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Competencies in trauma counseling: A qualitative investigation of the knowledge, skills and attitiudes required of trauma-competent counselors

Melinda Paige

ACCEPTANCE

This dissertation, COMPETENCIES IN TRAUMA COUNSELING: A QUALITATIVE INVESTIGATION OF THE KNOWLEDGE, SKILLS AND ATTITUDES REQUIRED OF TRAUMA-COMPETENT COUNSELORS, by MELINDA PAIGE, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chairperson, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty.

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COMPETENCIES IN TRAUMA COUNSELING: A QUALITATIVE INVESTIGATION OF THE KNOWLEDGE, SKILLS AND ATTITUDES REQUIRED OF TRAUMA-COMPETENT COUNSELORS

by

Melinda R. Paige

Under the Direction of Dr. Catherine Y. Chang

ABSTRACT

Trauma is ubiquitous (Beck & Sloan, 2012: Brown et al, 2011; Solomon & Johnson, 2002). Beck and Sloan (2012) reported that the vast majority of United States residents have experienced one or more posttraumatic stress disorder-level events as defined by the Diagnostic and Statistical Manual of Mental Disorder (5th ed). Additionally, the persistent negative physical and psychological consequences of traumatic stress is a growing public health concern (Lupien, Mc Ewen, Gunnar & Heim, 2009). Nonetheless, there remains a paucity of training about posttraumatic stress in graduate counselor education programs (Courtois & Gold, 2009; Layne et al, 2014; Litz & Salters-Pedneault, 2008; Logeran et al, 2004). Since counselors working in a variety of mental health settings will likely be working with survivors of trauma, it is imperative that their training include foundational trauma knowledge and trauma-competent clinical skills (Layne et al, 2014). Standardized trauma-based curriculum to inform the education of professional counselors have yet to be integrated into graduate training despite the fact that researchers report high trauma-exposure rates among United States residents (Courtois, 2009). Further, trauma counseling competencies to inform the education of trauma counselors have yet to be identified (Layne et al, 2014; Mattar, 2010; Turkus, 2013). This study addressed these gaps in the literature using Qualitative Content Analysis (Schreier, 2012) to examine the experiences of thirty-nine trauma-competent mental health professionals. Participants with advanced counseling skill who scored in level 3 or 3i on the Supervisee Levels Questionnaire-Revised (McNeill, Stoltenberg, & Romans, 1992) were included in the data analysis. Authors developed trauma competencies, including intervention objectives and practice elements (Layne et al, 2014), based on the derived categories and subcategories emerging from the data. These trauma competencies are consistent with the Core Curriculum on Childhood Trauma training tool

(Layne et al, 2014) as well as the New Haven Trauma Competencies (Cook & Newman, 2014) and include trauma-informed attitudes and beliefs, knowledge and skills essential to trauma competency.

INDEX WORDS: Stress disorders, Competencies, Professional competence, Professional training

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DEDICATION

To my sons, Eric and Alex Paige, may this inspire you to aim high and never give up on your dreams.

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CHAPTER 1
COMPETENCIES IN TRAUMA COUNSELING: A QUALITATIVE INVESTIGATION OF THE KNOWLEDGE, SKILLS AND ATTITUDES REQUIRED OF TRAUMA-COMPETENT COUNSELORS

Introduction

Trauma is a substantial public health concern (Beck & Sloan, 2012: Brown et al, 2011; Solomon & Johnson, 2002), with 82.8% of individuals in the U.S. reporting exposure to a traumatic event sometime during their life-time and the majority of individuals in the U.S. reporting having experienced at least one Post Traumatic Stress Disorder (PTSD)-level event as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013) (Beck & Sloan, 2012). Although traumatic stress is common, the psychological and physical effect on the survivor varies depending on a wide range of individual risk factors such as age, gender, race and socioeconomic status (Briere & Scott, 2015). Additionally, the life-threatening physical and psychological consequences of traumatic stress are a matter of considerable public health concern (Lupien, Mc Ewen, Gunnar & Heim, 2009). The Adverse Childhood Experiences Study (ACES) identified an increased risk for a variety of health-related issues, such as substance abuse, depression, suicide attempts, chronic obstructive pulmonary disease, ischemic heart disease, liver disease, sexually transmitted diseases and smoking for individuals with negative childhood experiences (Edwards et al., 2003). A report published by the U.S. Department of health and human services (2003) affirms the need for improved mental health strategies given the inordinate amount of traumatic stress and its negative impact on public health. Notwithstanding, there is a lack of trauma and posttraumatic stress training in graduate counselor education programs (Courtois & Gold, 2009; Layne et al, 2014; Litz & Salters-Pedneault, 2008; Logeran et al, 2004). It is imperative that counselor

education include foundational trauma knowledge and trauma-competent clinical reasoning skills (Layne et al, 2014), since counselors working in a variety of mental health settings will likely be working with survivors of trauma. Therefore, a critical need for established trauma competencies to inform and support developing trauma counselors exists. More specifically, "the dissemination of a comprehensive model of trauma-focused, empirically informed competencies (knowledge, skills, and attitudes) is currently required to provide the foundational training for a "trauma-informed mental health workforce." (Cook & Newman, 2014, p. 300). In this paper, the authors will review and summarize core trauma concepts, which include intervention objectives and practice elements (Layne et al, 2014) as well as trauma training implications for counselor educators.

