisor/colleagues how to respond and work with clients without asking questions or giving advice.	6.07	7	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Skills Subcategory: Techniques & Training (cont.)			
<ul style="list-style-type: none"> <li>• Avoid over-questioning the client or asking intrusive questions the client may not be willing or comfortable initially sharing and that the counselor may not know how to respond to. Allow the client to share their history first and what they feel is important as this can set the tone for disclosure over time (i.e., avoid asking, “Do you have a history of trauma?”)</li> </ul>	6.00	7	1
<ul style="list-style-type: none"> <li>• Use the client’s own language, language they prefer when discussing their trauma, or the appropriate person-first language, for example, instead of calling someone an “abused spouse” or a “victim of war,” shifting to person-first monikers such as “a spouse who experienced abuse” or “someone who experienced war.”</li> </ul>	6.50	7	1
<ul style="list-style-type: none"> <li>• CIT’s should be able to use validation skills (validate the trauma, worth of the client, and difficulty of discussing history) and confirm that there is a way through and that they (the counselor) know the way through, and that they (the counselor) are willing to walk with the client through to conclusion of treatment.</li> </ul>	5.29	5.5	2.5
Category: Skills Subcategory: Establishing Safety			
<ul style="list-style-type: none"> <li>• Ability to create safety plans (e.g. IPV survivors) and/or understand duty to warn and make appropriate reports if needed (e.g., child abuse reporting, elder abuse reporting, etc.).</li> </ul>	6.50	7	1
<ul style="list-style-type: none"> <li>• Ensuring the safety of the client and peripheral parties by bringing the client back to a state of equilibrium comparable to that prior to the onset of the crisis, while also setting the stage for future, long term care that can</li> </ul>	5.29	5.5	2.5

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
Category: Skills Subcategory: Establishing Safety (cont.)			
focus on more specific issues, provide more depth in services, and work toward “post traumatic growth.”			
<ul style="list-style-type: none"> <li>• Know how to establish and sustain safety which means addressing the physical, emotional, social, mental, and spiritual needs of the client both outside of counseling and inside the counseling setting by creating an atmosphere of safety including asking the client what they would prefer (e.g., curtains open or drawn, where to sit in the room, temperature, handshake or not).</li> </ul>	6.60	7	0.75
<ul style="list-style-type: none"> <li>• Be able to build rapport in a compromised environment immediately following a crisis.</li> </ul>	<b>5.93</b>	<b>6</b>	<b>1</b>
Category: Attitudes			
<ul style="list-style-type: none"> <li>• Enter into the counseling relationship as an authentic helper, humble, empathetic, and focused on the client in order to set the counselor-client relationship in the proper and most helpful tone.</li> </ul>	6.57	7	0.75
<ul style="list-style-type: none"> <li>• A willingness to continue reading, learning, growing, and seeking supervision and ongoing education within the trauma field.</li> </ul>	6.29	6.5	1
<ul style="list-style-type: none"> <li>• Openness—always remain open to learning from every client.</li> </ul>	6.57	7	0.75
<ul style="list-style-type: none"> <li>• Presuming nothing and be open to anything, as difficult as that can be for beginning and more experienced counselors, it is essential.</li> </ul>	6.57	7	0.75
<ul style="list-style-type: none"> <li>• Have a healthy level of caring and a non-judgmental curiosity.</li> </ul>	6.36	7	1
<ul style="list-style-type: none"> <li>• Truly caring about understanding how they are experiencing their symptoms, how their life has changed as a result, how they experience their body (if they are in a place to go there), etc. This is from a place of wanting to facilitate the client’s own awareness</li> </ul>	6.00	6	1

Table 26

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
<b>Category: Attitudes (cont.)</b>			
around how they are experiencing their lives and symptoms now and help the counselor work with the client to determine windows of autonomic arousal and affective tolerance.			
• Flexibility—even if working with manualized treatments.	6.50	7	1
• Respect—have and demonstrate respect for all persons.	6.50	7	1
• Belief in recovery—resilience trumps trauma. Trauma is not a life sentence.	6.50	7	1
<b>Category: Professional Characteristics</b>			
• Trustworthiness and transparency	6.36	7	1
• Be compassionate, kind, and gentle	6.36	7	1
• Recognize the limits to one’s own empathy and being able to pull back in empathy a bit when needed.	<b>5.50</b>	<b>6</b>	<b>2.75</b>
• Optimistic	<b>5.93</b>	<b>6</b>	<b>1.75</b>
• Self-control and composure—maintaining one’s “cool” under pressure	6.29	7	7
• peaceful/calm	5.79	6	1.75
• persistent and possess initiative	5.71	6	1
• Relentless pursuit of resilience.	5.20	6	2.75
• Creative	5.86	6	0.75
• Courageous	6.29	6.5	1
• Objective and consistent.	<b>6.07</b>	<b>6</b>	<b>1.75</b>

### Delphi Round 3 Results

Delphi Round 3, again, addressed Research Question 1. In the third round, each Delphi panelist received an e-mail at the preferred e-mail address they previously provided. An e-mail was sent to 19 participants who responded to Round 2 along with the

Qualtrics link to the Round 3 Questionnaire, as well as an attached document that included the items, ratings, and all the comments summarized by the researcher from the previous round for items that did not reach consensus. Panelists were asked to review the document including all the panelists comments and rationales for items that did not reach consensus. They were then instructed to again consider their response and revise their judgments, or if their level of agreement had not changed, to provide their rationale for remaining outside of consensus. This round gave panelists an opportunity to view all other participants responses to the items, as well as an opportunity to make further clarifications of both the information and their judgements of their agreement of the relative importance of the items. However, compared to the previous round, only a slight increase in the degree of consensus was expected (Dalkey & Rourke, 1972).

### **Response Rate**

The link to the online questionnaire was sent via e-mail to the 14 panelists who responded to Round 2. Of the 14 individuals who responded to Round 2, 10 responded to Round 3 (N=10, Response Rate = 71.43%). This indicates a 28.57% attrition rate from Rounds 2 to 3 and a 33.57% attrition rate from Rounds 1 to 3.

### **Round 3 Questionnaire Results**

The Round 3 Questionnaire included 37 items addressing the knowledge, skills, attitudes, and professional characteristics that may be foundational for master's students' trauma education. The questionnaire asked panelists to review their previous responses, as well as those of their colleagues, and again indicate their level of agreement that each item should be included as a foundational component of trauma education. In addition,

they were asked to provide their justification for this rating regardless of agreeing or disagreeing with the median rating. Results were compiled into a descriptive analysis table that included the mean, median, and interquartile range. All comments made by the participants, along with the aggregate statistics can be found in Appendix M.

Ten participants responded to the Round 3 Questionnaire. Delphi methodology indicates that only items that receive a consensus median rating of 6 or higher (on a 1-7 scale) should be kept (Stone Fish & Busby, 2005). Two predetermined cutoff scores (i.e., an IQR of 1.00 or less and a median of 6 or greater) were used to determine whether panelists agreed that an item was foundational and would be included in the final list. Mean scores for the 37 items in Round 3 varied between 3.6 and 5.9. Median scores varied between 3.5 and 6. Of the 37 items, consensus ( $IQR \leq 1.0$ ) was reached for 13 items. Of the 13 items for which consensus was reached, 9 items had a median rating of greater than or equal to 6 and an IQR of less than or equal to 1. These items were:

- Trauma is especially shaped by racial-ethnic perceptions and responses to violence;
- CBT is important, but only one dimension of efficacious care;
- Acknowledge the strength and resiliency in the client's coping skills even if you disagree with how they are coping;
- PTSD assessment and treatment may be one helpful paradigm to use;
- Approach clients as if they may have a history of trauma, since 8 out of 10 clients will probably have experienced trauma;
- Adapt core counseling theories to suit the needs of a trauma victim;

- Collaborate with the client to choose which treatment option is best for trauma processing;
- Collaborate with family and peer support system; and, a trauma counselor should possess the character attributes of being objective and consistent.

The expert panel reached consensus that 4 of the items were not necessary, and those items were: Trauma is often at the core and symptoms are a way that clients are trying to control the effects/impact of their trauma; Resource building for a client must be provided before any trauma work is to be initiated; Psychological first aid; and, be able to build rapport in a compromised environment immediately following a crisis. Although consensus was reached on a majority of items, panelists agreed the language in some items needed to be changed, and that there were two components in several items that needed to be broken up into two statements. Thus, 15 items were edited and added by the panel. These items may be found in the next section outlining the list of final results in Round 4. 24 of the items from Round 3 were included in the final list of foundational trauma education components. The expert panel agreed 4 of the items were not necessary and panelists failed to reach consensus on 24 items summarized in Table 27. Panelists' comments and aggregate statistics for the 24 items not reaching consensus in Round 3 may be found in Appendix M.

Table 27

Round 3—Mean, Median, and IQR for Knowledge, Skills, Attitudes, and Professional Characteristics for Trauma Education Survey Responses Lacking Consensus

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
• Know how to differentiate the reactions and needs of a client immediately following a traumatic event, and in long-term trauma-specific care.	5.7	6	1.5
• Acknowledge the competencies published by Social Work Education and APA Division 56 of the American Psychological Association that are organized around core competencies for different levels of expertise and they may serve as best practices	4.7	5.5	2
• Audio tape sessions for supervision of the counseling session with client permission	5.1	6	1.75
• Know the appropriateness of gathering content from a client versus processing trauma prematurely.	5.5	6	2
• Let the client's narrative lay the foundation and organization of trauma assessment.	5.5	6	1.5
• Culture, systems, context, empowerment.	4.8	5	2
• Distinctives of trauma interventions (trauma-specific or trauma-sensitive counseling approaches and interventions (e.g., TF-CBT), as opposed to regular traditional	4.5	5	2.75
• interventions, or crisis interventions.	4.8	5.5	1.75
• Policy and social justice issues associated with trauma work.	4.6	5	2
• Wellness model	4.4	4.5	3
• Motivational interviewing	4.9	5	1.75
• Let the client define what is traumatic, lead you into trauma processing, and dictate the speed work.	4.8	5	1.75
• Do not collude with learned helplessness/hopelessness while not giving up on clients.	3.6	3.5	4.25
• Recognize the limits to one's own empathy and being able to pull back in empathy a bit when needed.	4.7	5	15

Table 27

Cont.

Please indicate on a scale of 1 ( <i>strongly disagree</i> ) to 7 ( <i>strongly agree</i> ), how necessary you believe each item is for the trauma training and education of counselors-in-training.	Mean	Median	IQR
• Optimistic	5	6	2
• Peaceful	4.7	6	1.75
• Relentless pursuit of resilience.	4.7	5	1.75
• Desensitization techniques	4.8	5.5	1.75
• EMDR Exposure therapies such as Prolonged Exposure, Cognitive Processing therapy, Mindfulness-based therapies such as ACT, Skills Training for Affective and Interpersonal Regulation/Narrative Story Telling, Brain-spotting, Somatic	4.7	5	1.5
• integration.	4.1	4	3
• Understand basic medical first aid.	4.9	6	1.75
• Reality testing.	4.6	4.5	2
• Unique utilization of core counseling skills as appropriate when related to the precipitating event (e.g., excessive eye contact with an individual diagnosed with schizophrenia during a psychological decompensation may elicit paranoia).	5.2	6	2.5
• Have the ability to implement phasic treatment.	5.93	6.5	1.75
• Be able to employ specific strategies, trauma interventions, and trauma treatment to help clients work through traumatic experiences.	4.1	5	3.5

### Delphi Round 4 Results

Delphi Round 4, in keeping with Rounds 1-3, addressed Research Question 1:

What do a group of counselor educators with trauma expertise deem as the foundational components of trauma education to prepare counselors-in-training to an entry-level of competence to provide trauma-informed counseling? In Round 4, the final phase, panelists were provided with the final items for the study. No changes or edits were made

on these items from Round 3; instead; panelists were given one more opportunity to see one another's opinions or ratings (Appendix M). The items that met consensus from Rounds 1, 2, and 3 were compiled into a final categorized list. The final list of items reaching consensus, items and comments from Round 3, and the link to the final Round 4 Qualtrics questionnaire (Appendix N) was e-mailed to the ten participants who continued to participate in Round 3. For Round 4, the questionnaire panelists asked three open-ended questions (Appendix O). The final comments from Round 4 (Appendix P) and a summary of the final list of items that reached consensus were e-mailed to each panelist upon conclusion of the study (Appendix Q).

### **Response Rate**

The final questionnaire with the link to the online Qualtrics survey for Round 4 (Appendix N) was sent via e-mail to the 10 panelists who responded to Round 3. Of the 10 individuals who responded to Round 3, 10 responded to Round 4 ( $N=10$ , Response Rate = 100%). This indicates a 0% attrition rate from Rounds 3 to 4 and a 52% overall attrition rate from Rounds 1 to 4.

### **Round 4 Questionnaire Results**

The Round 4 questionnaire asked panelists three open-response questions (Appendix O). Panelists were asked first, to review the final list of foundational trauma education components and then, provide their interpretation of the results. Second, they were asked to communicate any questions they were left with. Lastly, to end this final round, panelists were given the opportunity to provide any comments or thoughts they

wished to include. Panelists responses from the Round 4 questionnaire are compiled and may be found in Appendix P.

At the completion of the four rounds, panelists (a) agreed that 119 of the items originating out of Rounds 2 and 3 were foundational for the trauma education of entry-level masters counseling students, (b) agreed that seven items were no necessary, and (c) did not reach consensus on 24 items. These items were either too specific, general to counseling and not trauma-specific, or the items included a specific treatment or theory. Panelists commented that knowledge of these treatments and theories would be important, but that entry-level masters counseling students did not need to ascribe to just one theory or know how to treat a client using a particular trauma treatment (i.e., EMDR, Motivational Interviewing, and Desensitization techniques). The final list of foundational components panelists deemed as foundational for trauma training and education included the 119 items in Table 28.

Table 28

Round 4—The Knowledge, Skills, Attitudes, and Professional Characteristics Deemed as Foundational for Trauma Education in Masters Counseling Programs ( $N=10$ )

Category: Trauma Knowledge Subcategory: Relational Aspects
<ol style="list-style-type: none"> <li>1. Patience and pacing are important as this one area of trauma counseling where counselors can actually do damage.</li> <li>2. Trauma work is a process, sometimes a long one that should not be rushed.</li> <li>3. Clients are learning to “hold” something cognitively and physically that has been entirely overwhelming or oppressive to them in the past, that they have pushed away.</li> <li>4. Be aware of the existential issues of safety, meaning, loss, suffering, identity, and death and that these cannot all be resolved at once.</li> </ol>

Table 28

Cont.

<p>Category: Trauma Knowledge Subcategory: Relational Aspects (cont.)</p>
<ol style="list-style-type: none"> <li>5. Possess an understanding of attachment and trauma and that clients' secure attachments may be torn, so it may take longer or be challenging to establish a strong therapeutic relationship.</li> <li>6. Some skills are classic counseling skills and others are unique to trauma work (although some could argue they would be beneficial to all).</li> <li>7. Understand a solid set of foundational client-centered counseling skills (reflections, active listening, immediacy, etc.) and person-centered and relationship building skills are essential – empathy, unconditional positive regard, affective and cognitive reflections, etc.</li> <li>8. Core counseling conditions of respect, unconditional positive regard, and empathy are first and foremost--the relationship is the most powerful "tool" any counselor brings into the room.</li> <li>9. Acknowledge the relational importance of trauma counseling and the focus on integration and self-regulation versus focusing on a client being asked to verbally state the details of an event repeatedly.</li> <li>10. Understand how trauma may influence the counseling relationship (i.e. transference, countertransference, etc.)</li> <li>11. Know the impact of trauma on individuals who are peripheral to the client (i.e., family systems) and the potential for peripheral trauma reactions.</li> </ol>
<p>Category: Trauma Knowledge Subcategory: Trauma Defined/Nature of Trauma</p>
<ol style="list-style-type: none"> <li>12. Possess basic knowledge of the various definitions of trauma and the variability of what trauma can be/mean (or potentially traumatic for the individual), and how such an experience might relate to a client's mental health, relational, and physical health.</li> <li>13. Be aware of the prevalence of trauma exposure and incidence of PTSD in a general sense, as well as in terms of specific populations (e.g. sexual abuse among children, both male and female etc.) with the understanding that trauma can impact anyone across any age, class, gender, etc.</li> <li>14. Understand the distinction between stress, a crisis, a trauma, PTSD, and natural disaster.</li> <li>15. Demonstrate a basic understanding of the various types of trauma (e.g. complex, emotional abuse, intergenerational, IPV) and the potential connection between trauma and what the client experiences (emotionally, behaviorally, relationally etc.).</li> </ol>

Table 28

Cont.

<p>Category: Trauma Knowledge Subcategory: Trauma Response</p>
<p>16. Know the physical manifestations of psychological trauma, as well as the psychological manifestations of physical trauma.</p> <p>17. Know the potential and various effects that trauma can have on an individual, specifically neurobiological, as well as developmental, relational, emotional, and behavioral effects.</p> <p>18. Recognize and understand the signs, symptoms, impact, and common responses of trauma, as well as the adaptive responses to trauma and opportunities for recovery.</p> <p>19. Demonstrate a working understanding of causation of trauma and the mechanisms behind trauma response.</p> <p>20. Demonstrate an understanding of the neurological and brain-based aspect of trauma and effects on the autoimmune system and physical health.</p> <p>21. Understand that trauma is subjective (e.g., some experiences can be traumatizing to a person even if the situation does not appear extreme or dangerous, so understanding how objective and subjective factors related to trauma interact is important).</p>
<p>Category: Trauma Knowledge Subcategory: Approach/Theory/Model</p>
<p>22. Demonstrate an understanding that there is not one approach to trauma care, as individuals may experience or react to traumatic events in different ways, and a variety of factors may influence someone's reactions.</p> <p>23. Understand a meta model or staged approach that informs trauma treatment in three stages (though not necessarily linear) including safety and stabilization; mourning and remembrance; and finally, reconnection and reintegration.</p> <p>24. Understand an ecological perspective in trauma work.</p> <p>25. CBT is important, but only one dimension of efficacious care.</p> <p>26. Demonstrate an understanding of the clinical intentions behind specific trauma interventions.</p> <p>27. Understand a trauma-informed approach which calls for more training regarding socio-economic, political, neurobiological, relational, and cross-cultural issues related to trauma for the sake of students' well-being, as well their clients. It "1) realizes the prevalence and influence of trauma; 2) recognizes how trauma affects all individuals involved in the program, organization, or system; 3) responds with trauma-sensitive practices and policies; and 4) works against re-traumatization" (SAMHSA, 2012).</p>

Table 28

Cont.