Trauma and Posttraumatic Stress

Trauma is ubiquitous, as demonstrated by researchers highlighting the prevalence of trauma in the United States (Beck & Sloan, 2012: Brown et al, 2011; Solomon & Johnson, 2002). Trauma results from negative life events that overwhelm an individual's coping resources and ability to cope adaptively with the traumatic stressor (Van der Kolk, 1996). "Stress becomes trauma when the intensity of the frightening events becomes unmanageable to the point of threatening physical and psychological integrity" (Lieberman & Van Horn, 2008, p. 15). Traumatic stressors are events that transcend typical human experience. The DSM-5 (APA, 2013) defines trauma as: exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend – in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental;

(4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). The fact that the DSM-5 does not include emotional abuse in the current definition of trauma is a point of debate in the trauma literature. The concern among trauma professionals is that many individuals experiencing posttraumatic distress as a result of "extreme emotional abuse, major losses or separations, degradation or humiliation, and coerced (but not physically violent) sexual experiences" are not accounted for in the general population, nor are they being accurately diagnosed and treated (Briere & Scott, 2015, p. 10).

A review of treatment outcome research related to posttraumatic stress by Solomon and Johnson (2002) stated that "the array of treatments and the explosion of recent journal reports become understandable when viewed in light of the tremendous amount of trauma experienced in our society" (p. 948). They further concluded that a majority of individuals from the United States experience at least one traumatic event and that trauma exposure is common. These researchers reported that the rates of trauma-exposure ranged from 21% of the population to a high of 89%. According to the National Comorbidity Survey, approximately 50% of all U.S. women will be exposed to at least one traumatic event during their lifetime (Kessler et al, 1995). Findings from another study reported that women experience an average of 4.3 distinct trauma causing events in their lifetimes. (Breslau et al, 1998). The most frequently experienced traumatic stressors reported are childhood sexual assault, physical or sexual assault, natural disasters, domestic violence and school and work-related violence (James & Gilliland, 2001).

Women report exposure to a range of traumatic events and are especially vulnerable to sexual assault in both childhood and adulthood. It is estimated that between 17% and 34% of women will experience rape at some point during their lifetime (Brener et al, 1999; Tjaden &

Thoennes, 2000). Researchers (Breslau et al, 1998; Kessler et al., 1995) have also indicated that women are at higher risk for sexual molestation, childhood parental neglect, childhood physical abuse, domestic violence, and the sudden death of a loved one. According to McHugo et al. (2005), exposure to one traumatic stressor can increase the likelihood that an individual will experience additional traumatic stressors. These researchers further concluded that posttraumatic stress is often comorbid with other mental health conditions including substance abuse. In addition, Mockus et al. (2005) posited that mental health practitioners are often not abreast of current evidence-based literature indicating best practices in the treatment of posttraumatic stress and comorbid mental health and substance dependency issues. Mueser et al. (1998) found that 43% of consumers of public mental health services had a diagnosis of PTSD not previously identified by other facilities, and mental health staff had noted a diagnosis of PTSD in the charts of 2% of these mental healthcare consumers.

Trauma-informed Care

According to Hopper et al. (2007), trauma-informed, strengths-based care empowers clients to identify their strengths, thereby fostering the development of new coping skills. For example, a service system is trauma-informed when an emphasis on rules is decreased and clients' personal choice, agency and collaborative problem solving is emphasized. Trauma-informed mental health care (Harris & Fallot, 2001) supports treatment approaches that acknowledge both the ubiquity of trauma and the significant psychological and physical health consequences of posttraumatic stress on survivors. The trauma-informed care movement seeks to provide effective, trauma-specific treatment for trauma survivors. The trauma-informed literature (Fallot, 2008) highlights key principles and guidelines for mental health care providers interested in providing this trauma-specific care. This treatment framework includes trauma-specific

diagnostic and treatment services within a trauma-informed environment. Trauma-specific diagnostic and treatment services include: safety from physical harm and re-traumatization; 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; an understanding that symptoms are contextual and vary according to life experience and culture; and 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 her (Fallot, 2008; Harris & Fallot, 2001).

The *trauma-informed* literature includes an article by Elliot et al. (2005) which echoes the seminal work of Maxine Harris and Roger Fallot (2001) and the trauma committee of the Women, Co-occurring Disorders and Violence Study (WCDVS) funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The WCDVS sites made two important initial steps in this study. First, they achieved a consensus understanding of the key principles of trauma-informed services and outlined several trauma-specific interventions for mental health and substance abuse service providers. Second, the WCDVS project demonstrated the feasibility of implementing a trauma-informed service model (Elliot, 2005). When trauma professionals include the voices of survivors who have recovered from trauma in the development of mental health services, we are more likely to meet their specific treatment needs. In addition, asking trauma survivors to serve in this capacity is empowering and, thus, the antithesis of the disempowering and violating traumatic and abuse experiences. By involving trauma surviving individuals in all aspects of their care, we broaden their potentials for growth and transformation.

A second trauma-informed article was written by Mockus et al. (2005) who held leadership roles in The Women, Co-Occurring Disorders and Violence Study (WCDVS). The

authors of this article are consumer/survivor/recovering women with histories of trauma, mental health difficulties, and substance abuse disorders. Their collective voice reflects the growth and transformation acquired from trauma recovery. Mockus et al. (2005) concluded that most of the trauma treatment outcome research regarding best practices has been written from the perspective of those who have not had the actual experience of using trauma services for their own recovery. "Even the best science available has lacked a vital component: the insight and wisdom that can only come through the lived experience of recovery" (Mockus et al., 2005, p. 515).

Trauma Training in Counselor Education

Since professional counselors working in a variety of mental health settings will likely be working with survivors of trauma, it is imperative that they are aware of these key trauma-specific principles and guidelines. Yet, there remains a paucity of training about trauma in graduate education in the counseling professions (Courtois & Gold, 2009; Layne et al, 2014; Litz & Salters-Pedneault, 2008; Logeran et al, 2004). According to Gold (2008), therapists seeking to develop trauma competency must pursue education outside their graduate training institutions. Further, standardized trauma-based curriculum to inform the education of mental health providers have yet to be integrated into graduate training despite the fact that researchers report high trauma-exposure rates among United States residents (Courtois, 2009). Mattar (2011) further stated that "the field of trauma psychology is experiencing sustained growth that requires the establishment of standards in trauma education" (p. 13). Many mental health disciplines, such as social work (Council on Social Work Education, 2012) and marriage and family therapy (Nelson et al, 2007), already have established trauma competency training models (Kaslow et al, 2009).

While the trauma-informed services movement has made considerable progress toward creating integrative treatment guidelines which incorporate the specialized needs of trauma survivors into mental health services, little is known about the trauma therapist's experience providing this trauma-specific mental health care or trauma counseling competency. However, two seminal articles broaden the literature to include the study of trauma therapists and suggest a process of development specific to trauma therapists (Logeran et al, 2004) as well as a multifaceted model of trauma therapist development (Turkus, 2013). These studies will be described in more detail following a review of literature on counseling competency development and trauma competency development.

Counseling Competency Development

According to Hanson and Kerkhoff (2011):

> The backbone of the competency movement reflects our need to operationalize what competence to practice means from a developmental perspective and to create enough synergy that competence assessment becomes central to the educational process and is valued as such (p. 220).

The modern competency movement originated in 2002 with the Future Directions in Education and Credentialing in Professional Psychology conference convened to explore the development and assessment of competence (Kaslow et al., 2004; Rodolfa et al., 2005). Conference participants, such as the American Psychological Association (APA) and thirty organizations including educational, public interest, professional and regulatory groups, were surveyed to identify eight domains that would serve as the basis of the work groups to define competency components. The eight domains are as follows: scientific foundations and research methods; assessment; intervention; supervision; consultation and interdisciplinary relationships;

ethical, legal and policy issues; diversity; and professional development (Rodolfa et al., 2005). Work group participants conceptualized competencies as a three dimensional cube model that included foundational competency domains (e.g., scientific knowledge, ethical standards, and graduate school training), functional competency domains (e.g., knowledge, skills and values required for practice), and professional developmental stages throughout one's professional career (Hanson & Kerkhoff, 2011). Participants also concluded that specialization "requires additional knowledge and skills beyond the basic foundational and functional competencies" (p. 222). Further, Hanson and Kerkhoff (2011) posited that "the values and attitudes of specialists are refined by the philosophical underpinnings of the specialty area, as well as the practical realities of service delivery with specific populations within specific settings" (p.222).

The momentum in counseling competency development begun by the 2002 conference culminated in the 2006 APA Task Force on the Assessment of Competence in Professional Psychology. Task force members were charged with recommending models involving competency and evaluation in order to successfully implement competence assessment in professional psychology. Fifteen guiding principles emerged from their work that emphasized assessment of competency throughout one's professional career and emphasized the importance of identification of core competencies followed by evidence-based assessment. Further, three new competencies, professionalism, teaching and advocacy, "were added, thereby expanding the original cube model (Foaud et al, 2009).