<p>Category: Trauma Knowledge Subcategory: Approach/Theory/Model (cont.)</p>
<p>28. Be familiar with trauma-informed care and interventions. 29. Demonstrate an understanding of a semi-structured protocol with knowledge of empirically-validated interventions/approaches.</p>
<p>Category: Trauma Knowledge Subcategory: Culture</p>
<p>30. Demonstrate an understanding that trauma is shaped by culture (e.g., racial ethnic perceptions and responses to violence, historical and intergenerational oppression, etc.) 31. Demonstrate an understanding of cultural, historical, and gender issues related to trauma and ways in which culture, development, and power/systems intersect with trauma experiences (events and responses). 32. Acknowledge integrated knowledge about trauma policies, procedures, and systems, cultural, historical, and gender issues.</p>
<p>Category: Trauma Knowledge Subcategory: Self-Awareness &amp; Reflexivity</p>
<p>33. Demonstrate an understanding self-care (i.e., genuinely take care of yourself in part by seeking supervision/consultation, obtaining personal counseling to do work surrounding personal trauma narratives and trauma reactions, continuous development of self-awareness, and know how to identify and watch for personal signs of vicarious trauma/burnout).</p>
<p>Category: Trauma Knowledge Subcategory: Research</p>
<p>34. Understand the importance of staying current in trauma research and literature; know strategies for continuing education regarding trauma.</p>
<p>Category: Trauma Knowledge Subcategory: Supervision</p>
<p>35. Acknowledge engagement in ongoing supervision, beyond that which is required for licensure, is beneficial for all counselors regardless of client narratives or experience.</p>
<p>Category: Trauma Knowledge Subcategory: Re-traumatization</p>
<p>36. Know how to work with a client and avoid re-traumatization of the client. 37. Demonstrate an understanding of how counselors may retraumatize clients.</p>

Table 28

Cont.

<p>Category: Trauma Knowledge Subcategory: Ethics</p> <hr/> <p>38. Demonstrate a thorough understanding of ethics in relation to trauma work.</p>
<p>Category: Trauma Knowledge Subcategory: Safety</p> <hr/> <p>39. Understand the client's need for safety and security and recognize basic needs for survival that have not been met. 40. Know standard safety procedures. 41. Understand how to promote emotional safety and integration. 42. Demonstrate an understanding that trauma may require action for the safety of client that is outside scope of client's acceptability, so core therapeutic relationality is important.</p>
<p>Category: Trauma Knowledge, Cont'd. Subcategory: Resources &amp; Referral</p> <hr/> <p>43. Demonstrate an understanding of the ethical assessment of personal competence (i.e., one's bounds of competence related to trauma-specific concerns) to be able to address trauma specific client concerns; know when to refer a client. 44. Be aware of referral resources, a mentor, or supervisor that may provide guidance and support in the event you are not equipped to help the trauma-exposed individual and seek support from these supervisors, mentors, or colleagues. 45. Demonstrate an understanding of the importance of and have a working knowledge of referral sources and resources relevant to trauma care (e.g., trauma-informed yoga practitioners, biofeedback practitioners, resources of the local community, trauma-focused groups, medical providers).</p>
<p>Category: Trauma Knowledge Subcategory: Post-traumatic Growth</p> <hr/> <p>46. Possess an understanding of posttraumatic growth, resilience, and recovery. 47. Understand the importance of not making assumptions about trauma survivors' reactions or assume that all individuals who have experienced trauma will be negatively impacted.</p>
<p>Category: Trauma Knowledge Subcategory: Assessment-Knowledge</p> <hr/> <p>48. Understand the unique nature of assessing safety, progress, and stages in the cycle of trauma reactions. 49. Be familiar with the appropriate assessments to screen for a history of trauma. 50. Understand the similarities and differences between a trauma response and PTSD.</p>

Table 28

Cont.

<p>Category: Trauma Knowledge Subcategory: Assessment-Knowledge (cont.)</p>
<p>51. Demonstrate an understanding of the various signs of dissociation.</p> <p>52. Know how to incorporate an understanding of trauma when assessing for suicide risk.</p> <p>53. Recognize the high rates of co-morbidity and potential presence of addiction, self-harm, and ongoing relationship dysfunction for those who have been traumatized to understand how this may affect the client's experience and the work done with the counselor (i.e., behavior as a mean to cope, self-destruct, numb, escape).</p> <p>54. Understand addiction and differential diagnosis for addiction and mental health concerns.</p>
<p>Category: Skills Subcategory: Assessment</p>
<p>55. Be able to identify signs/indications of trauma in a client, while acknowledging the unique variations between them for any given individual.</p> <p>56. Demonstrate assessment skills for trauma and respond with clinically appropriate and intentional, trauma-informed interventions.</p> <p>57. Possess skills for addressing traumatic beliefs and meanings attached to self, other, and world.</p> <p>58. Identify any maladaptive coping mechanisms that may put the client's safety or the safety of others in jeopardy.</p> <p>59. Demonstrate competency in the assessment of trauma, client safety, and personal safety (ability to ask questions to appropriately assess for the potential experience of a traumatic event)</p> <p>60. Possess the ability to ask permission and initiate appropriate conversations to discuss a client's trauma history.</p> <p>61. Considering the situation, therapeutic relationship, and emotional stability/resourcing capabilities of client, be able to directly inquire about past or current trauma in a sensitive and gentle manner to assess for trauma history and/or their suspicions of a trauma history rather than ignoring it or shying away from discussing its possible relationship to symptoms.</p> <p>62. Demonstrate competency in the clinical assessment of self-harm and suicidality and intervene appropriately.</p> <p>63. Demonstrate competency in an intake to be able to assess for trauma in a manner sensitive to client needs (i.e., ask in general terms if the client feels like anything from their past is impacting their present or if they have ever felt unsafe).</p> <p>64. Demonstrate diagnostic skills to assess for substance misuse/abuse.</p>

Table 28

Cont.

<p>Category: Skills Subcategory: Assessment (cont.)</p>
<p>65. Demonstrate the ability to recognize and be acutely aware of clients' non-verbal and paralinguistic cues.</p> <p>66. Demonstrate competency in assessment of the impact of trauma on a client's current experience, post-trauma dynamics, and somatic effects of trauma.</p> <p>67. CIT's (counselors-in-training) should possess the ability to approach rather than avoid a trauma history in a manner appropriate to the client.</p> <p>68. Identify, address, and manage the potential barriers to counseling when working with clients with trauma histories (e.g., trust issues, a client's possible self-sabotage/self-injury, trauma reenactments, transference and countertransference).</p> <p>69. Demonstrate the ability to notice micro-shifts and hyper/hypo arousal responses and upon recognition, work with the client to determine windows of autonomic arousal and affective tolerance.</p> <p>70. Be able practice and demonstrate with a supervisor/colleague how to respond to clients without asking questions or giving advice.</p> <p>71. Avoid over-questioning the client or asking intrusive questions that the client may not be willing or comfortable initially sharing and that the counselor may not know how to respond.</p> <p>72. Allow the client to share their history first and what they feel is important as this can set the tone for disclosure over time (i.e., avoid asking "Do you have a history of trauma?").</p>
<p>Category: Skills Subcategory: Interventions, Treatments, and Models</p>
<p>73. Develop an individualized intervention based off the unique aspects of the trauma.</p> <p>74. Demonstrate the ability to integrate holistic (mind and body) approaches.</p> <p>75. Demonstrate the ability to consult and seek support in treatment of those living with trauma; do not try to do this work alone—have a team backing you up and a team for supporting the client.</p> <p>76. Demonstrate a strengths-based approach and acknowledge the resiliency in clients' coping skills.</p> <p>77. Approach clients with the understanding that they may have experienced some form of trauma (being that 8 out of 10 clients will probably have experienced trauma).</p> <p>78. Be able to employ crisis intervention techniques.</p>

Table 28

Cont.

<p>Category: Skills Subcategory: Psychoeducation</p>
<p>79. Be able to provide and deliver developmentally appropriate psychoeducation to the client in a way that is most appropriate to them (e.g., kids, teens, combat trauma survivors) to normalize the clients' experience.</p> <p>80. Articulate the importance of understanding how a client's past trauma experience (or experiences in general) are impacting their present moment.</p>
<p>Category: Skills Subcategory: Collaboration</p>
<p>81. Be able to establish a collaborative alliance as it is core to the therapeutic relationship and foundational throughout the counseling process to monitor and maintain.</p> <p>82. Work with the client to monitor and adapt support systems and coping mechanisms that may be beneficial to or hindering the client's safety and progress in therapy.</p> <p>83. Collaborate with family and peer support systems to facilitate reconnection to others.</p> <p>84. Recognize ruptures in the counseling relationship and initiate repair.</p> <p>85. Facilitate the reintegration and consolidation of client gains recognizing the client for accomplishing the goals.</p> <p>86. Use the client's own language, or language they prefer when discussing their trauma (e.g., the appropriate person-first language, not an "abused spouse" or a "victim of war," but "a spouse who experienced abuse" or "someone who experienced war").</p>
<p>Category: Skills Subcategory: Self-Care</p>
<p>87. Possess the ability to maintain strong clinical and personal boundaries, which includes not telling the victim how they should feel or what they should do (regarding reporting assaults), being mindful of self-disclosure, and possessing the ability to maintain a healthy distance.</p> <p>88. Counselors must demonstrate the ability to manage a relational treatment and possible personal vicarious traumatization by monitoring self-care (awareness of signs of burnout/compassion fatigue), having a personal self-care plan (counseling/supervision/support), and engaging in personal self-care to reduce possibility of vicarious traumatization.</p>

Table 28

Cont.

<p>Category: Skills Subcategory: Emotional Regulation</p>
<p>89. Counselors-in-training must prepare themselves to hear things they never thought would be possible from clients' trauma narratives and be mindful of their reaction to the client and what it brings up in them personally when listening to the client.</p> <p>90. CITs should have the ability to hold the space for a client's story, be with others in their trauma responses, stay emotionally engaged, and emotionally regulated to manage reactivity in response to the client, practicing an ongoing mindfulness of language used, attend to their physical presence in the counseling relationship, and energetic relationality.</p> <p>91. Know and be able to teach a range of grounding and autonomic regulation (body and sensory awareness) skills and how to facilitate those (i.e., contraindications, speed of language, pacing) in session to maintain one's own grounding and self-care and to help the clients develop these skills for affective regulation.</p> <p>92. Demonstrate the ability to maintain connection with the client to support and ground a client presenting with dissociative symptoms while remaining emotionally present and self-regulating themselves.</p> <p>93. Be able to facilitate the clients' own awareness around how they are experiencing their lives and symptoms now.</p> <p>94. The counselor should possess the ability to engage in relaxation techniques, breathing exercises, and emotional regulation techniques personally, as well as be able to teach and lead clients through these techniques.</p> <p>95. Ensure the safety of the client and peripheral parties by being able to keep the client emotionally present.</p> <p>96. Demonstrate the ability to bring the client back to a state of equilibrium comparable to that prior to the onset of the crisis; while also setting the stage for future, long term care that can focus on more specific issues, provide more depth in services, and work toward "post traumatic growth."</p>
<p>Category: Skills Subcategory: Safety</p>
<p>97. Demonstrate the ability to construct safety plans with a client (e.g., IPV survivors).</p> <p>98. Regarding duty to warn, be able to make appropriate reports if needed (e.g., child abuse reporting, elder abuse reporting).</p> <p>99. Address the physical, emotional, social, mental, and spiritual needs of the client both outside of counseling and inside the counseling setting by establishing and sustaining an atmosphere of safety including asking the client what they would prefer (e.g., curtains open or drawn, where to sit in the room, temperature, handshake or not).</p>

Table 28

Cont.

<p>Category: Skills Subcategory: Safety (cont.)</p>
<p>100. Know what safety means for the client and work to build that in the counseling room/setting and outside if needed, on an ongoing basis.</p>
<p>Category: Attitudes and Beliefs</p>
<p>101. Enter into the counseling relationship as an authentic helper, humble, empathetic, and focused on the client in order to set the counselor-client relationship in the proper and most helpful tone.</p>
<p>102. Possess a willingness to continue broadening knowledge and clinical experience by reading, seeking supervision, personal counseling, and ongoing education within the trauma field.</p>
<p>103. Possess an openness to learn from every client.</p>
<p>104. Do not assume or presume anything.</p>
<p>105. Possess a non-judgmental attitude towards clients.</p>
<p>106. Self-care is a priority.</p>
<p>107. Truly care about clients and understand how clients are experiencing symptoms, how life has changed as a result, and how they experience their body (i.e., if they are in a place to go there).</p>
<p>108. Remain flexible—even if working with manualized treatments.</p>
<p>109. Possess a belief in recovery—resilience trumps trauma. Trauma is not a life sentence.</p>
<p>Category: Professional Characteristics/Attributes</p>
<p>110. Trustworthiness</p>
<p>111. Transparency</p>
<p>112. Have and demonstrate respect for all persons.</p>
<p>113. Compassionate, kind, and gentle</p>
<p>114. Self-control and composure -maintaining ones' "cool" under pressure</p>
<p>115. Persistence</p>
<p>116. Possess initiative</p>
<p>117. Creative</p>
<p>118. Courageous</p>
<p>119. Remain objective and consistent</p>

### Summary of Results

The panelists' responses to open-ended interview questions 1–6 in Round 1 of this study generated 135 items related to the knowledge, skills, attitudes, and professional characteristics that were deemed foundational for trauma education in counselor education. Of these 135 items from Round 1, consensus was reached on 111 (88%) of the 135 items. 7 of these 111 items for which consensus was reached had a median score of less than 6, but an interquartile range of less than or equal to 1, meaning the panelists agreed these 7 items were not foundational. Of the 111 items for which consensus was reached, 104 (94%) of the items had a median rating of greater than or equal to 6, and an IQR of less than or equal to 1, meaning panelists agreed these items were indeed foundational. 15 items were added or edited and agreed upon in Round 3, resulting in a total of 119 representative statements that were presented to panelists in the final Round 4, as the foundational components for trauma training and educational in counselor education (Appendix P). Panelists interpretation of the results, questions they are left with, and any additional comments made will be discussed in Chapter V and are included in Appendix Q.

## **CHAPTER V**

### **DISCUSSION**

In Chapter IV, results of the current Delphi study that produced consensus on components viewed as foundational among a panel of experts for the education of counselors-in-training related to trauma-informed counseling were presented. The current chapter provides a brief overview of the study and detailed discussion of the findings in relation to the current literature. Lastly, implications of the results for trauma training in counselor education, limitations, and areas for future research are presented.

#### **Overview of the Study**

The current CACREP standards identify educational components related to trauma as a mandatory part of graduate counselor preparation (CACREP, 2015). While these standards are helpful in delineating general trauma-focused knowledge and skills for entry-level professional counselors, they provide minimal guidance for designing and implementing trauma training (Courtois & Gold, 2011). Many standards, competencies, and guidelines related to trauma training exist, however the American Counseling Association has not yet officially endorsed a set of trauma training competencies or guidelines. It is important that guidelines and competencies set forth, align with the unique tenets of the counseling field, so as not to adopt existing standards specific to another field (e.g., Social Work, Marriage and Family Therapy, etc.). However, there is not yet a consensus in the counseling profession as to what knowledge, skills, and

attitudes that are foundational for the trauma education of counselors-in-training.

Consequently, it is difficult for counselor educators to adequately prepare counselors-in-training to provide trauma-informed care when they encounter trauma survivors in their pre-service training. The preparation of students and what counselor educators are teaching related to trauma has been examined minimally (Black, 2008; Courtois & Gold, 2009; McCammon, 1995).

The purpose of the current study was to explore this lack of knowledge related to trauma education in masters counseling programs and engage in the initial step of developing an empirically-based set of preliminary guidelines for trauma training and education specific to counselor education. To determine what trauma education components were essential, consensus opinion among a set of recognized experts was sought. This was accomplished using the Delphi method (Linstone & Turoff, 2002) to solicit opinion statements from the panelists as to the knowledge, skills, attitudes, and professional characteristics they deemed as foundational to prepare counselors-in-training to provide trauma-informed care as they encounter trauma survivors. The results of the research revealed four categories, along with subcategories. Category 1, "Knowledge," generated the most opinion statements and several subcategories emerged which provided nuanced information specific to trauma. Category 2, "Skills," generated the second largest amount of opinion statements and included several subcategories as well. Category 3, "Attitudes," and emergent Category 4, "Professional Characteristics," stand alone with no subcategories and were comprised of mostly abbreviated or one-word statements.

### Summary of Findings

From the original 135 items generated, the expert panel came to consensus and agreed upon 119 (82.3%) items as foundational for the trauma education and preparation of counselors-in-training. Twenty-five items (17.77%) did not reach consensus. Fifteen items were edited by panelists and agreed upon in Round 3. One hundred nineteen items reached consensus based on pre-determined cutoff scores of an interquartile range (IQR) of less than or equal to 1, and a median score of greater than or equal to 6. Six items that reached consensus had an IQR of less than or equal to 1, and a median score of less than 6, and were determined as not foundational. One hundred percent (10) of the panelists who participated throughout rounds 1-4 strongly agreed that the following 119 items were foundational for trauma education as summarized below (Table 29).

Table 29

#### Round 3 Final Results: Summary of Foundational Components for Trauma Education

Foundational Components for the Trauma Education and Training of Counselors-in-training	Mean	Median	IRQ
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Knowledge of Relational Aspects</b>			
1. Patience and pacing	6.50	6.5	1
2. Trauma work is a process that should not be rushed	6.36	6.5	1
3. Clients are learning to “hold” something overwhelming	5.71	6	1
4. Existential issues of safety, meaning, loss, suffering, & identity	6.71	7	0
5. Understand attachment and trauma	5.93	6	0.75
6. Understand counseling skills that are unique to trauma work	6.43	6.5	1
7. Understand foundational client-centered counseling skills	6.43	6.5	1
8. Core counseling conditions	6.29	6.5	1
9. Integration and self-regulation	6.21	6	1
10. Impact on the counseling relationship (i.e. transference, countertransference, etc.)	6.93	7	0
11. Impact potential for peripheral trauma reactions	5.79	6	0.75

Table 29

Cont.

Foundational Components for the Trauma Education and Training of Counselors-in-training	Mean	Median	IRQ
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Knowledge of Definitions and the Nature of Trauma</b>			
12. Definitions, variability, and interconnections (mental, relational, emotional, behavioral, and physical health)	6.64	7	1
13. Prevalence of exposure and incidence of PTSD	6.14	6.5	1
14. Distinguish between stress, crisis, trauma, and PTSD	5.40	6	0.75
15. Various types of trauma (e.g. complex, emotional abuse, IPV, etc.)	6.29	6	1
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Knowledge of Trauma Responses</b>			
16. Physical/psychological manifestations of trauma	6.79	7	0
17. Neurobiological, developmental, relational, emotional, and behavioral effects	6.57	7	1
18. Signs/symptoms, impact, and common responses of trauma and adaptive responses to trauma and opportunities for recovery	6.57	7	1
19. Causation of trauma and mechanisms behind trauma response	6.21	6	1
20. Neurological effects on autoimmune system and physical health	6.50	7	1
21. Objective and subjective factors related to trauma interactions	6.64	7	0.75
22. Posttraumatic growth, resilience, and recovery	6.21	6	1
23. Do not make assumptions trauma reactions	6.29	7	1
24. Know how to counsel a survivor and avoid re-traumatization	6.79	7	0
25. Understand how counselors may retraumatize clients	6.79	7	0
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Knowledge about Approach/Theory/Model</b>			
26. There is not one approach to trauma care	6.43	7	1
27. Meta-model or staged approach	5.86	6	1
28. Ecological perspective	5.50	6	1
29. Cognitive behavioral therapy	5.6	6	0
30. Know clinical intentions behind trauma interventions	6.50	7	1
31. Trauma-informed approach	5.93	6	1
32. Trauma-informed care and interventions	6.21	6.5	1
33. Semi-structured protocol with knowledge of empirically-validated interventions/approaches	5.23	6	1
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Knowledge about Culture</b>			
34. Trauma, exposure and response, is influenced by culture and identity (e.g., racial ethnic perceptions, responses to violence, historical, and intergenerational oppression)	5.50	6	0.75

Table 29

Cont.

Foundational Components for the Trauma Education and Training of Counselors-in-training	Mean	Median	IRQ
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Knowledge about Culture (cont.)</b>			
35. Understand cultural, historical, and gender issues and ways culture, development, and power/systems intersect	6.50	7	1
36. Integrated knowledge of trauma policies, procedures, systems	6.07	6	1
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Self-Awareness &amp; Reflexivity</b>			
37. Understand the self-care, awareness, and vicarious trauma	6.64	7	0.75
38. Ongoing supervision	6.00	6.5	1
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Knowledge of Ethics</b>			
39. Understand ethics in relation to trauma work	6.21	6.5	1
40. Current trauma research, literature, and strategies for cont. ed.	6.14	6	1
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Knowledge of Safety</b>			
41. Understand client's need for safety/security/survival	6.21	6.5	1
42. Know standard safety procedures	6.21	6.5	1
43. Understand how to promote emotional safety and integration	6.21	6.5	1
44. Trauma may require actions for safety outside the scope of client's acceptability; core therapeutic relationality is important	5.90	6	1
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Resources &amp; Referral Knowledge</b>			
45. Understand ethical assessment of personal competence and know when to refer	6.43	7	1
46. Be aware of referral resources, a mentor, or supervisor	6.07	6	1
47. Know referral sources/resources relevant to trauma care	6.21	6	1
<b>Category: Trauma Knowledge</b>			
<b>Subcategory: Assessment Knowledge</b>			
48. Assessment of safety, progress, and stages in trauma reactions	6.50	7	1
49. Appropriate assessments to screen for trauma history	6.50	6.5	1
50. Distinguish between trauma response and PTSD	5.40	6	0.75
51. Understand various signs of dissociation	6.50	6.5	1
52. Incorporate an understanding of trauma in suicide risk/assessment	6.71	7	0.75
53. Recognize high rates of co-morbidity and how this may affect the client's experience and counseling process	6.43	7	1
54. Addiction/differential diagnosis related to mental health concerns	6.36	7	1

Table 29

Cont.

Foundational Components for the Trauma Education and Training of Counselors-in-training	Mean	Median	IRQ
<b>Category: Skills</b>			
<b>Subcategory: Assessment Skills</b>			
55. Identify unique signs/indications of trauma-exposure in clients	6.71	7	0.75
56. Trauma assessment skills with clinically appropriate trauma-informed response	6.29	6	1
57. Address traumatic beliefs and meanings attached to self/other/world	6.00	6	0.75
58. Identify maladaptive coping mechanisms	5.60	6	0.75
59. Competent assessment of trauma, client, and personal safety	6.50	6.5	1
60. Initiate appropriate conversations to discuss trauma history	6.29	6	1
61. Directly inquire about past/current/suspicions of trauma history in a sensitive manner and discuss possible symptoms	5.93	6	1
62. Assessment of self-harm, suicidality, and appropriate intervention	6.71	7	0.75
63. Complete an intake in a manner sensitive to the client	5.79	6	0.75
64. Diagnostic skills to assess for substance misuse/abuse	6.71	7	0.75
65. Recognize clients' non-verbal and paralinguistic cues	6.57	7	0.75
66. Assess impact on client's current experience, post-trauma dynamics, and somatic effects	6.36	6.5	1
67. Ability to approach rather than avoid a trauma history	6.07	6	1
68. Identify, address, and manage potential barriers to counseling	6.50	7	1
69. Recognize micro-shifts and hyper/hypo arousal responses and determine windows of autonomic arousal/affective tolerance	6.21	6	1
70. Respond to clients without asking questions or giving advice	6.07	7	1
71. Avoid over-questioning the client or asking intrusive questions	6.00	7	1
72. Allow clients to share history first and what they feel is important	6.00	7	1
<b>Category: Skills</b>			
<b>Subcategory: Interventions, Treatments, and Approaches</b>			
73. Develop individualized interventions	5.86	6	1
74. Integrate holistic (mind and body) approaches	5.64	6	1
75. Consult and seek support in treatment of those living with trauma	6.57	7	0.75
76. Strengths-based approach acknowledging resiliency in clients' coping skills	5.60	6	0.75
77. Approach every client understanding they may have experienced some form of trauma	5.40	6	0.75
78. Employ crisis intervention techniques	6.57	7	1
79. Deliver developmentally appropriate psychoeducation to normalize the clients' experience	6.50	7	1
80. Discuss how past trauma experience may impact the present	5.76	6	0.75

Table 29

Cont.

Foundational Components for the Trauma Education and Training of Counselors-in-training	Mean	Median	IRQ
<b>Category: Skills</b>			
<b>Subcategory: Interventions, Treatments, and Approaches (cont.)</b>			
81. Establish collaborative alliance and monitor/maintain therapeutic relationship	5.90	6	1
82. Work with the client to monitor/adapt support systems and coping mechanisms	5.60	6	0.75
83. Collaborate with supportive systems to facilitate reconnection	5.20	6	1
84. Recognize ruptures in counseling relationship and initiate repair	5.2	6	1
85. Facilitate reintegration/consolidation of client gains recognizing the client for accomplishing goals	6.29	7	0.75
86. Use the clients' own language, or preferable/person-first language	6.50	7	1
<b>Category: Skills</b>			
<b>Subcategory: Self-Care Skills</b>			
87. Maintain strong clinical and personal boundaries	6.43	7	1
88. Manage a relational treatment and vicarious traumatization by monitoring self-care	6.43	7	0.75
<b>Category: Skills</b>			
<b>Subcategory: Emotional Regulation Skills</b>			
89. Listen to clients' narratives and be mindful of personal reactions	6.43	7	1
90. Hold the space for a client's story, be present with clients in their trauma responses, stay emotionally engaged and regulated, practice an ongoing mindfulness of language used, attend to client's physical presence and energetic relationality.	6.64	7	1
91. Teach grounding and autonomic regulation skills in session to help the clients develop these skills for affective regulation.	6.36	6	1
92. Ground and support a client presenting with dissociative symptoms	6.29	6	1
93. Facilitate clients' awareness of how they are experiencing their lives and symptoms now	6.00	6	1
94. Counselors engage in emotional regulation techniques to remain grounded and present in session	6.36	6	1
95. Ensure safety by keeping the client and self emotionally present	6.29	6	1
96. Bring the client back to a state of equilibrium; set up future long-term care that can focus on specific issues, provide in-depth services, and work toward post traumatic growth	5.93	6	1
<b>Category: Skills</b>			
<b>Subcategory: Safety Skills</b>			
97. Construct safety plans with clients (e.g. IPV survivors)	6.60	7	0.75
98. Appropriate reporting (e.g., child/elder abuse reporting)	6.60	7	0.75

Table 29

Cont.

Foundational Components for the Trauma Education and Training of Counselors-in-training	Mean	Median	IRQ
<b>Category: Skills</b>			
<b>Subcategory: Safety Skills (cont.)</b>			
99. Address physical, emotional, social, mental, and spiritual needs of the client by establishing a safe atmosphere, asking about client preferences	6.64	7	0.75
100. Continually build safety for client in/outside the counseling room	6.43	6.5	1
<b>Category: Attitudes and Beliefs</b>			
101. Authentic, humble, and empathetic	6.57	7	0.75
102. Willingness to continue learning/development	6.29	6.5	1
103. Openness to learn from every client	6.57	7	0.75
104. Do not assume or presume anything	6.57	7	0.75
105. Non-judgmental attitude	6.36	7	1
106. Self-care is a priority	6.64	7	0.75
107. Truly care about clients and attempt to understand	6.00	6	1
108. Remain flexible, even with manualized treatments	6.50	7	1
109. Belief in recovery—resilience trumps trauma	6.50	7	1
<b>Category: Professional Characteristics/Attributes</b>			
110. Trustworthiness	6.36	7	1
111. Transparency	6.36	7	1
112. Have and demonstrate respect for all persons	6.50	7	1
113. Compassionate, kind, and gentle	6.36	7	1
114. Self-control and composure under pressure	6.29	7	1
115. Persistence	5.71	6	1
116. Possess initiative	5.71	6	1
117. Creative	5.86	6	0.75
118. Courageous	6.29	6.5	1
119. Remain objective and consistent	5.2	6	1

Note. N=10.

Three *a priori* categories of knowledge, skills, and attitudes were drawn from the literature of higher education and psychology and based upon the construct of competency (Rodolfa et al., 2005). The fourth emergent category, professional characteristics, was drawn from panelists responses. Based on the construct of

competency (Rodolfa et al., 2005), each response was categorized as either knowledge-based (i.e., what trauma-informed counselors should know), skill-based (i.e., what trauma-informed counselors must be able to do), an attitude (i.e., an outlook or stance that one takes), or a professional characteristic (i.e., a personality characteristic, attribute, or trait). The researcher organized panelists' responses into these four categories, along with emergent subcategories to provide a meaningful framework for representing the 119 foundational items. Several recurring themes were prominent across the trauma counseling categories.

Key findings from the study indicate that trauma counseling is nuanced and complex, as evidenced by the large amounts of data captured with very specific details, relayed across a variety of perspectives. First, both breadth and depth of trauma counseling knowledge and skills were emphasized, however, in different ways. Panelists results relay that they conceptualized trauma in a manner that is developmentally appropriate for counselors-in-training accounting for an entry-level of competence (Rodolfa et al., 2005) and panelists' responses affirm the relational tenets of counseling as a client-centered, collaborative, healing process. Key themes include awareness, assessment, response, and resisting re-traumatization (SAMHSA, 2014). Representative items from the categories of *attitudes* and *professional characteristics* reflect a strengths-based perspective. Generally, the findings align with the client-centered focus predominant in the field of counseling, however, this focus was highlighted as uniquely important to trauma counseling, as special efforts are needed to convey unconditional positive regard, establish trust, and overcome relational barriers among traumatized

clients (Cook & Newman, 2014). It is noteworthy that panelists emphasized this strengths-based theme across all categories and subcategories. Finally, across categories, the panelists suggested that the approach to and demonstration of practice, or the “how,” of trauma counseling was nuanced yet relevant for trauma-informed counseling.

### **Knowledge**

The first category, *knowledge*, describes the trauma-specific content that counselors-in-training must know to provide trauma-informed care (e.g., concepts, theories, facts, foundational information, or practical understanding). Panelists identified 54 items under the category of knowledge and 10 subcategories emerged. Subcategories included: 1. relational aspects, 2. definitions and nature of trauma, 3. trauma response, 4. approaches, theories, and models, 5. culture, 6. self-awareness and reflexivity, 7. ethics, 8. safety, 9. resources and referral, and 10. assessment knowledge. Panelists emphasized that continued education, clinical supervision, and knowledge of assessments for trauma are a dynamic and ongoing source of knowledge. These findings are consistent with both the trauma training guidelines of the American Psychological Association (2015), as well as those of Complex Trauma Task Force (CCTF) (Cloitre et al., 2012), in their inclusion of knowledge development as a continuous process. Largely overlooked in the literature, Turkus (2013) and Logeran (2004) stressed that trauma work is complex and should be conducted only with ongoing clinical supervision, consultation, training and education.

Expert panelists agreed that trauma-informed counseling requires knowledge of many approaches, interventions, theories, and models. Breadth was emphasized around knowledge of current research, the variability of clients’ trauma responses that are

possible, and theories and models, both inside and outside of the field of counseling. Panelists stressed that obtaining more detailed knowledge of assessments, resources and referral sources, and safety procedures was crucial. The panel agreed that although knowledge of various interventions, treatments, methods, and approaches is important (i.e., breadth of knowledge), counselors-in-training were not expected to possess mastery of in-depth skills for implementing advanced trauma treatments (e.g., Cognitive Reprocessing, Eye Movement Desensitization Reprocessing, Prolonged Exposure Therapy, etc.).

This emphasis on knowledge of many approaches, models, and theories aligns with other items panelists supported, such as understanding the subjective nature of trauma, the many types of trauma, and various systems interacting (i.e., cultural, politics, context, etc.). Results also suggested knowledge of common signs and responses (i.e., neurobiological, relational, emotional, behavioral, and physical, spiritual, etc.) was important, while at the same time, acknowledging the uniqueness of individuals, cultures, contexts, and responses. Given the political climate of the United States in which refugees and racial-ethnic minorities experience fear and persecution, to say nothing of the historical basis of intergenerational trauma (Trippany, White, Kress, & Wilcoxon, 2004), approaches to trauma education should be developed that highlight the conditions which exacerbate the impact of trauma. Relatedly, sensitivity to social, political, cross-cultural issues that affect trauma were stressed by this group of experts. Panelists supported the idea that educators must convey to trainees that the very conditions that create trauma can make it difficult for individuals to participate in treatment (e.g., fear of

persecution, difficulties with trust, and emotional regulation) (Mattar, 2011). Therefore, Counselor Educators would be well-served to train counselors to recognize and address unique client characteristics and cultural considerations, as well as be informed about populations with higher risk exposure (i.e., complex, lower socioeconomic status, children, women, LBGTQIA individuals, addictions, severe mental health, low access to mental health care, immigrants, etc.) (Chen & Matthews, 2003; Gold, 2004; Kessler, 2000; Walker, 1999). Coinciding with a culturally responsive framework and that of trauma-informed care, cultural considerations relayed by panelists indicate an acknowledgement of the impact of gender, sex, race, ethnicity, politics, religion, and attitudes toward violence that perpetuate exposure to possible traumatic events (SAMHSA, 2014; Walker, 1999). Care must be offered to contribute to trauma survivors obtaining psychosocial balance.

An important theme emerging across panelists' responses included an emphasis on the subjectivity and ubiquity of trauma. Also noted was the importance of understanding common responses to trauma and possible effects, while acknowledging that trauma responses may be unique to an individual and may not be maladaptive. This finding differs from the prevalent biomedical model and diagnosis stipulations indicated in the current DSM-5 (American Psychiatric Association, 2013) related to trauma (Mattar, 2011; Turkus, 2013). Realizing the widespread impact of trauma, understanding potential signs and paths to recovery, recognizing signs, symptoms, and interacting systems, and resisting re-traumatization all underscore the core person-centered tenets of the

counseling profession as well as aligning with a trauma-informed approach (Harris & Falot, 2001; SAMHSA, 2014).

Surprisingly, the results did not explicitly mention interdisciplinary work or collaboration with other professionals. However, this is understandable when considering the developmental level of counselors-in-training and the panelists focusing on the importance of training counselors to possess a breadth of knowledge, understanding of reliable resources/referrals, continued education, and engagement in clinical supervision. A need exists for future movement and research to understand what an integrative and interdisciplinary approach to trauma, even for beginning counselors-in-training would entail. Viewing trauma, trauma exposure, impact, and care from a systemic lens affords the emerging perspective of trauma care and considerations as a social justice issue and one of advocacy on the part of the counselor. Counselors-in-training must be aware of the systemic aspects of trauma care for an individual within a family, society, or in a particular cultural context. This shift also has important implications for practitioners and the field, which will be discussed below. Resources and referral items constituted an entire subcategory of items. Knowledge of resources, referral sources, community sources, trauma-specific resources, processes within reporting, and understanding safety procedures and protocol are always important aspects of counseling, however this is especially relevant for clients with trauma exposure and the accompanying physical health problems, experiences of violence and abuse, and impaired psychological functioning (Yonkers et al., 2014). The results of the current study did suggest that staying abreast of the emerging research findings, awareness of advances in allied fields,

and continuing education and training were essential for knowledge currency and resource building.

As evidenced by panelists' emphasis across comments and categories, as well as dialogue between rounds, the knowledge gains needed are so that counselors-in-training can understand how to establish safety and do no harm. This includes attention to their own safety and well-being. Having an awareness and understanding of how counselors may retraumatize clients, how to interact with trauma survivors to avoid re-traumatization, and how to establish safety and stabilization for clients was strongly supported by the panel of experts. At times the very institutions and service systems that provide counseling services and supports to individuals are inadvertently trauma-inducing or re-traumatizing (Harris & Falot, 2001). Harris and Falot (2001) presented guidelines for the application of five trauma-informed principles including (a) ensuring physical and emotional safety; (b) maximizing trustworthiness through clear service delivery, consistency, and establishment of interpersonal boundaries; (c) maximizing the client's experience of choice and control; (d) collaboration and power-sharing; and (e) the prioritization of client empowerment and skill-building to promote safety in the classroom for trauma-sensitive education (Harris & Falot, 2001). A central tenet of these principles is individual safety must be ensured through efforts to minimize the possibilities for inadvertent re-traumatization, secondary traumatization, or new traumatization in the delivery of education or trauma services. The results of the study mirror these five trauma-informed guidelines (Harris & Falot, 2001).