Competency-based Education

Competency-based education (CBE) is a student-centered model that "guides the educational process toward acquisition of the knowledge, skills, and attitudes needed for effective professional practice in service of the public" (Hatcher et al., 2013, p.1). The model

involves formulating competencies and curricula aimed at student learning toward competence benchmarks producing graduates with knowledge and skill in "explicitly identified competency domains" (p. 4). Nelson (2007) concluded that psychology education and credentialing are shifting toward an approach that is committed to outcome-based education and training which includes specific competency-based curricula and learning outcome measurement.

Competency Development for Counselors

According to Myers (1992), competency is an essential component of professionalism as "competencies are the areas in which a professional should be capable of performing to a certain standard" and "that standard is typical set by a profession" (p. 3). In the counseling profession, organizations such as the American Counseling Association (ACA) provide direction for counselors seeking competency guidelines in specialty areas. The ACA has already endorsed competencies in the following specialty areas: advocacy (Lewis, Arnold, House, & Toporek, 2003), counseling with transgender clients (ALGBTIC, 2009), lesbian, gay, bisexual, queer, intersex, questioning and ally individuals counseling (ALGBTIC LGBQQIA, 2010), spiritual and religious issues in counseling (ASERVIC, 2009), and career counseling (NCDA, 2009). Toporek et al. (2009) affirmed that counselor competencies are essential to ethical clinical practice. Further, these counselor competencies should include operationalized knowledge, skills and attitudes (Sue et al., 1992) and provide specific guidelines for counselors engaged in ethical and informed clinical practice (Ratts et al, 2010). Competence is a core component of ethical conduct according to the ACA Code of Ethics (2014). The ethical code specifically addresses counselors engaging in practice in specialty areas stating that "counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience" (C.2.b; ACA, 2014).

Trauma Competency Development

The International Society for Traumatic Stress Studies published expert consensus treatment guidelines by the Complex Trauma Task Force (CTTF) for complex PTSD in adults (Cloitre et al., 2012). These guidelines included prominent areas of psychological and physical distress within the symptom profile of Complex PTSD. Upon review of the trauma treatment literature the task force suggested "phase-oriented or sequential treatment guided by a hierarchy of treatment needs assessed prior to treatment" (p. 7). Trauma training guidelines on an international level were also published by the ISTSS and the Task Force on International Trauma Training (Weine, 2002). These leading traumatologists identified eight core curricular training standards to inform trauma training curricula: competence in basic counseling and crisis stabilization skills; awareness of contextual factors and appropriate therapeutic interventions; treatment of "medically unexplained somatic pain"; collaboration with the local community; and ongoing supervision, self-care and assessment (p. 161). While the ISTSS and the CTTF provide guidance in the areas of trauma training curricula and the treatment needs of complex trauma survivors, core trauma concepts including intervention objectives and practice elements (Layne et al, 2014) for trauma counselors are still lacking in the literature.

The Core Curriculum on Childhood Trauma (CCCT) was developed by Layne et al. (2011) to provide trauma-informed and evidence-based training in graduate education and professional development. The CCCT and its framework were developed to support practice behavior and competencies essential to trauma-informed and evidence-based trauma counseling. The seminal research of Fouad (2009) and Kaslow (2009) specifically outlined a framework for trauma-informed clinical practice in the following areas: assessment and information gathering; building a working clinical theory; assessing, evaluating and applying the empirical literature to

individual clients; case conceptualization; and intervention planning. The development of the aforementioned framework and foundational trauma principles, 12 Core Trauma Concepts, provided guidelines for practice building upon the trauma-informed care movement's efforts to develop trauma-informed organizations providing trauma-specific services tailored to the unique health care needs of trauma survivors. The foundation of the CCCT model rests on a five-tiered integrative and hierarchical conceptual framework referred to as C.O.P.E.S.- E. supporting integrative clinical practice (Ghost-Ipen, Layne & Pynoos, 2013).

Specifically, the C.O.P.E.S.-E framework includes five levels: the empirical evidence base; core trauma concepts; intervention objectives; practice elements and therapeutic skills (procedural and process oriented). The therapeutic skills level consists of two levels (how and how well) and supports: evidence-based practice guidelines; core trauma concepts; specific intervention objectives; client factors such as strengths, needs and context; practitioners' "clinical wisdom and professional judgment" and evidence-based practice as well as competence-based training and credentialing (Layne et al., 2014).

The CCCT was developed in 2007 by a panel of experts convened by the National Child Traumatic Stress Network (Layne et al., 2013). These experts agreed on the core trauma concepts in order to create a consensus understanding among mental health practitioners working with children and families experiencing traumatic stress. Similarly, other coalitions of mental health practitioners, such as social workers (Counsel on Social Work Education, 2012), psychologists (Kaslow, 2012; Fouad et al., 2009), and professional counselors (Webber & Mascari, 2009) added standards for competency-based practice in trauma and crisis counseling to the literature. The Council on Social Work Education (2012) published guidelines for advanced social work practice in trauma in order to educate social workers on trauma-informed practice.