## Skills

The second category, *skills*, is made up of practice elements inherent to trauma counseling with panelists relaying 46 items. Five subcategories emerged: 1. assessment (18 items); 2. interventions, treatments, and approaches (14 items); 3. self-care (2 items); 4. emotional regulation (8 items); and 6. safety (4 items). The data reflected in the following category of skills, speak to themes of assessment, and safety.

The subcategory, *assessment skills*, included 18 items and was the largest subcategory to emerge across categories. Skills were defined as an ability, facility, or specific learned activity students develop through training to be able to perform a task; the observable application of theory and knowledge a student can demonstrate. Responses included, for example, “Identify any maladaptive coping mechanisms endangering the client’s safety or the safety of others in jeopardy,” and “Possess the ability to ask permission and initiate appropriate conversations to discuss a client’s trauma history.” Items emphasized the person-centered nature of the counseling profession in asking permission and being sensitive to a client’s culture, history, gender identity, etc., while at the same time not being hesitant to act and ensure the safety of clients.

Findings in the *skills* category relate to a predominant theme of assessment. The results suggest the need for more training around assessments and differential diagnosis, including addiction, severe mental illness, and comorbidity. These results coincide with a study in the field of psychology in which a specialized course in traumatic stress for graduate students was developed (Newman, 2011). Newman’s (2011) pilot study

analyzed the results of this standalone course and found students reported the need for more education around differential diagnosis, knowledge about culturally appropriate assessments, and ethical decision-making (Newman, 2011). The need for more the dissemination of culturally appropriate assessments is prevalent throughout the trauma education literature in the fields of psychology, social work, and medicine (Briere & Scott, 2006; Levers, 2012; Mattar, 2011; Newman, 2011).

The subcategory of *interventions, treatments, and approaches* under the *skills* category included developmental considerations, individualized interventions based on the unique aspects of trauma, holistic mind/body approaches, consultation and resourcing, a strengths-based approach, a trauma-informed approach, attention to the therapeutic alliance, and sensitivity to language when discussing trauma history. These results speak to the approach of counseling and the practitioner focus of the field. The uniqueness of the counseling practitioner is in the “how” and the client-centered approach to counseling. The humanistic roots of counseling mirror attention to the ‘other’ and inclusion that is also found within the culturally responsive model (Hood, Hughes, & Frierson, 2006).

The results highlighted the importance of the counselor-in-training’s therapeutic response. The theme of therapeutic response is evidenced throughout panelists’ responses which highlight the collaborative nature of the therapeutic alliance. The open-ended survey questions in the current study were designed to explore the knowledge, skills, and attitudes that are foundational for beginning counselors to understand how to provide competent care upon encountering trauma survivors. The questions were geared towards

what counselors-in-training should be aware of, understand about trauma, specific skill development, approach, and abilities. Due to the exploratory nature of this study and the paucity of empirical research related to trauma training in counselor education, it was important to establish a baseline.

An emphasis on the client-centered and relational components of trauma counseling are imperative because at the core of the traumatic experience is terror, suffering, disconnection, disempowerment, abandonment, oppression, abuse, betrayal, and helplessness or shattered trust (Courtois, 2004). A person's worldview may be shaken to its foundation. Herman notes, "traumatic events call into question basic human relationships" (p. 51), and trauma survivors may experience disconnection from others as well as a sense of separation from self (Herman, 1997).

The critical nature of the therapeutic response results coincides with Harris and Falloot's (2001) guiding principles of trauma-informed care, as well as the trauma trauma-informed approach (SAMHSA, 2014). Counselors-in-training working with trauma survivors while also acknowledging the clients' resilience and possible adaptive responses was a unique emphasis of the results that is not found in other trauma guidelines. Collaboration with support systems, the ability to provide resources, psychoeducation, and normalizing a client's trauma experience were subthemes. The trauma-informed approach (SAMHSA, 2014) is based on Uri Bronfenbrenner's (1994) bioecological model of human development for understanding the bidirectional influence of multiple factors and multiple systems on human development. This articulation of an ecological and transactional model offers a necessary means of understanding the

complex effects of trauma on individuals, communities, and populations at multiple systemic levels and offers a holistic framework to view and conceptualize trauma. A bioecological model also offers a framework in which to understand the role of attachment across the lifespan. This aspect aligns with the ACA's 20/20 definition of counseling, as well as understanding the highly subjective ways in which individuals experience traumatic events and construct personal meanings. The model also illuminates trauma as a clinical issue, a phenomenological issue, and a systemic issue. Understanding context, the complex and systemic nature of trauma and trauma-inducing environments, systems, and policies, is an essential aspect of understanding the impact of trauma. This bioecological model allows counselors to situate the experiences of trauma-exposed individuals within space, time, culture, political climate, etc., and to also consider the systems interacting that may form oppressive and damaging environments. Perhaps most importantly, the bioecological model may assist counselors in situating trauma and traumatic responses within a system of influences. Thereby recognizing that the agency for responding to a complex traumatic event does not lie solely within the individual but is, in fact, a system issues warranting a systems response.

The theme of response and resisting re-traumatization is evident in the emergent subcategory of *emotional regulation* and *safety*. These two subcategories appear related to one another, as some of the skills necessary for the client and counselor to remain safe are similar. *Emotional regulation* items included, "Counselors-in-training should demonstrate the ability to hold the space for a client's story, be with others in their trauma responses, stay regulated to manage reactivity in response to the client, practicing an

ongoing mindfulness of language used, attend to their physical presence in the counseling relationship, and energetic relationality.” Another item states, “Possess the ability to teach a range of grounding and autonomic regulation (body and sensory awareness) skills and how to facilitate those (i.e., contraindications, speed of language, pacing) in session to maintain one’s own grounding and self-care and to help the clients develop these skills for affective regulation.” The ability for counselors to emotionally regulate themselves is often taken for granted in trauma education and training however this group of panelists emphasized the importance of this skill. The research suggests counselors-in-training should be taught breathing exercises, guided-imagery and safe place guided imagery, mindfulness, muscle relaxation techniques, grounding techniques and de-escalation techniques, first for themselves and then to teach a client by practicing these techniques in session to establish safety and stabilization (Cook & Newman, 2014; DePrince & Newman, 2013; Harris & Fallot, 2001). A trauma-informed approach includes the four key assumptions of realization, recognition, response, and resisting re-traumatization of the client. Results of the current study relate to these categories in a foundational way as awareness, assessment, response, and resisting re-traumatization were the key themes. The largest subcategories of the current study were *assessment skills* and *emotional regulation skills*. These two subcategories generated the most responses from the expert panel. Results of the current study suggest that the most important “intervention” counselors-in-training is to do no harm and use minimally invasive interventions while establishing and supporting physical and emotional safety.

The focus of the field of counseling is largely on the individual and the therapeutic relationship, which denotes the practitioner/client emphasis of the profession and the context in which counseling occurs; face-to-face, commonly one-on-one at the beginning stages. A major implication of the current study is the necessity of counselors-in-training to help trauma-exposed clients to experience safety and security within the therapeutic relationship. An essential component of trauma interventions is to facilitate healing through the qualities of a positive and empathetic therapeutic relationship. This may sound obvious, however given the nature of trauma, the context of a therapeutic relationship is likely to be much more successful when a counselor exhibits qualities of empathy, self-awareness, and compassion (Norcross, 2011). The clinical relationship and interpersonal elements continue to represent some of the most consistently supported findings of therapy in the outcome literature (Briere & Scott, 2006).

### **Professional Attitudes and Characteristics**

The third and fourth category of *attitudes* and *professional characteristics* included the fewest items, and the most abbreviated responses and comments. Examples of the nine items that made up the category of *attitudes* included “Possess a willingness to continue broadening knowledge and clinical experience by reading, seeking supervision, personal counseling, and ongoing education within the trauma field,” and “Possess a non-judgmental attitude towards clients.” Examples of characteristics panelists relayed included transparency, creativity, courage, objectivity, consistency, self-controlled/calmness, compassion, kindness, gentleness, respect, trustworthiness, and possession of initiative. These items appeared to be more general and applicable to the

counseling field, so further analysis is needed to determine what attitudes and characteristics are especially important for trauma counseling. Even so, research indicates that counseling in the context of a caring and nonjudgmental relationship is more likely to be successful when a counselor exhibits qualities of self-awareness, respect, and empathy (Gilbert, 2009; Martin, Garske, & Davis, 2000; Norcross & Wampold, 2011). The finding that trauma-informed counselors hold a belief in recovery and show respect for all clients, rather than sympathy, is affirmed by the literature (Cook & Newman, 2014). This emphasis affirms a strengths-based and client-centered approach to trauma counseling.

### **Items for Which Consensus Was Not Reached**

Twenty-four items did not reach consensus. The statistical aggregates for these items, as well as all comments provided by panelists from Round and 3 may be found in Table 27 and are outlined in the results of Chapter IV. Panelists' comments and discussion on the items not reach consensus provided valuable information, given the dearth of empirical research on this topic in counselor education. Common reasons items did not reach consensus included an item was too specific, too vague and required context, a difference of opinion existed, or the item needed to be re-worded.

These items should be explored in a future study to highlight important dialogues and points of contention in the counseling field regarding trauma, defining trauma, differentiating trauma, crisis, and natural disaster in the research and literature, and operationalizing these terms. The items not reaching consensus affirm the challenge facing the field in the clarification of what trauma is as multiple definitions and conceptualizations of trauma exist. Trauma, crisis, and natural disaster have often been

grouped together throughout counseling literature, research, and training, therefore ensuring counselors-in-training can differentiate between these is important for the field in terms of practice, training, and research (Webber & Mascari, 2009).

### **Conclusion**

Understanding what knowledge, skills, attitudes, and professional characteristics are foundational for the trauma education and training of counselors-in-training was an essential first step towards developing an empirically derived baseline specific to the field of counseling. This study was based upon previous research, researchers' directives, and critical calls to action in the field of trauma counseling and counselor education (Courtois, 2002; Courtois & Gold, 2009; Levers, 2012; Mattar, 2011; McCammon, 1995; Webber et al., 2016). In addition, results extend the empirical knowledge base by providing an understanding of the client-centered, collaborative, and strengths-based foci of educational trauma components that are specifically derived from the field of counseling and posit the areas of awareness, assessment, and safety as a developmentally appropriate benchmark, based upon the key assumptions of a trauma-informed approach (Harris & Falot, 2001; Herman, 1992; SAMHSA, 2014). Trauma educational components need further narrowing and context, so that this critical dialogue may continue towards the future development of best practices, guidelines, and ultimately, trauma competencies that are derived from the field of counseling. If the field of counselor education shifts its focus of trauma, which has historically been viewed as a specialty area, to view trauma as a normal part of the human experience, then training guidelines may be further established to meet the developmental level of counselors-in-

training and provide more appropriate care for the trauma-exposed individuals they will encounter.

### **Implications for Counselors-in-Training**

The results of the current study highlight important considerations for counselors-in-training in graduate programs as they encounter and work with trauma survivors in their pre-service training and entry-level positions. Understanding the core relational tenets of counseling and having a solid set of foundational counseling skills is essential. Appropriate assessment of trauma histories, knowing how to ask questions on an intake, how to teach the client to emotionally regulate, and how to join with a client given possible relational barriers were agreed upon as foundational. The ACA Code of Ethics (ACA, 2014) stipulates counselors are only to practice within the boundaries of their competence. The construct of competency was defined as a professional being capable and able to understand and provide helping services in an appropriate and effective manner (McIlvried & Bent, as cited in Rodolfa et al., 2005). The results of the current study elucidated areas within the tri-partite construct of competency, including knowledge, skills, and attitudes/professional characteristics (Rodolfa et al., 2005). Specifically, the importance of awareness or a breadth of knowledge. The items panelists included in the skills categories suggest the field of counseling offers a unique perspective on what developmental benchmarks may be for entry-level counselors (i.e., collaborative care, assessment, safety, stabilization, resourcing, referring, emotional regulation techniques). Analyzed through a constructivist and culturally responsive lens, awareness, recognition, appropriate assessment and establishment of safety for client,

counselor and peripheral parties, consulting, reporting, resourcing, and referring are foundational components for competent care. In fact, knowing the bounds of one's personal counseling competence is an ethics responsibility. Results of the current study suggest that awareness and appropriate use of assessment, along with skills for safety and stabilization utilizing core counseling skills while working from a strengths-based, systemic, culturally sensitive approach formulate the important benchmarks for counselors-in-training to provide competent trauma-informed counseling. The results align with Judith Herman's first stage in her phasic trauma model of safety and stabilization. Appropriate assessment, and the establishment of safety and stabilization may be viewed as the "intervention" counselors-in-training must be able to demonstrate.

Furthermore, results imply that trauma-informed counseling knowledge and skills must be built upon a core foundation of strong client-centered counseling skills. These results align with seminal trauma-informed principles (Harris & Falot, 2001; SAMHSA, 2014) in that panelists endorsed a client-centered and strengths-based perspective which includes belief in recovery, belief in a client's control of their process, collaborative care, and a recognition that trauma symptoms are adaptive responses to cope with trauma (Cook & Newman, 2014; Falot, 2008).

The results of this study mirror the existing literature on trauma-informed care (SAMHSA, 2014) and client-centered counseling grounded in common factors of a positive therapeutic outcome (Messer & Wampold, 2013). Ironically, there exists a rediscovering of these relational therapy components that were developed outside of the context of scientific medicine. Client-centered components have sometimes been rejected

by empirically focused research. The relational or client-centered elements continue to represent the most frequently supported findings of therapy outcome literature (Cloitre et al., 2010; Courtois & Ford, 2013; DePrince & Newman, 2011; Foa, 2011; Herman, 1992; Linehan, 1993; Shapiro, 1995). The results of the current study stress the client-centered elements, emphasizing the importance of a positive and nonjudgmental therapeutic relationship, empathy, attention to shifts in the counseling relationship, transference, and countertransference, boundaries, and attachment. This was not surprising given the practitioner-based focus of the counseling field. Panelists agreed upon the necessity of a strong set of core counseling skills as essential to this relational care of trauma survivors.

### **Implications for Counselor Educators**

The current study has important implications for counselor education. Trauma has historically been viewed as a specialty area within counseling. Given the prevalence of trauma-exposure in the population (e.g., U.S. Department of Health and Human Services, 2003; U.S. Surgeon General, 1999) and the likelihood counselors-in-training will encounter trauma-exposed individuals, it was expedient to explore educational components specific to trauma counseling, however not specific to a specialty (e.g., child abuse, intimate partner violence, PTSD) or specific orientation (e.g., cognitive-behavioral therapy, narrative therapy, cognitive reprocessing). The intent of the current study was to develop an empirically derived baseline of trauma training components that could be applied across trauma-exposed populations, theories, and specific disciplines (addictions, interpersonal violence, sexual abuse, etc.). An empirical knowledge base was called for to

provide a foundation for further research and dialogue regarding trauma preparation in counselor education (Black, 2008; Courtois & Gold, 2009; Mattar, 2011; Sommer, 2008).

Critical interconnections have developed between trauma training movements in counseling (i.e., culturally responsive practices, empirically informed services, trauma-informed services, neurobiological considerations, etc.) (DePrince & Newman, 2011), and allied fields (e.g., medicine, social work, and marriage and family therapy). The need has increased for trauma education that mirrors the cultural complexities and ubiquity of trauma in society (Beck & Sloan, 2002; Kilpatrick et al., 2013; Mattar, 2011).

A multi-faceted trauma educational model should honor the core tenets of the counseling profession. One such framework may be the trauma-informed approach which is based on Bronfenbrenner's socioecological model (Bronfenbrenner & Ceci, 1994). This model could account for the unique individual, as well as systemic factors that are imperative to understand as it relates to trauma conceptualization and care. Educational components of trauma may include attention to parallel process, safety, and vicarious trauma in the classroom. First, attending to the parallel process (Berger & Quiros, 2013; Ganzer & Ornstein, 1999), research indicated that educators should underscore the possibilities of reactions or reenactment between the counselor and client. The client may react to the counselor in ways that carry out their psychology of the perpetrator and/or identification with the aggressor (Berger & Quiros, 2013). Second, due to the prevalence of trauma, many counseling students sitting in the classroom are trauma survivors so understanding how to establish safety and supports at the beginning of the class is important. Third, course materials used to teach about trauma may impact students and

induce vicarious responses. Establishing a protocol for safety, support, and how the educator and students should proceed is preferable prior to the start of any course. This may also include the educator first establishing, teaching, and practicing emotional regulation techniques at the beginning of the course to mirror a congruence in care (Black, 2008).

The importance of utilizing a holistic model for trauma training that synthesizing cultural, relational, and biomedical components are highlighted in the current study. The results suggested the relational nature of trauma care and its importance to the process, understanding neurobiological reactions to normalize and provide psychoeducation, and the use of culturally appropriate assessment and intervention. Culture, biology, nor relationality were emphasized above the other, rather all were deemed as important to include in training. A trauma-informed approach (SAMHSA, 2014) ascribes to Bronfenbrenner and Ceci's (1994) bioecological model which considers the unique individual, systems, and the many layers of context necessary to understand the nuances of trauma.

Additionally, these preliminary components for trauma education may be used to inform curriculum. Recommendations from the results of the current study suggest an emphasis on awareness, assessment, response (i.e., core counseling skills and emotional regulation techniques) and safety protocol to resist re-traumatization (i.e., referral, consultation, supervision, counseling, resources, and reporting). Within the field of counselor education, much of what is known about trauma education is conjecture, conceptual, and anecdotal based on counselor educators' personal experience (Black,

2008; Courtois & Gold, 2009; McCammon, 1995). Missing from the research have been the voices of the counselor educators who provide trauma education to counselors-in-training and specific knowledge to enrich the general CACREP standards related to trauma (CACREP, 2016). This is a unique contribution of the current study

These 119 preliminary guidelines provide a baseline to establish the empirical knowledge base related to trauma training and education in counselor education. These items and are not intended to be prescriptive or exhaustive or to supersede clinical judgment. These findings suggest important themes of awareness, assessment, response, and safety or resisting re-traumatization, and a needed narrowing and specification of foundational trauma educational components for entry-level counselors. A trauma-informed approach may be a useful paradigm for counselor educators to use in training entry-level counselors (SAMHSA, 2014). The trauma-informed approach stresses four key assumptions which are realization of the prevalence, complexity of interconnected systems, and impact of trauma; recognition or culturally appropriate assessment; response considering safety and stabilization; and resisting re-traumatization by consulting, ongoing clinical supervision and training, supplying resources and referral sources. This approach aligns with many of the trauma-phased or staged models (Herman, 1992; Levine, 1996) by focusing on the first step of trauma care which is safety and stabilization. The researcher proposes that the field of counselor education make a developmental shift related to what constitutes “competence” in trauma counseling for entry-level counselors-in-training. Awareness, assessment, safety, and stabilization, and

resisting re-traumatization may provide the “intervention” counselors-in-training need learn and demonstrate (Harris & Fallot, 2001; SAMHSA, 2014).

### **Implications for the Field of Counseling**

First, it remains important for the field to define and distinguish between crisis, trauma, stress, and natural disaster to ensure competent training of counselors, as well as to advance research and operationalize these terms. Crisis, trauma, and natural disaster have often been grouped together in the research and literature of counseling and counselor education. While it may not be necessary to adhere to one static definition of trauma, the combined or collective definitions that the field of counseling promotes is important to identify for future training and research.

Second, movement towards the establishment of evidence-based trauma competencies or training guidelines specific to the profession is necessary. Competencies are critical as they provide useful resources for developing trauma training, education, and curricula design (Kaslow, 2006; Rodolfa et al., 2005). It would benefit the field of counseling to survey allied fields competency domains and categories and specify the categories that align with the unique tenets of counseling from the perspective of our profession and then form work groups to formulate items within these categories. Work groups could consist of counselor educators, practicing counselors, counselors-in-training, and trauma survivors so to represent and empower the voices of relevant stakeholders.

Third, participants in the current study emphasized the role that relational components play in trauma-informed care, including the importance of awareness,

assessment, emotional regulation, and safety. The data revealed the centrality of establishing safety and stabilization by fostering beginning counselors' ability to recognize, refer, and provide psychoeducation and resources for a trauma survivor. An immediate solution may be to facilitate further collaboration and support by providing a webpage for trauma resources. The American Counseling Association could support a webpage dedicated to trauma resources to include information for professional development, continuing education training, trauma course syllabi, and a forum to a community of fellow trauma counselors to engage in continued learning, collaboration, and interdisciplinary support.

Finally, expert panelists endorsed items related to the critical importance of demonstrating a knowledge of cultural, sociopolitical, intergenerational, and historical factors related to trauma. The core experiences of traumatic events affect survivors on personal and systemic levels. Therefore, an implication for the field of counseling may include a shift towards working within the client-clinician dyad along with attention to broader systemic and cultural influences on trauma. This would promote social justice and increase advocacy for trauma survivors by extending the therapeutic alliance to the counselors' colleagues, service delivery systems, and survivors' social units, among others. An ecological perspective of trauma provides a lens for understanding and incorporating care for the needs of individuals, families, communities, organizations, and the broader society that are often overlooked and undertreated. Thus, implications for the field include exploring issues of inequality, oppression, discrimination, interactions of

systems and policies, and access to mental health services that further affirm why issues of trauma extend to the area of human rights and social justice (Levers, 2012).

### **Suggestions for Future Research**

Implications for future research suggested by the current study are in the areas of counseling and counselor education. Future research should support the development of trauma counseling guidelines, best practices, and ultimately trauma training competencies. Panelists perceived a lack of trauma competencies to guide the education of counselors and to support clinical practice. Thus, there is a need to narrow and investigate ways to effectively integrate trauma-specific training into the counseling curricula. Research involving ways to integrate trauma-specific skills into basic counseling helping skills class, human development, and or theories class is preferable given the fact that counselor educators already must include so many curricular requirements.

A need exists for future movement towards and research examining an integrative and interdisciplinary approach to trauma, even for beginning counselors-in-training. Viewing trauma, trauma exposure, impact, and care from a systemic lens affords the emerging perspective of trauma care and considerations as a social justice issue and one of advocacy on the part of the counselor. Counselors-in-training should be made aware of the systemic aspects of trauma care for an individual within a family, society, in culture. This shift also has important implications for practitioners and the field in that it emphasized systemic support systems and interdisciplinary connections and care to remain abreast of the most current research literature, continued supervision, training, and

access to resources. With this movement, the alliance shifts to include colleagues, various fields, service delivery systems, and social units. Considering the bioecological model, the therapeutic alliance remains central, yet parallel to this framework, and considers the countless systems, contexts, and other individuals across varied environments. As the field of counseling embarks on providing services to trauma survivors, it is imperative that a holistic approach be considered.

Panelists indicated that there were many different courses in which they integrated trauma education in their respective programs. To move toward the ultimate goal of developing trauma education assessment measures. The creation of specific benchmarks for measuring proficiency levels among beginning counselors is a critical first step (Rodolfa et al., 2005). The results of the current study imply that benchmarks for counselors-in-training may include awareness/recognition, culturally responsive assessment, emotional regulation techniques, and resources and referral protocol are imperative to include in trauma training.

To achieve greater clarity, the preliminary list of educational components generated in the current study needs to be further narrowed and clarified. This may be accomplished by seeking the expertise of trauma practitioners, as well as trauma survivors, to provide clarification on items that are specific to trauma counseling and those that may be removed because they apply to counseling in general. Further, additional specification may be gained by utilizing focus groups made up of educators, practitioners, students, and survivors to review and narrow the scope of items related to

trauma education to provide counselor educators with specific components to integrate into their already full curricular requirements.

An effective metric for measuring the intellectual and emotional processing of trauma-related content in the classroom has not yet been established. Such a measure would be beneficial to move towards adequately assessing the training goals of a curriculum. Moreover, it would be worthwhile to develop a generalized trauma-specific program evaluation tool that could be used across programs. The development of such an instrument would aid in the comparison of the effectiveness of different course approaches so that additional information about trauma pedagogy could be shared and improved upon. This tool could be built upon specific domains or categories from the CACREP standards or competency domains, once established.

Prior to the development of any evaluation tool, an important first step for the field of counseling is to define trauma and establish trauma-related competencies across the curriculum by expert consensus that identify specific content, principles, skills, and attitudes counselors must have; this approach aligns with an overall approach to defining and measuring learning outcomes in psychology training (Kaslow et al., 2009; Rodolfa, et al., 2005). Once this occurs, the appropriate course material could be established and consistently delivered.

Continued dialogue and research on effective trauma training and pedagogy in counselor education is needed. Stand-alone courses on trauma are created by counselor educators in relative isolation. There is a need for academic discourse and exchanges via online forums on special issues related to trauma pedagogy to share strategies,

challenges, and research. This may be created in conjunction with the ACA's Trauma Interest Network and/or as part of the initiative of the ACA Trauma and Crisis Taskforce including an updated webpage dedicated to trauma resources supported on the website of the American Counseling Association.

### **Strengths**

The current study had multiple strengths, the first of which was the methodology chosen. The Delphi method utilized experts to draw information from educators with trauma expertise in the counseling field and provided much needed content validity. This method allowed the researcher to include the results of current research in allied mental health fields and determine alignment with the perspective of counselor educators. The method is said to have both quantitative and qualitative components, allowing a more in-depth understanding of the results. The method allowed the researcher to bring together an expert panel from across the country while providing relative anonymity of the participants.

The expert panel is the most central component of the Delphi method and was made up of participants who were purposefully selected based on objective standards. Expert panelists exceeded inclusion criteria and were counselor educators with expertise in various areas of trauma (i.e., trauma survivors, trauma supervisors, trauma educators, authors, presenters, researchers, and trauma counselors). The majority of panelists actively practiced as professional trauma counselors, were actively teaching, and engaged in trauma counseling and supervision with diverse groups and populations. Panelists responded to twenty-seven demographic questionnaires that provided a rich description

of their experience, expertise, and cultural backgrounds and worldviews. The panelists were invested and passionate about the topic, thus their responses and comments provided rich information from multiple perspectives.

While attrition rates and survey fatigue influenced participation in the study. Of the 20 participants who initially generated the majority of the items, 15 continued through Round 2, and ten faithfully participated through all four rounds. This number is in keeping with a preferred number of participants as stipulated in the research literature, i.e., optimal number of no less than ten and up to 20 (Doughty, 2009; Gustafson, 1975; Ludwig, 1997; Powell, 2003).

Finally, the current study is extremely applicable to the educational development and training of counselors-in-training. Results can be utilized to inform professional trauma counseling development in counselor education programs and promote further dialogue and research. Results provide an empirically derived set of data as a strong basis for future research to be conducted on trauma education and training in the profession of counseling and are a first step in strengthening the profession through the improvement of counselors-in-training to encounter trauma-exposed populations.

### **Limitations**

As with any study, the current study had some clear limitations. Researcher bias may be evident in the analysis and selection of items from the research literature, and the strong influence of the trauma-informed approach which is grounded in the socioecological model. Given the breadth of research on trauma education in other fields,

allied mental health fields, as well as components of higher education influenced this study.

Such rich data were collected, however the time-frame for the study was limited to three months. This limitation prevented further discussion and limited the dialogue which could have led to greater clarity, context, and further narrowed the determination of importance. Retaining the method's staple of anonymity of the panelists may have stifled dialogue, yet this is an important aspect of the methodology in an effort to limit group think. Despite the originality of some of the items panelists included specific to trauma training in counselor education, several of the items were general for counseling and some items are already embedded in the general counseling standards for counselor education, such as the Council for Accreditation and Related Education Programs (CACREP, 2015) and the ACA Code of Ethics (ACA, 2014). Researchers have argued that individuals cannot focus on more than 20 areas of development at a time (Fulmer, et al., 2009). Given this information, the 119 items produced by the expert panelists are extensive and need to be further narrowed and specified in context.

Another limitation included a lack of direct representation of the voices of trauma survivors. The panel did, however, have vast experience and active professional interaction with trauma counseling and/or supervision of trauma counselors. Survivor voices were only represented indirectly. Along those same lines, the voices of counselors-in-training were not represented in terms of their experiences and levels or lack of trauma preparation.

Lastly, the use of open-ended questions to allow categories to emerge, expanded the original survey questions in Round 1 from 5 to 11. Thereby, vastly increasing the time of the study for Round 1 from 30 minutes to an average of one and a half hours. This generated an enormous amount of data and while the questions were not guiding or leading, they did not solicit some of the specific responses sought. Panelists responses were sometimes general or vague and the use of more pointed questions may have solicited more specific items unique to trauma-informed counseling. Additionally, with twenty-seven demographic questions and 11 open-ended questions on the Round 1 survey, panelists may have experienced fatigue which would impact responses and attrition rates.

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## APPENDIX A

### INTRODUCTION AND CONTEXT FOR THE STUDY: ROUND 1

**I invite you to complete the following: 1. Please read the synopsis below for context; 2. Open the Qualtrics link and answer the brief demographic questions in Section 1, and then, 3. Answer the five open-ended questions.**

This study aims to ascertain and explore the foundational trauma-informed knowledge, clinical skills, attitudes, and teaching practices necessary to inform the education of master's-level counseling students to prepare them for entry-level work with trauma survivors. After carrying out a systematic review of the empirical literature in the field of counselor education and allied mental health fields, relevant themes emerged. Below is a summary of those themes.

#### **Background of Trauma Education in Counselor Education**

According to Kilpatrick et al. (2013), 89.7% of individuals in the United States are exposed to traumatic events in their lifetimes. Exposure to traumatic events is a public health concern, placing individuals at risk for adverse mental and physical health consequences (U.S. Department of Health and Human Services, 2003). Counselors working in various settings will likely work with survivors of trauma, so it is imperative that their training include foundational trauma knowledge and trauma-competent clinical skills (Layne et al., 2014). Unfortunately, formalized trauma-based curriculum to inform the education of professional counselors have yet to be integrated into the core curriculum of graduate counseling programs, despite the fact that researchers report high trauma-exposure rates among U.S. residents (Courtois, 2009). With the rapid advances in traumatology and changes in the Council for Accreditation of Counseling and Related Educational Program Standards related to trauma from 2009 to 2016 (CACREP, 2009; 2015), there remains a paucity of training about trauma in graduate counselor education programs (Courtois & Gold, 2009). There is a dearth of literature in the field of counselor education related to the necessary training master's students need for entry-level trauma work. Trauma counseling competencies in counselor education to inform the training of master's counseling students have yet to be identified (Layne et al., 2014; Turkus, 2013).

#### **Emerging Movements in the Literature Related to Trauma Education**

Significant growth in the field of traumatology has been paralleled by growth in evidence-based practices approaches to education (Bray, 2010), constructivist approaches to student learning (Mascolo, Pollack, & Fischer, 1997), and the current competency-based movement in education (Newman, 2011). Scientific, relational, and cultural components emerged from the literature as critical considerations for competent practice in trauma so as not to exacerbate the effects of trauma in survivors or students in the

classroom. These components required sensitivity to socioeconomic, political, relational, and cross-cultural issues. However, more information is still needed regarding trauma education for counselors-in-training.

## APPENDIX B

### INTERVIEW PROTOCOL: OPEN-ENDED QUESTIONS FOR PANELISTS BRAINSTORMING: ROUND 1

Please review the definitions and instructions below, and then provide your expert opinions regarding the trauma training and educational components that are foundational for counselor educators to include in their curriculum to prepare master’s counseling students as they encounter trauma survivors in their pre-service training and entry-level counseling positions. To develop this baseline for trauma-informed counseling in counselor education programs, please consider the core components you think students must know to provide competent trauma-informed care as they encounter trauma survivors in their work.

#### DEFINITION OF TERMS

<p><b><u>Trauma-informed Competence</u></b> – is defined as the <i>minimal</i> knowledge, skills, and attitudes that are foundational for counselors-in-training (i.e., entry-level master’s counseling students) to possess as they encounter trauma-exposed individuals.</p>
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<p><b><u>Trauma-informed approach</u></b> - includes research, clinical practice, and the voices of trauma survivors to inform conceptualizations of trauma and trauma care (Harris &amp; Fallot, 2001; SAMHSA, 2014), and “emphasizes physical, psychological, and emotional safety for both providers and survivors in the delivery of services to improve clinical practices (Hopper, Bassuk, &amp; Olivet, 2010, p. 82, SAMHSA, 2014). A trauma-informed approach “1) realizes the prevalence and influence of trauma; 2) recognizes how trauma affects all individuals involved in the program, organization, or system; 3) responds with trauma-sensitive practices and policies; and 4) works against re-traumatization (SAMHSA, 2012, p. 4).”</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**While there are many definitions of trauma and specialties areas, these trauma training guidelines are designed to provide a baseline for counselor educators and to be applied across trauma-exposed groups, specialty areas, and theoretical stances.**

Not all counselors-in-training are expected to have specialized trauma training, nevertheless, there is an increased need for trauma-informed competence as our students start their pre-service training and encounter traumatized individuals. Please click on the link below to complete the demographic questions and the open-ended questionnaire:

[https://uncg.qualtrics.com/jfe/form/SV\\_bNksSsRamjCsYoR](https://uncg.qualtrics.com/jfe/form/SV_bNksSsRamjCsYoR)

**Please answer the following open-ended questions with your thoughts and opinions from your personal expertise and experience within the provided text boxes.**

*\*List as many statements as you wish to answer each question below:*

- 1. How would you describe the best practices in trauma-informed counseling?**
2. What would a newly graduated counselor need to be aware of to be able to work with a client who had experienced a traumatic event?
3. What specific things would they need to understand about trauma?
4. What trauma-specific skills might they need to have developed?
5. What other abilities might they need to demonstrate?
6. How should newly-graduated counselors approach clients when they suspect a history of trauma?
7. What should counselor educators consider when they set up course content or curricular tasks focused on trauma?
8. What classroom or workshop activities have you seen that have helped counselors-in-training learn about how to work with clients who have experienced trauma?
9. What challenges specifically related to teaching about trauma might counselor educators need to consider?
10. What do you believe is lacking within trauma training and education in counselor education?
11. Related to the topic of trauma training and education in counselor education, would you like to add any additional comments, opinions, or ideas that you did not include in the above responses? If so, please add your comments below:

## APPENDIX C

## DEMOGRAPHIC QUESTIONNAIRE: ROUND 1

1. Gender:  
 Female  
 Transgender Male  
 Male  
 Transgender Female  
 These do not represent how I identify. I identify as: \_\_\_\_\_
  
2. Please indicate the category below that includes your age:  
 20-30  
 30-40  
 40-50  
 50-60  
 60-70  
 70-80  
 80-90+
  
3. Which of the following best describes your race/ethnicity?  
 Asian American / Pacific Islander  
 American Indian  
 African American / Black  
 Caucasian / White  
 Hispanic / Latino/a  
 Multiracial  
 Other (please specify) \_\_\_\_\_
  
4. Please indicate the number of years of teaching experience you have as a counselor educator?  
 6 months – 1yr  
 1-4  
 5-10  
 11-15  
 16-20  
 <20
  
5. Please indicate your current primary work role(s):  
 Counselor Educator

- Supervisor  
 Professional Counselor (actively counseling 2+ clients a week)  
 Counselor Administrator  
 Agency Director  
 Other, please specify: \_\_\_\_\_

6. Do you teach at a CACREP accredited counselor education program?  
 Yes  No  CACREP accreditation pending

7. Please specify your personal counseling track:
- Community Agency  
 Clinical Mental Health  
 School  
 College/Student Development  
 Couple and Family  
 Addition/Substance Abuse  
 Career  
 Other, please specify: \_\_\_\_\_

8. How many years of teaching experience do you have as a counselor educator in which you have included trauma-related content in your curriculum?  
 \_\_\_\_\_

9. List the course names of the classes you integrate trauma-related material in?  
 \_\_\_\_\_

10. Describe the diversity of the student population you teach?  
 \_\_\_\_\_

11. What is your area of specialization within trauma (i.e., addictions, sexual abuse, veterans, children, IPV, etc.)?  
 \_\_\_\_\_

12. How many years of experience do you have as a counselor working with trauma-exposed populations?  
 \_\_\_\_\_

13. In terms of trauma counseling, describe the population(s) you have the most experience working with (e.g., rural Latina females, individuals from lower SES backgrounds, teenagers who evidence self-harming behaviors, Asian male celebrities at an inpatient addictions treatment center, LGBTQ individuals, or Turkish immigrants).