Guidelines emphasize that social work curricula should actively recognize the impact of trauma symptoms and disorders, take into account this impact's detrimental effects, and provide students with the trauma-informed and evidenced-based skills necessary for effective trauma intervention (The Council on Social Work Education, 2012, p.3). Competency for trauma-informed social work practice emphasizes that practitioners should recognize the following: traumatic experiences are inherently complex; trauma affects children, adults, and families in unique and specific ways; and trauma recovery is possible but presents specific challenges.

The American Psychological Association (APA) also convened a group of experts to create a core competency model in trauma care (Wilson, 2013). APA members recognized the lack of identified competencies to support the practice of trauma counseling and gathered sixty national experts in traumatology for the Advancing the Science of Education, Training and Practice in Trauma conference. A primary goal of the conference is publishing an evidenced-based core competency model in trauma mental health to serve as an exemplar for professional organizations and graduate programs seeking to increase competency in the assessment and treatment of trauma. This core competency model was published in April 2014 and identified the "knowledge, skills and attitudes that competent clinicians must demonstrate when counseling traumatized children and adults. (Cook & Newman, 2014, p. 301). These five essential competencies included: "scientific knowledge about trauma, psychosocial trauma-focused assessment, trauma-focused psychosocial intervention, trauma-informed professionalism, and trauma-informed relational and systems" (Cook & Newman, 2014, p. 302).

The Council for Accreditation for Counseling and Related Standards (CACREP) developed new competencies (CACREP, 2008) for crisis, disaster, and trauma response for both core counseling and program specific curricula. This shift from a generalist model of training

toward competency-based education for counselors in trauma mirrored other mental health care professions.

According to Webb and Mascari (2009):

> Counselor educators and professionals unfamiliar with this growing specialty will need to be well versed in the theory and practice of traumatology, crisis intervention, and emergency preparedness in order to infuse new standards into program objectives and syllabi (p. 128).

Additionally, CACREP (2009) provided the following standards relating to trauma competency in addiction, career, clinical mental health, marriage, couple and family, school, student affairs and college counseling. More specifically, it is suggested that clinical mental health counselors understand the following: the impact of crises, disasters, and other trauma-causing events on people; the operation of an emergency management system within clinical mental health agencies and in the community; crisis intervention for people during crises, disasters, and other trauma-causing events; the appropriate use of diagnosis during a crisis, disaster, or other trauma-causing event; differential diagnosis, and developmentally appropriate reactions during crises, disasters, and other trauma-causing events. Doctoral standards were also established suggesting that doctoral-level training include: theories pertaining to the principles and practice of counseling, career development, group work, systems, consultation, and crises, disasters, and other trauma causing events; the effectiveness of models and treatment strategies of crises, disasters, and other trauma-causing events; and models, leadership roles, and strategies for responding to community, national, and international crises and disasters (CACREP, 2009) .

Webber, Mascari, Dubi, and Gentry (2006) identified nine key trauma counseling related issues and provided the impetus for the American Counselor Association (ACA) Trauma Interest

Network. According to Webber et al. (2006), the most salient item 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).

In addition, mental health departments throughout the country have developed trauma initiatives and coalitions to support trauma-competency among mental health workers. Independent professional membership organizations also exist to support trauma practitioners such as the Association of Traumatic Stress Specialists (ATSS), the Green Cross Academy of Traumatology, and the International Society for Traumatic Stress Studies (ISTSS). Universities are also offering certificate programs in trauma response and crisis intervention and trauma-informed care and counseling.

Trauma Therapist Development

Logeran et al. (2004) examined the trauma therapist's perspective and experience in working with traumatized children. According to Logeran et al. (2004), acquiring skill as a trauma therapist is a transformative process requiring self-reflection, willingness to grow, and disciplined self-care. Further, Logeran et al. (2004) extended the Integrated Developmental Model, posited by Stolenberg and Delworth (1987) to capture these themes of trauma therapist development: (1) view of therapy, (2) self-care issues, and (3) view of self. A second article (Turkus, 2013) confirmed Logeran's supposition that trauma therapists change, both personally and professionally, as they develop their trauma counseling competency. However, Turkus (2013) described a multifaceted model of the process of trauma therapist development in which education, clinical practice, research and self-reflection are significant and interrelated factors. Overall, little has been published about trauma therapists and their experiences. Although the research reviewed above identified significant themes regarding the personal and professional

development of trauma therapists, these two articles alone provide insufficient evidence.