If you have provided trauma counseling to primarily more than one population, please describe all the primary populations:

---

13 a. Describe the primary setting in which you have trauma counseling experience (i.e., urban, rural, etc.):

---

13 b. Please specify the primary type of trauma counseling you engaged in (i.e., face-to-face, online, hotline, etc.):

---

14. What dominant knowledge system(s) do you think impact trauma education?

---

15. Please describe your cultural norms, personal beliefs, identity, biases, and values that strongly inform or influence your approach to teaching about trauma:

---

16. Do any issues of power and privilege inform your curriculum design and teaching process? Please describe below:

---

17. As an educator, how do you address the diversity of the trauma population in your teaching?

---

18. In your opinion, are the professional norms, policies, and ideologies that guide our trauma education practice within the field of counselor education commensurate with the needs of our local communities and the current trauma exposure rates of the U.S. population?  
(Yes, No, Other and please explain why):

---

19. How many years of experience do you have as a supervisor, supervising counselors who are working with trauma-exposed populations?

---

20. What number of trainings or continuing education sessions you have attended in the last 5 years on the topic of trauma?

---

21. List any certifications or designations you hold related to trauma.

---

22. How many published peer-reviewed articles, books, and/or book chapters you have written related to the topic of trauma?

---

23. How many times have presented on trauma or trauma-related topics for at professional state, regional, or national conferences?

---

24. What professional counseling license(s) and/or certifications do you hold (e.g., LPC, NCC, CCTP, LCAS, LPCS)?

---

25. Do you believe counselor education programs should have a stand-alone course solely related to trauma?

---

26. If yes, assuming counselors-in-training will start their practicum and see clients their 1st year, in the 2nd semester, at what point in their pre-service training in a 2-year master's program should students take this trauma course?

---

27. Please provide your preferred email address you wish to be contacted at:

---

\*A unique identification code will be assigned and e-mailed to you to ensure the anonymity of your responses.

**APPENDIX D****RECRUITMENT EMAIL: PHASE 1**

Dear XXXX,

As part of my pilot study prior to enacting my Delphi study, I am inviting you to participate. I have selected counselor educators with expertise in trauma to review and provide feedback on my 1-page synopsis and the Delphi questionnaire that will be used for the main study.

Study Title: The Knowledge, Skills, Attitudes, and Teaching Practices that are Foundational to Prepare Counselors-in-Training to Provide Trauma-informed Counseling

IRB #: 17-0435

*\*This study seeks expert opinion and due to the level of risk, it has been deemed as IRB exempt.*

Please review the two 1-page documents attached. I am not asking you to complete the questions, but simply read them for clarity, comprehension, understanding and provide me with your feedback. Feedback may be provided via e-mail with your response, or if you prefer, by inserting comments on the actual Word documents.

Please keep the following questions in mind as you review and provide your feedback on these 2 forms that will be used for the main Delphi study:

1. Is the form clear? Are there any edits you would make to increase clarity?
2. Is the one-page synopsis helpful to provide context or do you find it leading?
3. Are the questions comprehensible?
4. Do you understand how to answer the questions or would an example of a response to the questions be helpful?
5. Are there any questions you would change, collapse, or add?
6. Please let me know any thoughts, suggestions, impressions, changes, or additions you would make to improve these forms for use in the main Delphi study.

The questions are purposefully open-ended and are informed by the literature and the construct of competency. The Delphi questionnaire is set up so that participants can brainstorm and insert their own thoughts and opinions. Let me know if you have any questions. You may respond directly back to my email address here at [lrland@uncg.edu](mailto:lrland@uncg.edu).

Thank you,

Laura R. Land

**APPENDIX E****RECRUITMENT EMAIL TO POTENTIAL PARTICIPANTS:  
PHASE 2, ROUND 1**

Dear Counselor Educator,

I would like to invite you to participate in a study I am conducting as part of my dissertation research at The University of North Carolina at Greensboro. This study is focused on developing consensus opinion about what knowledge, skills, and attitudes counselor educators with expertise in trauma deem as foundational to prepare counselors-in-training to provide trauma-informed counseling. You have been chosen for this study because you are currently serving or have served in a counselor educator role within the counseling profession, with clinical trauma expertise. It is my hope that your expertise can help inform the field of counselor education and the training of future counselor educators.

In this research, there is a potential to participate in 4 rounds of data collection over a period of 2 months. A detailed timeline will be e-mailed to you upon your consent to participate.

All data will be collected through online surveys and your responses will remain anonymous. The first round will solicit your opinions through open-ended questions to identify and describe competencies you deem as necessary for trauma education. The results from this questionnaire will be used to develop representative competency statements based on the data collected from all participants. This collective list of competencies will be utilized in the following three rounds.

The subsequent rounds will involve your ranking of each statement on a Likert scale from 1 to 7 based on your level of agreement. Opportunities for altering, adding, or providing personal reasoning for statements will be allowed in the second and third rounds. The initial round should take around 30 minutes and subsequent rounds should take around 15 minutes each. It is expected that the total time requirement for this study should be about 1.5 hours. The fourth and final round will relay the final items that reached consensus. No changes will be made on these items in the fourth round from Round 3; instead, you will be given this last opportunity to view yours and your colleagues' opinions and ratings to determine whether opinions changed. You will be given the opportunity to include your thoughts about the results surrounding areas of agreement, disagreement, what the results suggest, questions that remain, and take-aways.

Participants must meet the criteria below to be eligible to participate:

- (a) Have a history of teaching experience or are currently teaching trauma-related content in a CACREP accredited counselor education program.
- (b) Have extensive professional trauma counseling and/or trauma supervision experience.

If you would like to participate in this study, please click the link below. It will direct you to an online survey tool that includes the informed consent form, a demographic questionnaire, and the initial open-ended questionnaire. Within the questionnaire you will be asked to provide an e-mail so that I can contact you with information about each round with the responses from each round. If you agree to participate in the study, you will be

assigned an anonymous participant ID. At the conclusion of this study, your email and demographic data will be removed from the research data to protect your anonymity.

Thank you for considering participating in this research opportunity.

Sincerely,

Laura R. Land

**APPENDIX F****NOMINATION EMAIL TO POTENTIAL PARTICIPANTS: PHASE 2, ROUND 1**

Dear Counselor Educator,

I would like to invite you to nominate eligible peers for participation in a study focused on developing consensus opinion about what knowledge, skills, and attitudes are foundational to prepare counselors-in-training to provide trauma-informed counseling. I am conducting as part of my dissertation research at The University of North Carolina at Greensboro.

I am asking if you would be willing to nominate counselor education faculty members who you believe are experts about trauma in the counseling profession and meet the criteria of the study. *To nominate an individual, please forward this e-mail to them directly via email.* There is no limit on the number of individuals you can nominate for this study. Nominating an individual does not guarantee their eligibility to participate. The researcher will close the study for participation once the goal number of participants has been reached. Please do not post this email on a public website, social media, or listserv.

In this research, there is a potential to participate in 4 rounds of data collection. All data will be collected through online surveys and your responses will remain anonymous. An electronic questionnaire will be used to identify and describe competencies for trauma education in Round 1. The first round will solicit your opinions through open-ended questions to identify and describe competencies for trauma education. The results from this questionnaire will be used to develop representative

statements based on the data collected from all participants. This collective list of competencies will be utilized in the following three rounds of research.

The subsequent rounds will involve your ranking of each statement on a Likert scale from 1 to 7 based on your level of agreement. Opportunities for altering, adding, or providing personal reasoning for statements will be allowed in the second and third rounds. The initial round should take around 30 minutes and subsequent rounds should take around 15 minutes each. It is expected that the total time requirement for this study should be about 1.5 hours. The fourth and final round will relay the final items for the study. No changes will be made on these items in the fourth round from Round 3; instead, you will be given this last opportunity to view yours and your colleagues' opinions and ratings to determine whether opinions changed. You will be given the opportunity to include your thoughts about the results surrounding areas of agreement, disagreement, what the results suggest, questions that remain, and take-aways.

Participants must meet the criteria below to be eligible to participate:

- (a) Have a history of teaching experience or are currently teaching trauma-related content in a CACREP accredited counselor education program.
- (b) Have extensive professional trauma counseling and/or trauma supervision experience.

If you would like to participate in this study, please click the link below. It will direct you to an online survey tool that includes the informed consent form, a demographic questionnaire, and the initial open-ended questionnaire. Within the questionnaire you will be asked to provide an e-mail so that I can contact you with information about each round with the responses from each round. If you agree to

participate in this study, you will be assigned an anonymous participant ID. At the conclusion of the study, your email and demographic data will be removed from the research data to protect your anonymity. Thank you for considering participating in this research opportunity.

Sincerely,

Laura R. Land

**APPENDIX G**  
**CONSENT FORM**

UNIVERSITY OF NORTH CAROLINA AT GREENSBORO CONSENT TO ACT AS A  
HUMAN PARTICIPANT

Project Title: The Knowledge, Skills, and Attitudes that are Foundational Prepare  
Counselors-in-Training to Provide Trauma-Informed Counseling

Project Director: Laura R. Land

This dissertation study is approved by the UNCG IRB, as well as my dissertation co-  
chairs Dr. J. Scott Young and Dr. Carrie A. Wachter Morris

Participant's Name: \_\_\_\_\_

**What is the study about?**

You are being asked to participate in a research study. The purpose of this study is to learn about the knowledge, skills, attitudes, and teaching practices that are that are essential for trauma education in counseling to prepare master's counseling students to an entry-level of competence for trauma work.

**Why are you asking me?**

You have either been selected as a counselor educator professional with expertise in trauma or nominated as a counselor educator with expertise in trauma by one of your peers.

**What will you ask me to do if I agree to be in the study?**

You will be asked to participate in responding to 4 rounds of questionnaires across 9 weeks (1 questionnaire for every 2 weeks), the first taking approximately 30 minutes and the rounds two, three, and four taking approximately 15 minutes each (Total of 1 hour and 15 minutes). This would require you spending approximately 1½ hours total to complete all questionnaires in the 9-week timeframe. All questionnaires will be sent to you via email and will be able to be completed online. All answers are completely anonymous. The last round is only for the review and discussion of the results.

**What are the dangers to me?**

The risks involved in this study include the potential that confidentiality is not guaranteed since information is being gathered through an online questionnaire format that must contain an identifying email so that the participants responses after each round can be reported back to the participant. In order to maintain confidentiality for the data gathered through the questionnaires, they will be labeled with this email. These email addresses will be removed from the data set and erased from the temporary account within 30 days of the final presentation of the research.

**Are there any benefits to me for taking part in this research study?**

There are no direct benefits to you by participating in this study. However, you will have the opportunity to reflect on the knowledge, skills, attitudes, and teaching practices that are essential for trauma education in the profession of counseling. This could potentially prompt you to improve on your own teaching skills or to attempt to further implement core competencies in trauma training into your core course curriculum. After completion of all four rounds, you will be entered into a raffle for one of 2 \$50 gift certificates.

**Are there any benefits to society as a result of me taking part in this research?**

Increasing the understanding of the knowledge, skills, attitudes, and practices that are essential for trauma education in counseling could help inform the development and training of master's level counselors. Preparing counselors more effectively for future competent trauma work could result in better services for clients and an overall improvement in mental health services provided by counselors. Also, your contribution to the field of counselor education will aid other educators in their training efforts and curriculum design.

**Will I get paid for being in the study? Will it cost me anything?**

There are no costs to you or payments made for participating in this study.

**How will you keep my information confidential?**

Your privacy will be protected by keeping all questionnaires in the online format as well as being assigned an anonymous unique identifier code. The questionnaire results will be converted into an excel data file after each of the rounds in order to report back the results in the following questionnaire. The data for the final round will contain no identifying information. All of the data files will be saved on the researcher's computer. The computer and the data file will be password protected. Within 30 days of the final research presentation all identifying e-mail addresses will be erased from the Qualtrics temporary account. All information obtained in this study is strictly confidential unless disclosure is required by law.

**What if I want to leave the study?**

You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of your data, which has been collected be destroyed unless it is in a de-identifiable state.

**What about new information/changes in the study?**

If significant new information relating to the study becomes available which may relate to your willingness to continue to participate, this information will be provided to you.

**Voluntary Consent by Participant:**

By completing the demographic questionnaire, you are agreeing that you read and fully understand the contents of this document and are openly willing consent to take part in this study. All of your questions concerning this study have been answered. By

completing this questionnaire, you are agreeing that you are 18 years of age or older and are agreeing to participate, or have the individual specified above as a participant participate, in this study described to you.

**APPENDIX H****RECRUITMENT EMAIL: PHASE 2, ROUND 2**

Dear XXXX,

Thank you for your participation in Round 1 of my research. This email is to invite you to participate in Round 2, the details for which are explained in the last paragraph of this email. Directions to participate in this round are below:

Attached you will find the answers you provided for the questionnaire in Round 1.

Open the Round 2 questionnaire by clicking the link below:

[https://uncg.qualtrics.com/SE/?SID=SV\\_9mM5ogvCZusDY7G](https://uncg.qualtrics.com/SE/?SID=SV_9mM5ogvCZusDY7G)

Open the attachment and the questionnaire.

Within the next questionnaire you will find the median (the middle value of an ordered set of values) and the Interquartile Range (IQR = a measure of statistical dispersion, being equal to the difference between the third and first quartiles) for each of the items for which consensus (consensus = an IQR of 1 or less) reached during this round.

Rate the necessity of the items on the Round 2 questionnaire by indicating your level of agreement.

If you choose to add or comment on any statement, space is provided for you to give a rationale for your opinion.

Submit the questionnaire.

The questionnaire should take you no longer than 15 minutes.

If you would like to participate, please open the following link

[https://uncg.qualtrics.com/SE/?SID=SV\\_9mM5ogvCZusDY7G](https://uncg.qualtrics.com/SE/?SID=SV_9mM5ogvCZusDY7G)

As a reminder, in this research, there is a potential to participate in 3 rounds of data collection with round 4 being the final round to review and discuss the results. These

four rounds involve answering questionnaires at four separate time points via an online survey tool. These questionnaires will be utilized to reach a consensus about what knowledge, skills, attitudes, and teaching practices are necessary for trauma education.

Opportunities for open-ended responses of personal reasoning will be provided in this round and the third round so that participants will have the opportunity to explain their answers. This questionnaire should take you no longer than 15 minutes.

Taking the survey will indicate that you are willing to continue to participate in the study. Within the questionnaire you will be asked to provide an email so that I may email with information about each subsequent round and provide you with your responses from the previous round. At the conclusion of the study, your email and demographic data will be removed from all research data.

Thank you for your participation.

Laura R. Land  
The University of North Carolina at Greensboro  
[lrland@uncg.edu](mailto:lrland@uncg.edu)

\*This dissertation study is approved by the UNCG IRB, as well as my dissertation co-chairs Dr. J. Scott Young and Dr. Carrie A. Wachter Morris

**APPENDIX I****STUDY QUESTIONNAIRE: ROUND 2**

The Knowledge, Skills, and Attitudes that are Foundational to Prepare Counselors-in-  
Training to Provide Trauma-Informed Counseling

Thank you for participation in Round 1! You have the opportunity to participate in 3 more rounds. This study is focused on developing consensus opinion about what knowledge, skills, and attitudes counselor educators with expertise in trauma deem as foundational to prepare counselors-in-training to provide trauma-informed counseling. You have been chosen for this study because you are currently serving or have served in a counselor educator role within the counseling profession, with clinical trauma expertise. It is my hope that your expertise can help inform the field of counselor education and the training of future counselor educators.

In this research, there is a potential to participate in a total of 4 rounds of data collection over a period of 2 months. Next to each item in this section the median and IQR based on the results of Round 1 which are provided to indicate the average of the expert groups' ratings of each item.

Completing the survey and choosing "I agree" below indicate that you have read the informed consent attached to your email and agree to continue to participate in this study.

- I Agree

**Section 1:**

1. To which gender identity do you most identify?
  - Female
  - Transgender Female
  - Male
  - Transgender Male
  - Other \_\_\_\_\_
  
2. Please indicate the category below that includes your age:
  - 20-30
  - 30-40
  - 40-50
  - 50-60
  - 60-70
  - 70-80
  - 80-90+
  
3. Which of the following best describes your race/ethnicity?
  - Asian American / Pacific Islander
  - American Indian
  - African American / Black
  - Caucasian / White
  - Hispanic / Latino/a
  - Multiracial
  - Other (please specify) \_\_\_\_\_
  
4. Please indicate the number of years you have worked as a teacher within counselor education?
  - 6months – 1yr
  - 1-4
  - 5-10
  - 11-15
  - 16-20
  - <20
  
5. Please indicate your current primary work role(s):
  - Counselor Educator
  - Supervisor
  - Professional Counselor (actively counseling 2+ clients a week)
  - Counselor Administrator
  - Agency Director
  - Other, please specify: \_\_\_\_\_

6. Do you teach at a CACREP accredited counselor education program?  
 Yes  No  CACREP accreditation pending
7. Please specify your personal counseling track:  
 Community Agency  
 Clinical Mental Health  
 School  
 College/Student Development  
 Couple and Family  
 Addition/Substance Abuse  
 Career  
 Other, please specify: \_\_\_\_\_
8. Please provide your preferred email address so that the researcher may email you with the results from this round of data gathering, your responses to this round, and an invite to participate in the next round of study. What e-mail address may I use to contact you throughout this study?  
 \_\_\_\_\_

## Section 2:

Please indicate on a scale of 1 (Strongly Disagree) to 7 (Strongly Agree), how necessary you believe each item is for trauma education.

Results of Round 1 are provided with each item. Median and IQR are shown. Should you choose a rating that is different from the median, please provide your reasoning in the text box below the rating number provided.

**APPENDIX J****RECRUITMENT EMAIL: ROUND 3**

Dear XXXX,

Thank you for your participation in Round 2 of my research. This email is to invite you to participate in Round 3, the details for which are explained in the last paragraph of this email. Directions to participate in this round are below.

Attached you will find the answers and comments provided from the questionnaire in Round 2.

Open the link to Round 3 questionnaire by clicking on the link below:

[https://uncg.qualtrics.com/SE/?SID=SV\\_9mM5ogvCZusDY7G](https://uncg.qualtrics.com/SE/?SID=SV_9mM5ogvCZusDY7G)

Open the attachment and the questionnaire.

Within the questionnaire you will find the median (the middle value of an ordered set of values) and the Interquartile Range (IQR = a measure of statistical dispersion, being equal to the difference between the third and first quartiles) for each of the items for which consensus (consensus = an IQR of 1 or less) was not reached during Round 1.

Re-rate the necessity of the items on the Round 3 questionnaire.

If you choose to rate the items' differently than the median, space is provided for you to give justification for your opinion. You may also add or edit any comment you wish.

Submit the questionnaire.

The questionnaire should take you no longer than 15 minutes.

If you would like to participate, please open the following link below:

[https://uncg.qualtrics.com/SE/?SID=SV\\_9mM5ogvCZusDY7G](https://uncg.qualtrics.com/SE/?SID=SV_9mM5ogvCZusDY7G)

As a reminder, in this research, there is a potential to participate in 3 rounds of data collection with round 4 being the final round to review and discuss the results. These four rounds involve answering questionnaires at four separate time points via an online survey tool. These questionnaires will be utilized to reach a consensus about what knowledge, skills, attitudes, and teaching practices are necessary for trauma education. Opportunities for open-ended responses of personal reasoning will be provided in this and the third round so that participants will have the opportunity to explain their answers. This questionnaire should take you no longer than 15 minutes.

Taking the survey will indicate that you are willing to continue to participate in the study. Within the questionnaire you will be asked to provide an email so that I may email with information about each subsequent round and provide you with your responses from the previous round. At the conclusion of the study your email and demographic data will be removed from all research data.

Thank you for your participation.

Laura R. Land  
The University of North Carolina at Greensboro  
[lrland@uncg.edu](mailto:lrland@uncg.edu)

\*This dissertation study is approved by the UNCG IRB, as well as my dissertation co-chairs Dr. J. Scott Young and Dr. Carrie A. Wachter Morris

## APPENDIX K

### STUDY QUESTIONNAIRE: PHASE 2, ROUND 3

#### The Knowledge, Skills, and Attitudes that are Foundational for to Prepare Counselors-in-Training to Provide Trauma-Informed Counseling

This study is focused on developing consensus opinion about what knowledge, skills, and attitudes counselor educators with expertise in trauma deem as foundational to prepare counselors-in-training to provide trauma-informed counseling. You have been chosen for this study because you are currently serving or have served in a counselor educator role within the counseling profession, with clinical trauma expertise. It is my hope that your expertise can help inform the field of counselor education and the training of future counselor educators.

In this research, there is a potential to participate in 4 rounds of data collection over a period of 2 months. Your responses are strictly confidential. The first section will ask you to provide some of your personal demographics. The following section will address knowledge, skills, practices, and attitudes that may be necessary for trauma training and education in counselor education. Next to each item in this section the median and IQR based on the results of Round 2 are provided to indicate the average of the expert groups' ratings of each item. Please rate each item and you may add comments or provide a rationale for your rating if it differs from the median score. Completing the survey and choosing "I agree" below indicate that you have read the informed consent attached to your email and agree to continue to participate in this study.

- I Agree

#### **Section 1:**

1. To which gender identity do you most identify?
  - Female
  - Transgender Female
  - Male
  - Transgender Male
  - Other \_\_\_\_\_
  
2. Please indicate the category below that includes your age:
  - 20-30
  - 30-40
  - 40-50
  - 50-60

- 60-70  
 70-80  
 80-90+

3. Which of the following best describes your race/ethnicity?

- Asian American / Pacific Islander  
 American Indian  
 African American / Black  
 Caucasian / White  
 Hispanic / Latino/a  
 Multiracial  
 Other (please specify) \_\_\_\_\_

4. Please indicate the number of years you have worked as a teacher within counselor education?

- 6months – 1yr  
 1-4  
 5-10  
 11-15  
 16-20  
 <20

5. Please indicate your current primary work role(s):

- Counselor Educator  
 Supervisor  
 Professional Counselor (actively counseling 2+ clients a week)  
 Counselor Administrator  
 Agency Director  
 Other, please specify: \_\_\_\_\_

6. Do you teach at a CACREP accredited counselor education program?

- Yes  No  CACREP accreditation pending

7. Please specify your personal counseling track:

- Community Agency  
 Clinical Mental Health  
 School  
 College/Student Development  
 Couple and Family  
 Addition/Substance Abuse  
 Career

\_\_\_\_ Other, please specify: \_\_\_\_\_

8. Please provide your preferred email address so that the researcher may email you with the results from this round of data gathering, your responses to this round, and an invite to participate in the next round of study. What e-mail address may I use to contact you throughout this study?
- 

**Section 2:**

Please indicate on a scale of 1 (Strongly Disagree) to 7 (Strongly Agree), how necessary you believe each item is for trauma education.

Results of Round 2 are provided with each item. Median and IQR are shown. Should you choose a rating that is different from the median, please provide your reasoning in the text box below the rating number provided.

## APPENDIX L

### COMMENTS: PHASE 2, ROUND 2

#### ITEMS THAT DID NOT REACH CONSENSUS & PANELISTS' COMMENTS

- *Comments made by panelists to the items are bulleted.*

**The purpose of this document is to provide you with a list of other panelists' comments, so you may review the questions on the Qualtrics survey and read these responses to inform your justification/rating one way or another. You may decide you strongly disagree the item is foundational, or you may strongly agree and provide a rationale. Also, you can offer any other wording or edits that may make the comment viable in terms of a necessary component for trauma training.**

#### RESEARCH KNOWLEDGE

1. **Question 19.** Trauma is often at the core and symptoms are a way that clients are trying to control the effects/impact of their trauma  
Median = 6, IQR = 2
  - “control” applies at times, often symptoms are not related to client control
  - Symptoms are reactions to events in the life of a client. Symptoms are clues to the nature of the events they have experienced. The more clever we are at determining the antecedent events that lead to the symptoms, then the more likely it is that we will be able to track down the problem events and help the client overcome them.
  - this feels theoretically-grounded—may not apply to all frames. For beginning counselors, may be more important to have working understanding and awareness of some general theoretical frames.
  - I would not say that the symptoms are a volitional way of controlling the effects of the trauma. At times they are often very adaptive to the situation (as in trying to keep the person safe) but it is not that the individual is attempting to control the hypervigilance if that makes sense. But again, this is just my perspective and I am not sure how the author intended this.
2. **Question 23.** Know how to differentiate the reactions and needs of a client immediately following a traumatic event, and in long-term trauma-specific care.

Median = 6, IQR = 1.75

- This may be two items—understanding needs immediately following exposure to a traumatic event AND understanding needs in long-term trauma-specific care.
  - I agree with this statement, but think it needs to be expanded. There is not just the immediate aftermath and long-term care. Also, not all individuals will have the same reactions/needs immediately following or long-term. The author may not have intended it that way though. This statement to me gets into the different between distinguishing a crisis versus trauma versus posttraumatic stress, and I think it is important to speak about it from that perspective.
3. **Question 26.** Trauma is especially shaped by racial-ethnic perceptions and responses to violence.

Median = 6, IQR = 2

- cultural impact on trauma, coping and post trauma, including ego strength, is very under rated in counselor preparation and the literature now
- I think it is important to not place value over one part of the trauma puzzle over another
- Perhaps understand ways in which culture and identity influence exposure and response to trauma.
- I might take out the word “especially”. I absolutely agree with the statement that trauma is shaped by racial-ethnic perceptions and responses to violence. And, trauma can also be shaped by other contexts as well, so I don’t know that I understand the word ‘especially’ in that statement.
- I agree, I would also like to add that I think that as practitioners sometimes we underestimate how much violence can impact and traumatize populations who live in dangerous communities, and it is important to process events like that rather assume that because of ethnicity or race, the kind of impact that something may have.
- I am wondering if the author is referring to the actual traumatic event (whether something is or is not experienced as a trauma) or posttraumatic stress responses are shaped by racial-ethnic perceptions and responses to violence. I absolutely agree that both can be impacted by racial-ethnic perceptions. I also agree that they can be influenced by the perceptions of different sexes, genders, and sexual orientations. I think counselors always have to take into account the experiences of historically marginalized populations in terms of what may or may not be experienced as a trauma and/or how one may respond to a trauma. When historical (intergenerational) trauma is present, it can most definitely change such perceptions of and responses to traumas. Perhaps the concept of historical trauma/oppression as trauma/etc. (as a whole) should be included in knowledge.

4. **Question 32.** CBT is important, but only 1 dimension of efficacious care.

Median = 6, IQR = 2.5

- CBT is over rated as far effective, especially immediate trauma care
- CBT is a very effective tool to use in helping people deal with trauma.
- There isn't a one-size fits all approach to any trauma therapy
- Agree that it is one dimension. So, I think we need to look at what we want students to know. Perhaps something like "models and methods of trauma-informed care" or "models and methods of trauma-specific care"

5. **Question 33.** Acknowledge the competencies published by Social Work Education and APA Division 56 of the American Psychological Association that are organized around core competencies for different levels of expertise and they may serve as best practices (Cook, Newman, et al., 2012)

Median = 6, IQR = 2.5

- These bodies of work would be helpful in gaining information other mental health professionals view as essential skills and knowledge sets to instill in others.
- If they are relevant and up to date with the research and trends in trauma-informed care
- To some degree, but these competencies are specific to professional psychologists and psychiatrists correct? In that case, counselors-in-training should be learning about core competencies relevant to our profession.
- I would be in support of a competency that notes understanding interdisciplinary approaches to trauma care.
- Although I agree that it is important to know what other fields are doing, I think it is even more important that counseling begin to develop its own.

### **SUPERVISION KNOWLEDGE**

6. **Question 34.** Audio tape sessions for supervision of the counseling session with client permission.

Median = 6, IQR = 1.5

- I don't know about this for trauma focused care. It may be that after the sessions are ongoing and a relationship is established that the client would not find the process as intrusive. Timing would be important. Audiotaping is, however, far less intrusive than video-taping.
- This is a general strategy for supervision and not specific to trauma.

- I am not sure this fits in knowledge and is always important. To me, video recording and/or live supervision can be considerably more helpful for supervision (again, because we often underestimate how much information nonverbals provide, especially for this population)

### **KNOWLEDGE OF RETRAUMATIZATION**

7. **Question 38.** Know the appropriateness of gathering content from a client versus processing trauma prematurely.

Median = 6, IQR = 1.75

- not sure what is meant by “content”? Following client’s lead and not pushing them to disclose details of trauma or “tell their story”
- I believe this needs to be more general for this audience. Understand appropriate strategies for assessing trauma.
- AND - I would also add being able to distinguish those two - for example being able to distinguish trauma assessment v trauma processing and being vigilant around the timing/appropriateness of both.

### **KNOWLEDGE OF RESOURCES & REFERRAL**

8. **Question 46.** It is necessary to provide resource building for a client before any trauma work is to be initiated.

Median = 6, IQR = 1.75

- Begin where the client is. Begin the process of establishing rapport and find out what the client needs and then you can develop the list of resources for helping the client.
- Depends on the client and their circumstances
- Sounds like this links to a bigger understanding regarding general phases of trauma work.

### **KNOWLEDGE OF RESILIENCE & POST-TRAUMATIC GROWTH**

9. **Question 48.** Acknowledge the strength and resiliency in the client’s coping skills even if you disagree with how they are coping - remember they are trying to move forward with life.

Median = 6, IQR = 1.75

- guided by safety, safe space, and need avoidance of re-traumatization

- It would be inappropriate to encourage drug abuse or inappropriate relationships as coping mechanisms since they are destructive.
- sounds like this fits with broader competency of normalizing trauma responses and/or conceptualizing trauma responses within a strength-based lens
- I agree with this and I think it's important to be aware of and collaboratively discuss (and educate if needed) maladaptive responses with clients that have the potential to re-traumatize or harm the client. I think it's important for counselors in training to be able to identify what is a coping skill as opposed to a numbing mechanism for clients.
- I think this is absolutely important. I would only add that if the coping skills are maladaptive in some manner (i.e., substance abuse) that yes, you acknowledge the strength of the client in coping the most effective manner they know how AND you would work with the client to find more adaptive means of coping (which may be part of the process as a whole - so it may take a while).

#### **ASSESSMENT KNOWLEDGE**

10. **Question 52.** PTSD assessment and treatment may be helpful as a paradigm to use.

Median = 6, IQR = 1.75

- PTSD as a condition is complex and provides a model of the trauma and reaction process.
- This would fit within a general assessment item. Or perhaps, understand similarities and differences between trauma and PTSD.
- This may be helpful, and I think it's important for counselors to understand that PTSD is not the only response to trauma.

#### **ASSESSMENT: ABILITIES, SKILLS & APPROACH TO BE ABLE TO PERFORM**

11. **Question 61.** Let the client's narrative lay the foundation and organization of trauma assessment.

Median = 6, IQR = 2

- This is how you understand the client and know how to respond to them.
- This may be theory-specific. Not sure of "foundation and organization" wording for master's level students.
- You may be assessing/need to assess for the trauma exposure long before you have the trauma narrative

12. **Question 64.** Approach clients as if they may have history of trauma, since 8 out of 10 clients will probably have experienced trauma.

Median = 5, IQR = 3.5

- It is necessary to be especially sensitive to victims of trauma and not presume to be able to push this is delicate and dependent on the situation, therapeutic relationship, and emotional stability/resourcing capabilities of client then for too much information too soon.
- This is a philosophical statement and not a competency or skills statement. Agree that most clients have experienced trauma, but this doesn't help further dialogue.

### **KNOWLEDGE OF INTERVENTION, TREATMENT, OR APPROACH**

13. **Question 68.** culture, systems, context, empowerment (voice and choice)

Median = 6, IQR = 2

- Not sure what the skill set is here- not very clear
- these concepts are important, but this is not a skills item.

14. **Question 70.** distinctives of trauma interventions (trauma specific or trauma-sensitive counseling approaches and interventions (e.g., TF-CBT) as opposed to regular traditional interventions, or crisis interventions.

Median = 6, IQR = 2.75

- Depends.
- worried this may fall into the "one size fits most" approach. Some clients may respond very well to more traditional interventions, or may need crisis intervention depending on their emotional stability and internal resource capabilities
- this is not a skills item. Skills items would name the types of trauma-specific or trauma-sensitive approaches. Does not need to be either-or as many in crisis also have a trauma history.

15. **Question 72.** policy and social justice issues associated with trauma work.

Median = 5.5, IQR = 2

- This is not a skill
- if it is of importance/focus of the client

- Agree conceptually, but not a skills item. Belongs in knowledge (and needs to be made active)
- I would put this in knowledge rather than skills as well. Have knowledge of them and then know what to do with that. And I would not say that all counselors NEEDED to have these skills but do need to have the knowledge.

16. **Question 74.** adapt core counseling theories to suit the needs of a trauma victim.

Median = 6, IQR = 1.75

- worried this may fall into the “one size fits most” approach.
- Agree conceptually, but not a skills item. Belongs in knowledge (and needs to be made active). Attend to language.

17. **Question 76.** wellness model

Median = 6, IQR = 1.75

- What is the skill?
- understanding that this may or may not be the most clinically appropriate approach for all clients. Not fall into the “one size fits most”
- Agree conceptually, but not a skills item. Belongs in knowledge (and needs to be made active)

18. **Question 78.** Motivational Interviewing

Median = 6, IQR = 2.75

- Yes - this is a skill. Some of your other items are not.
- have a broad knowledge and understanding of traditional, researched, and more experiential therapy approaches. Know as the clinician what your specialty is and when to refer out if those specialties are not best practice for the client
- Agree conceptually, but not a skills item and not specific to trauma work.
- I guess see this more in knowledge section. I think it’s important to understand motivational interviewing, however, I don’t think it’s essential for counselors in training to have the skills to fully implement this approach necessarily.

### **SKILLS OF COLLABORATION**

19. **Question 80.** Collaborate with the client to choose which treatment option is best for trauma processing (i.e., CPT, TF-CBT, EMDR) and mutually develop skills and strategies to address trauma responses.

Median = 7, IQR = 1.75

- The client knows themselves better than anyone.
  - and that one approach/treatment option may not be sufficient. Perhaps a combination.
  - Agree, and item needs to be divided into different areas. Collaborate with client to develop treatment plan (which is a general item and not specific to trauma) and mutually development of skills/strategies.
20. **Question 81.** Let the client define what is traumatic, lead you into the trauma processing, and dictate the speed work.

Median = 6, IQR = 2

- If the client has only avoided processing the trauma they may continue to avoid and distract in session because it is easier for them. At times it maybe more beneficial to make sure they know how to ground and be willing to challenge/guide them more firmly.
  - Depends on the client and the circumstances
  - This reads as clinical wisdom and not so much as a competency. Seems like this is more generally about customizing pacing and approach to client need.
21. **Question 82.** Do not collude with learned helplessness/hopelessness while not giving up on clients

Median = 6, IQR = 1.75

- collude is a strong word. Being aware of the “stuck” and having an open dialogue about it when clinically appropriate
  - This is theoretically grounded. Also, not a specific clinical skill even if it is wisdom.
22. **Question 83.** Collaboration with family and peer support systems.

Median = 5.5, IQR = 2

- if they are a positive source of support
- This is a general counseling skill. Not sure it needs to be specific to trauma.
- Family only for personal support and self-care

## PROFESSIONAL CHARACTERISTICS

23. **Question 97.** Recognize the limits to one's own empathy and being able to pull back in empathy a bit when needed.

Median = 6, IQR = 2.75

- I think the more appropriate term is compassion. So we are aware of our own experiences that produce empathy, but their experience does not become our experience as we are working with them
- This is a general counseling approach/attribute. It is not specific to trauma.
- I'm not sure if I fully understand this. Could there be more detail around what this might mean?

24. **Question 98.** Optimistic

Median = 6, IQR = 1.75

- optimism is contagious.
- This is a general counseling approach/attribute. It is **not specific to trauma**.
- I think more so of an open mind because you don't want the CIT to make promises like "It's all going to be ok" and things of that nature and the client hang on to those promises and hold the clinician accountable for how their situation turns out. I hope that makes sense.

25. **Question 100.** Persistent and possess initiative

Median = 6, IQR = 1.75

- Sometimes it is appropriate to react to horrible events
- Sometimes the therapist showing emotion (regulated emotion) is a helpful learning tool to model for client. Or to help them see they can have a conflict or tension with someone, and talk through it
- This is a general counseling approach/attribute. It is not specific to trauma.
- Although there are times when other responses can be beneficial

26. **Question 102.** Relentless pursuit of resilience.