Conclusion

The studies presented above demonstrate the ubiquity of trauma in the United States (Beck & Sloan, 2012: Brown et al, 2011; Solomon & Johnson, 2002) as well as the persistent negative physical and psychological consequences of traumatic stress (Lupien, Mc Ewen, Gunnar & Heim, 2009). The existing literature also suggest that it is imperative that counselor training include foundational trauma knowledge and trauma-competent clinical reasoning skills (Layne et al, 2014), since counselors working in a variety of mental health settings will likely be working with survivors of psychological trauma. Further, the studies reviewed indicate that there remains a paucity of training about psychological trauma in graduate counselor education programs (Courtois & Gold, 2009; Layne et al, 2014; Litz & Salters-Pedneault, 2008; Logeran et al, 2004), despite the fact that researchers report high trauma-exposure rates among United States residents (Courtois, 2009). The studies above also state that trauma counseling competencies to inform the education of trauma counselors have yet to be identified (Layne et al, 2014; Mattar, 2010; Turkus, 2013) while several other mental health disciplines already have established competency-based training models to inform training and professional development (Kaslow et al, 2009).

Implications for Future Research

While the trauma-informed services movement has made considerable progress toward creating integrative treatment guidelines which incorporate the specialized needs of trauma survivors into mental health services, little is known about the trauma therapist's experience providing this trauma-specific mental health care or trauma counseling competency. Therefore, more research is needed to develop trauma counseling competencies grounded in the experiences

of expert trauma therapists to support trauma therapist training and development during their graduate and postgraduate training. Specifically, future research should focus on developing core trauma concepts which include intervention objectives and practice elements (Layne et al, 2014), as well as trauma training implications for the counselor educator.

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CHAPTER 2
COMPETENCIES IN TRAUMA COUNSELING: A QUALITATIVE INVESTIGATION OF THE KNOWLEDGE, SKILLS AND ATTITUDES REQUIRED OF TRAUMA-COMPETENT COUNSELORS

Introduction

Trauma is a significant public health concern (Beck & Sloan, 2012: Brown et al, 2011; Solomon & Johnson, 2002) in the United States. Beck and Sloan (2012) reported that the vast majority of United States residents have experienced one or more Post Traumatic Stress Disorder-level (PTSD) events as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-V; American Psychiatric Association, 2013); a national sample of the life-time cumulative exposure to a traumatic event was 82.8%. Additionally, the severe and persistent negative physical and psychological consequences of traumatic stress are a growing public health concern (Lupien, Mc Ewen, Gunnar & Heim, 2009). The Adverse Childhood Experiences Study (ACES) demonstrated that a significant positive relationship exists between negative childhood experiences and an increased risk for a variety of lifelong physical and mental health issues such as substance use and abuse, depression, suicide attempts, chronic obstructive pulmonary disease, ischemic heart disease, liver disease, sexually transmitted diseases and smoking (Edwards et al., 2003). Nonetheless, there remains a paucity of training about posttraumatic stress in graduate counselor education programs (Courtois & Gold, 2009; Layne et al, 2014; Litz & Salters-Pedneault, 2008; Logeran et al, 2004). Since professional counselors working in a variety of mental health settings will likely be counseling with survivors of trauma, it is imperative that their training include foundational trauma knowledge and trauma-competent clinical reasoning skills (Layne et al, 2014). According to the American Counseling Association (2014) specialized training and supervision are required before engaging in counseling in any specialty area,

therefore, without formal trauma training to support ethical and informed clinical practice with this vulnerable population, counselors are at risk for practicing outside the bounds of their counseling competency (Ratts et al., 2010). This study will address these gaps in the literature using Qualitative Content Analysis (Schreier, 2012) to examine the experiences of mental health professionals who self-identify as trauma-competent.

Trauma and Posttraumatic Stress

Trauma results from negative life events that overwhelm an individual's coping resources and ability to cope adaptively with the traumatic stressor (Van der Kolk, 1996). "Stress becomes trauma when the intensity of the frightening events becomes unmanageable to the point of threatening physical and psychological integrity" (Lieberman & Van Horn, 2008, p. 15). The most frequently encountered traumas reported in clinical practice include childhood sexual assault, physical or sexual assault, natural disasters, domestic violence and school and work-related violence (James & Gilliland, 2001). A review of treatment outcome research related to posttraumatic stress by Solomon and Johnson (2002) stated that the sharp increase in published trauma-related literature and the variety of new treatment modalities for posttraumatic stress injury makes sense given the increase in traumatic stress being experienced in our society. They further concluded that a majority of individuals from the United States experience at least one traumatic event and that trauma exposure is commonplace.

According to McHugo, Caspi, Kammerer, Mazelis, Jackson, and Russell (2005) exposure to one traumatic stressor can increase one's vulnerability to additional traumatic stressors and is often comorbid with other mental health conditions including substance abuse and dependency. In addition, Mockus et al. (2005) concluded that traditional mental healthcare providers are often unaware of the importance of treating posttraumatic stress and comorbid mental health and

substance dependency issues at the same time since these providers may be under the impression that posttraumatic stress is an additional problem for their clients rather than the central problem. An independent assessment of consumers of public mental health inpatient and outpatient services (Mueser et al., 1998) found that 43% had a diagnosis of PTSD not previously identified by other facilities and mental health staff had noted a diagnosis of PTSD in the charts of only 2% of the consumers.