Median = 6, IQR = 2.5

- relentless is too strong of a word to use with beginning counselors
- Relentless is too absolute of a term.
- This is a general counseling approach/attribute. It is not specific to trauma.

- Again, I might just add while be sensitive to the client and where they are at.
- again, without pushing the client

27. **Question 105.** objective and consistent

Median = 6, IQR =1

- This is a general counseling approach/attribute. It is not specific to trauma.

**SKILLS: TRAINING/TECHNIQUES TO APPLY & DEMONSTRATE**

28. **Question 116.** Desensitization techniques

Median = 5, IQR = 1.75

- Again, language is so important. Promoting self-regulation and modulation
- Agree conceptually, but not currently presented as a skill
- Not sure how this is intended out of context.

29. **Question 117.** EMDR Exposure therapies such as Prolonged exposure, Cognitive Processing therapy, Mindfulness based therapies such as ACT, Skills Training for Affective and Interpersonal Regulation/Narrative Story Telling, Brain-spotting, Somatic integration

Median = 5.5, IQR = 1.75

- especially for post trauma work
- I'm not sure if CIT need to learn EMDR while in training as they are just learning the basic skills. EMDR may be something to learn once they are out in the field.
- Too much
- A well-rounded knowledge to make clinically informed interventions. And not limited to these mentioned.
- Agree conceptually, but not currently presented as a skill
- I think these are important knowledge pieces to have, but I don't know that it is essential that Counselors in training need to be skilled at all of these different types of therapies.
- Or at least a subset of these. This is a LOT for an entry level counselor to know. Even experts typically only have training in a few of these interventions - knowledge of all yes, but ability to ethically carry out - no.

30. **Question118.** Understand basic medical first aid

Median = 5, IQR = 1.5

- such a simple but potentially life-saving skill set for all helpers
- I'm not sure this is within role/training as professional counselor—and, if it is, it's more setting than topic specific.
- I am not sure of the context here. Are they talking about crisis work?

31. **Question 119.** Psychological first aid

Median = 5, IQR = 1

- Not currently written as skill
- This is a crisis intervention and not necessarily a trauma intervention.

32. **Question 120.** Reality testing

Median = 4, IQR = 3

- Present moment awareness—if you are working with dissociative or DID clients, that may be their reality
- Not currently written as skill
- In what context? Assessing dissociation or psychosis? Or simply in terms of safety assessments?

33. **Question 121.** Unique utilization of core counseling skills as appropriate when related to the precipitating event (e.g., excessive eye contact with an individual diagnosed with schizophrenia during a psychological decompensation may elicit paranoia).

Median = 6, IQR = 1.75

- Not sure how this is specific to trauma uniquely. Also, incredibly specific.

34. **Question 122.** Have the ability to implement phasic treatment

Median = 4.5, IQR = 2

- if that is what is clinically appropriate
- Not operationalized. Seems to be specific to one model or perspective.
- I think it's important to have knowledge of this, and I also recognize this is one approach of many.
- This was included in another response and that one seemed to capture it a bit better in terms of what phasic treatment is.

35. **Question 124.** Be able to employ specific strategies, trauma interventions, and trauma treatment to help clients work through traumatic experiences

Median = 6, IQR = 2.5

- but not be limited to just trauma specific
- This is fine, but it's general. It's what the entire competency set/exercise is about.
- I believe it would be beneficial to break this one up and define what the strategies, interventions, and treatments are.

#### **SAFETY—SKILLS TO ESTABLISH AND MAINTAIN SAFETY**

36. **Question 131.** Be able to build rapport in a compromised environment immediately following a crisis

Median = 6.5, IQR = 1.75

- maintain rapport
- Rapport is general skill. Not sure how immediate crisis relates to trauma work.

#### **VALIDATION SKILLS**

37. **Question 135.** CIT's should be able to use validation skills (validate the trauma, worth of the client, and difficulty of discussing history) and confirm that there is a way through and that they (the counselor) know the way through, and that they (the counselor) are willing to walk with the client through to conclusion of treatment.

Median = 5, IQR = 3.5

- They may not be the one providing all of the treatment for those of us working with adolescent and young adults - they will see other counselors through their journey
- Don't like the language that the counselor knows the way. We don't always. And it can create a hierarchy...the counselor knows all of the answers
- “. . . that they (the counselor) know the way through . . .” if only!
- Agree conceptually, but this is a general counseling skill. It's not specific to trauma.

- I would also add that it's important that the counselor makes this a collaborative process. I'm not sure I completely agree with the statement that "the counselor knows the way through". I do agree the counselor needs to validate and affirm there is a way through and give the client confidence that the counselor can help them walk through it. But I think the key is also to add that it's a collaborative process and each individual client is unique with different needs that the counselor will seek to better understand.
- It may just be personal preference, but I am not sure I would bill myself as the "expert" in terms of "I know the way through". I may think of it more from the perspective of "I can work with you to find the best way through."

**APPENDIX M****RECRUITMENT EMAIL: ROUND 4**

Dear XXXX,

Thank you for your participation in Round 3 of my research. This email is to invite you to participate in the final Round 4, the details for which are explained in the last paragraph of this email. Directions to participate in this final round are below.

Attached you will find the final answers you and your colleagues provided for the questionnaire in Round 3. No changes or edits were made to these items from Round 3. This final round is the last opportunity to review one another's opinions and ratings and determine whether opinions changed and provide any comments regarding your interpretation of the results, and any questions you are left with.

**Step 1: Review Panelists Responses**

Open the following password protected link below:

[https://drive.google.com/open?id=1WlknFhFKuVfBtnVPEoBhXO\\_wNG2m-QcP4LuV8uxavbw](https://drive.google.com/open?id=1WlknFhFKuVfBtnVPEoBhXO_wNG2m-QcP4LuV8uxavbw)

Round 4 gives you and your colleagues the opportunity to review and comment on the results.

Please open the document with the password provided: \_\_\_\_\_

**Step 2: Complete Demographic Questionnaire**

Open the link below to complete the demographic questionnaire and the final Round 4 questionnaire consisting of 3 open-response questions.

[https://uncg.qualtrics.com/SE/?SID=SV\\_9mM5ogvCZusDY7G](https://uncg.qualtrics.com/SE/?SID=SV_9mM5ogvCZusDY7G)

Taking the survey will indicate that you are willing to continue to participate in the study.

At the conclusion of the study, your email and demographic data will be removed from all data.

Thank you for your participation!

Laura R. Land

The University of North Carolina at Greensboro, [lrland@uncg.edu](mailto:lrland@uncg.edu)

*\*This dissertation study is approved by the UNCG IRB, as well as my dissertation co-chairs Dr. J. Scott Young and Dr. Carrie A. Wachter Morris*

## APPENDIX N

### STUDY QUESTIONNAIRE: ROUND FOUR

*After reviewing the attached list of foundational trauma training components that the panelists of this study deemed 119 items as foundational for entry-level counseling students' trauma education. Please open the Qualtrics link and complete the final Round 4 questionnaire.*

Next to each item in this section the median and IQR based on the results of Round 3 that are provided to indicate the average of the expert groups' ratings of each item.

Completing the survey and choosing "I agree" below indicate that you have read the informed consent attached to your email and agree to continue to participate in this study.

- I Agree

#### **Section 1:**

1. To which gender identity do you most identify?

Female  
 Transgender Female  
 Male  
 Transgender Male  
 Other \_\_\_\_\_

2. Please indicate the category below that includes your age:

20-30  
 30-40  
 40-50  
 50-60  
 60-70  
 70+

3. Which of the following best describes your race/ethnicity?

Asian American / Pacific Islander  
 American Indian  
 African American / Black  
 Caucasian / White  
 Hispanic / Latino/a  
 Multiracial  
 Other (please specify) \_\_\_\_\_

4. Please indicate the number of years you have worked as a teacher within counselor education?

- \_\_\_\_\_ 6months – 1yr
- \_\_\_\_\_ 1-4
- \_\_\_\_\_ 5-10
- \_\_\_\_\_ 11-15
- \_\_\_\_\_ 16-20
- \_\_\_\_\_ <20

**Section 2:**

Please answer the following three open-response questions to complete this study.

1. What is your interpretations of the results?
2. What questions, if any, are you left with?
3. Please include any additional comments or thoughts below.

## APPENDIX O

### COMMENTS: ROUND 3

#### ITEMS THAT DID NOT REACH CONSENSUS & PANELISTS' COMMENTS

- *Comments made by panelists to the items are bulleted*

**The purpose of this document is to provide you with other panelists' comments so that you may review these along with the final list of 119 items that reached consensus, and then answer the three open-response questions on the Qualtrics survey to complete this final round.**

**Question 23.** Know how to differentiate the reactions and needs of a client immediately following a traumatic event, and in long-term trauma-specific care.

Mean=5.7    Median=6    IQR=1.5

- I could agree if it was something like “understand how trauma-related needs change over time.”
- I agree, and I think that in the moment, a traumatic event might not be terribly impactful long-term, and what one might deem a simple "bump in the road" could turn out to be VERY impactful long term
- There may be more to this statement that is important, which reviewers described, however, I do agree that this statement in itself is important for students to know

**Question 33.** Acknowledge the competencies published by Social Work Education and APA Division 56 of the American Psychological Association that are organized around core competencies for different levels of expertise and they may serve as best practices.

Mean=4.7    Median =5.5    IQR=2

- I'd agree with understanding consensus statements related to care, but I do not believe it appropriate to write other professions' competency documents into our own
- Counseling as a profession is still playing catch-up and still trying to find its own identity; we have to start somewhere
- Other professional associations are just as important. If you are training students to be LPC you need another set of standards. This will all be covered in their professional identity course. Not needed here. There are guidelines for trauma specific ethics in the SAMHSA TIP on Trauma.

**Question 34.** Audio tape sessions for supervision of the counseling session with client permission.

Mean=5.1    Median=6    IQR=1.75

- I prefer video tape to help trainees recognize things such as signs of dissociation and/or avoidance. However, audio tape is that is all that can be done.
- This is a general skill not specific to this issue.
- when possible, but video is better
- After reading reviewers comments, it makes sense to me that this seems to be a general strategy for supervision and not necessarily specific to trauma
- I have two trauma specific counselors who audio tape—clients rarely object. It is all in how you present it. But this is especially important for counselors in training because they cannot remember everything to tell you in supervision.
- and clinical appropriateness

**Question 38.** Know the appropriateness of gathering content from a client versus processing trauma prematurely.

Mean=5.5    Median=6    IQR=2

- I would agree if it was “Understand appropriate strategies for assessing trauma”—as written, reads like clinical wisdom.
- I’m not sure about this one
- I agree with this statement and I also think it could be reworded as some of the reviewers commented perhaps ‘understand appropriate strategies for assessing trauma and be able to distinguish trauma assessment vs. trauma processing’

**Question 61.** Let the client’s narrative lay the foundation and organization of trauma assessment.

Mean=5.5    Median=6    IQR=1.5

- after all, it is the CLIENT’s story
- Maybe you could re-word? I think sometimes the narrative can lay the foundation for better understanding the trauma and treatment AND as one reviewer stated you may also need to assess for trauma before actually obtaining a client’s full narrative—it seems situation dependent.

**Question 68.** Culture, systems, context, empowerment.

Mean=4.8    Median=5    IQR=2

- Are important factors to consider.
- not a skills item
- these are all important to factor in to care
- not a very clear statement
- Not clear what this means

**Question 70.** Distinctives of trauma interventions (trauma-specific or trauma-sensitive counseling approaches and interventions (e.g., TF-CBT), as opposed to regular traditional interventions, or crisis interventions.

Mean=4.5    Median=5    IQR=2.75

- It depends on the situation. DBT is effective for trauma work and may not be considered trauma specific. I am also confused by what you are asking here.
- not a skills item
- it depends on the client's needs and trauma history/narrative

**Question 72.** Policy and social justice issues associated with trauma work.

Mean=4.8    Median=5    IQR=2

- not a skills item. If moved to knowledge, would agree with “understands policy and social justice issues associated with trauma work”
- important for counselors to have knowledge about these
- I agree and do believe that social justice is an action and not just an attitude, knowledge, or concept. Perhaps this could be rewarded to specifically state social justice actions associated with trauma work as opposed to social justice ‘issues’ which seems to imply more of the knowledge side of social justice.
- Not a direct skill with client but part of professional boundaries and advocacy competency
- Not in beginning counselor training

**Question 76.** Wellness model

Mean=4.6    Median=5    IQR=2

- Not a skills item
- this can be vague; some clients need very concrete black and white goals from a more narrowed perspective rather than a holistic one

- Unclear statement regarding skills
- Meta practice guiding practice
- Not sure what this means

**Question 78.** Motivational interviewing

Mean=4.4    Median=4.5    IQR=3

- Depends
- Not a skills item and not specific to trauma work
- MI gets used a lot, but again, no one paradigm works best for all clients
- This approach is very helpful for graduate students. I have been teaching it to them for many years and it works well with traumatized clients for the initial sessions.

**Question 81.** Let the client define what is traumatic, lead you into trauma processing, and dictate the speed work.

Mean=4.9    Median=5    IQR=1.75

- clinical wisdom, but not competency so much.
- without a doubt
- I agree with the reviewer who stated that sometimes clients may avoid and distract, and it may be necessary to gently challenge them
- It needs to be a partnership. The traumatized brain cannot always process or plan well.

**Question 82.** Do not collude with learned helplessness/hopelessness while not giving up on clients.

Mean=4.8    Median=5    IQR=1.75

- not a clinical skill
- collude?
- Collude is too strong a word. Anchor your work in client autonomy and resilience would be a better way to say this.

**Question 97.** Recognize the limits to one's own empathy and being able to pull back in empathy a bit when needed.

Mean=3.6    Median=3.5    IQR=4.25

- not a skill item and not specific to trauma

- I don't think empathy can be managed like that
- never pull back on empathy with trauma. Help beginning counselors understand difference between empathy and sympathy. Sympathy is what gets them in trouble.

**Question 98. Optimistic**

Mean=4.7    Median=5    IQR=1.5

- not a skill item and not specific to trauma
- I don't think empathy can be managed like that
- never pull back on empathy with trauma. Help beginning counselors understand difference between empathy and sympathy. Sympathy is what gets them in trouble.

**Question 100. Peaceful**

Mean=5    Median=6    IQR=2

- not a competency and not specific to trauma
- it depends; energetically, clients present in different ways
- Part of safety monitoring.
- Sometimes it is appropriate to react to horrific events

**Question 102. Relentless pursuit of resilience**

Mean=4.7    Median=6    IQR=1.75

- not a competency and not specific to trauma
- not sure about this; relentless feels strong
- I think pursuit of resilience is important AND I would reword and take out 'relentless' and add while being sensitive to the client and where they are at
- Not relentless
- Hello burn out.

**Question 116. Desensitization techniques**

Mean=4.7    Median=5    IQR=1.75

- Not a skill item. I could agree if it was something like "strategies for promoting self-regulation"
- maybe, but for beginning counselors this would be tough
- I would re-word to make the statement present as a skill

- Don't need these yet

**Question 117.** EMDR Exposure therapies such as Prolonged Exposure, Cognitive Processing therapy, Mindfulness-based therapies such as ACT, Skills Training for Affective and Interpersonal Regulation/Narrative Story Telling, Brain-spotting, Somatic integration.

Mean=4.8    Median=5.5    IQR=1.75

- Not a skills item. We can't expect this of all students. I would agree to a knowledge item regarding having a working understanding of a variety of approaches to trauma care (e.g., ... LIST...)
- having a good "tool kit" of strategies is helpful, but a lot for a beginning counselor
- I think these are important to know about but I don't think it is essential for CITs to be skilled in all of these
- Critical to somatic effects of trauma and somatic monitoring and coping skills.
- Knowledge of these approaches but not the skills

**Question 118.** Understand basic medical first aid.

Mean=4.7    Median=5    IQR=1.5

- Not sure how this is relevant unless aiding in a crisis situation first hand.
- Not specific to trauma
- every professional helper needs this

**Question 120.** Reality testing.

Mean=4.1    Median=4    IQR=3

- I agree students should have this, but I'm not sure it's within the umbrella of your trauma competencies
- perhaps, not sure about this out of context
- I think more information is needed here with this statement

**Question 121.** Unique utilization of core counseling skills as appropriate when related to the precipitating event (e.g., excessive eye contact with an individual diagnosed with schizophrenia during a psychological decompensation may elicit paranoia).

Mean=4.9    Median=6    IQR=1.75

- Not specific to trauma

- being sensitive to the particular needs of clients is key, so yes
- I think this is very specific and maybe not necessary for CITs and basic trauma knowledge

**Question 122.** Possess the ability to implement phasic treatment.

Mean=4.6    Median=4.5    IQR=2

- I believe this needs to be operational. I would agree to a competency like “understands a general process for facilitating trauma work
- so context specific
- I think adding additional wording such as “if that is what is clinically appropriate and having a knowledge that this is one approach of many”  
However, as one reviewer stated, I also seems to remember another statement with this that may capture this better
- This needs to be clarified as to what the panelist is talking about

**Question 124.** Be able to employ specific strategies, trauma interventions, and trauma treatment to help clients work through traumatic experiences.

Mean=5.2    Median=6    IQR=2.5

- This is your overall objective—it’s what the competencies (together) should do. I don’t think it’s one competency.
- yes, important skills
- I agree with this sentiment, but I also agree that this is very general, and I think some of the other statements capture this same concept in more specific terms
- Not beginning counselors. Again, knowledge of this but not skills.

**Question 131.** Be able to build rapport in a compromised environment immediately following a crisis.

Mean=5.2    Median=6    IQR=2.5

- maintain rapport
- Rapport is general skill. Not sure how immediate crisis relates to trauma work.

**Question 135.** CIT’s should be able to use validation skills (validate the trauma, worth of the client, and difficulty of discussing history) and confirm that there is a way through and that they (the counselor) know the way through, and that they (the counselor) are willing to walk with the client through to conclusion of treatment.

Mean=5.93    Median=6.5    IQR=1.75

- Instill or inspire hope may be a worthy competency, but I believe that's more general to counseling than specific to trauma work.
- I don't like the language and belief: that they (the counselor) know the way through. The CIT may not know the way through, but they can aid the client in the journey
- but the counselor doesn't know the way through
- I disagree that the counselor 'knows the way through' and is the expert. I think it's a collaborative process
- I would word it that recovery from trauma is possible—not that the counselor knows what that is going to look like as it is different for every client