Trauma-informed Care

Trauma-informed care (Harris & Fallot, 2001) is an international trend in mental health treatment growing out of an increased awareness of the ubiquity of trauma in the U.S. The trauma-informed movement in mental health supports treatment approaches that recognize the pervasive impact of trauma on the lives of survivors and aims to provide curative, trauma-specific treatment rather than mental health care that exacerbates the effects of trauma. The trauma-informed literature arrived at a consensus understanding of the key principles of trauma-informed care (Fallot, 2008) and outlined guidelines for mental health care providers interested in providing this trauma-specific care. This systematic approach includes trauma-specific diagnostic and treatment services within a trauma-informed treatment environment. Trauma-specific diagnostic and treatment services include the following: (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).

Trauma Training in Counselor Education

Despite the considerable progress toward creating trauma-informed treatment guidelines incorporating the specialized needs of trauma survivors into mental health services, little is known about the trauma therapist's experience providing this trauma-specific mental health care or trauma counseling competency. Standardized trauma-based curriculum to inform the education of mental health practitioners have yet to be integrated into graduate training despite the fact that researchers report high trauma-exposure rates among United States residents (Courtois, 2009). Mattar (2011) further stated that "the field of trauma psychology is experiencing sustained growth that requires the establishment of standards in trauma education" (p. 13). Many mental health professions, such as social work (Council on Social Work Education, 2012) and marriage and family therapy (Nelson et al, 2007), already have established trauma competency training protocols (Kaslow et al, 2009). Since professional counselors working in a variety of mental health settings will likely be working with survivors of trauma, it is imperative that they develop their trauma-competency. Nonetheless, there remains a lack of education about trauma and posttraumatic stress in graduate training in the counseling professions (Courtois & Gold, 2009; Layne et al, 2014; Litz & Salters-Pedneault, 2008; Logeran et al, 2004).

Competency Development for Counselors

Toporek et al. (2009), defined counselor competencies as essential to ethical practice. These competencies should include operationalized knowledge, skills and attitudes (Sue et al., 1992) and provide a specific framework for counselors that supports ethical and informed clinical practice (Ratts et al., 2010). Additionally, competence is a core component of ethical conduct according to the ACA Code of Ethics (2014). This ethical code intentionally addresses

professional counselors engaged in clinical work in specialty areas emphasizing that "counselors practice in specialty areas new to them only after appropriate education, training, and supervised experience" (C.2.b; ACA, 2014). According to Myers (1992), competency is a critical component of professionalism as "competencies are the areas in which a professional should be capable of performing to a certain standard" and "that standard is typical set by a profession" (p. 3). In the counseling profession, organizations such as the American Counseling Association (ACA) provide leadership for counselors seeking competency standards in specialty areas. For example, the ACA endorsed competencies in the following specialty areas: advocacy (Lewis, Arnold, House, & Toporek, 2003), counseling with transgender clients (ALGBTIC, 2009), lesbian, gay, bisexual, queer, intersex, questioning and ally individuals counseling (ALGBTIC LGBQQIA, 2010), spiritual and religious issues in counseling (ASERVIC, 2009), and career counseling (NCDA, 2009).

Trauma Competency Development

Trauma training guidelines on an international level were spearheaded by the International Society for Traumatic Stress Studies (ISTSS) and the Task Force on International Trauma Training (Weine, 2002). These traumatologists identified eight core curricular training elements including the following: competence in basic counseling and crisis stabilization skills; awareness of contextual factors and applying appropriate interventions; life skills training, treatment of "medically unexplained somatic pain"; collaboration with local communities; ongoing supervision, self-care and assessment" (Weine, 2002, p. 161). The ISTSS also published expert consensus treatment guidelines by the Complex Trauma Task Force (CTTF) for complex PTSD in adults (Cloitre et al., 2012). These guidelines included salient areas of psychological and physical distress within the symptom profile of Complex PTSD. Upon review of the trauma

treatment literature the task force suggested "phase-oriented or sequential treatment guided by a hierarchy of treatment needs assessed prior to treatment" (Cloitre et al., 2012, p. 7). The Core Curriculum on Childhood Trauma (CCCT), published by Layne et al. (2011), provides trauma-informed and evidence-based training in graduate education and professional development. The CCCT and its framework were designed to support practice behavior and competencies essential to trauma-informed and evidence driven trauma counseling. However, this training framework supports trauma-informed clinical practice with traumatized children, and therefore, does not include trauma competencies for professional counselors working with traumatized adults. The New Haven Trauma Competency group developed comprehensive guidelines informing trauma treatment for both children and adults; however, professional counselors were not included in this critical dialogue (Cook & Newman, 2014). The ISTSS, CTTF and CCCT are also seminal trauma training and treatment protocols however, trauma competency standards and a trauma training model, including intervention objectives and practice guidelines, for professional counselors is currently unavailable in the literature (Layne et al, 2014).

Purpose of Study and Research Question

The purpose of this study is to explore the experiences of mental health professionals related to providing trauma-informed care. Licensed mental health professionals self-identified as trauma counselors from a wide-variety of mental health disciplines were invited to participate in this qualitative study. More specifically, the research questions addressed in this study include the following: What do trauma counselors' experiences reveal about trauma counseling competency and core trauma concepts? What are trauma counselors' perceptions about trauma competency? What concepts emerge from trauma counselors' perspectives that may assist counselor educators in developing competency-based trauma training?

Method

Warren (1996) suggested that the first person narrative is a considerable resource for feminist theory and practice. “The narrative mode takes relationships themselves seriously, giving expression to various ethical attitudes and behaviors as well as giving voice to marginalized peoples and underplayed or misrepresented viewpoints” (Hare-Mustin, 1996, p. 270). Further, Seibold (2000) highlighted Lengermann and Niebrugge-Brantley’s (1988) three tenets of feminist methodology, which are reflected in this qualitative content analysis. These tenets include the following: women’s experiences are foremost, research sets forth to view the world from her female participants’ perspectives, and feminist researchers seek to improve the conditions within which women live. A Cultural Ecofeminism perspective best informs my work for its relevance to multiple oppressions such as women and trauma. This feminist perspective uses ecology as a model for human interaction and suggests that we act from a place of interconnection and relatedness to others, both human and non-human; these are significant factors in trauma recovery. Also, Cultural Ecofeminism is concerned with the effects of gender, power inequities and human oppression; these are significant factors in victimization and posttraumatic stress. Furthermore, the Cultural Ecofeminist view that “graduated and responsive measures to multifarious problems are required to implement lasting social change and overturn oppressive paradigms” fits with my belief that social activism is mandated by my personal and professional privilege (Stephens et al., 2010, p. 373). As a social justice advocate, the Cultural Ecofeminist action-oriented philosophy informs my qualitative research designed to achieve social change and apply the experiences of trauma therapists to mental health practice.

Feminist researchers from a variety of disciplines integrate feminist philosophy within their qualitative content analysis studies. As a feminist researcher using qualitative content

analysis as the method for data analysis, I am aware of my own biases as a feminist researcher and the power differential inherent to the process of coding the lived experiences of research participants. I am aware of the subject-object duality inherent to the researcher-participant relationship as well, and will use the journaling process to attend to these salient feminist values and to account for my own subjectivities throughout the coding process. The research journal provides a means of reflection and documentation as well as a container for the interpretation of data and personal reactions throughout the research process (Creswell, 2007).

Participants

Eligible participants included fully licensed mental health professionals with a graduate degree in the mental health field and three or more years of experience as a certified trauma therapist. Forty-five (N=45) certified trauma counselors agreed to participate in this study and completed the on-line survey; however, six participants did not meet criteria for inclusion and, therefore, their responses were not used in data analysis. A total of 39 licensed mental health professionals met criteria for inclusion. A majority were female (*n*=37). Age ranges were 25-29 (*n* =3), 30-35 (*n* =2), 36-40 (*n* =2), 41-45 (*n* =2), 46-49 (*n* =4), 50-55 (*n* =10), 56-59 (*n* =3), 60-64 (*n* =6), 65-69 (*n* =5) and 70 years and older (*n* =2) with the highest proportions among the 50-55 category (*n* =10) and 60-64 (*n* =6) 65-69 (*n* =5) age ranges (Table 1). Thirty-five participants self-identified as "White/Caucasian", one as "Black", one as "Hispanic", and one as "Native American." One participant self-identified as "Other."

Table 1

Demographic Distribution of the Sample (N=39)

	Mean	Median	Range	Standard Deviation
Age	56-59	50-55	25-29 to 70 +	10.56

Years Licensed	16-20	16-20	3-5 to 25 +	8.20

Participants included licensed professional counselors/licensed mental health counselors (*n*=19), licensed clinical social workers (*n*=9), licensed marriage and family therapists (*n*=4), licensed psychologists (*n*=3), clinical nurse specialists in psychosocial nursing/advanced practice registered nurses (*n*=2), a board certified psychiatrist (*n*=1), and a licensed rehabilitation counselor (*n*=1). Years licensed in mental health profession ranged from 3-5 years (*n*=6) to 25 years or more (*n*=11) with the highest proportions among the 11-15 years category (*n*=13) and 25 years or more (*n*=11) ranges. Years providing trauma counseling ranged from 0-5 years (*n*=8) to 25 years or more (*n*=2) with the highest proportions among the 5-10 (*n*=13) and 16-20 ranges (Table 2).

Work settings represented included private practice (*n*=18), non-profit/public (*n*=4), college/university (*n*=6), private psychiatric/medical hospital (*n*=4), national department of veterans affairs (*n*=2), victim's assistance organization (*n*=1), correctional facility (*n*=1) and other (*n*=3). Populations served by participants included sexual violence survivors (*n*=14), intimate partner violence survivors (*n*=9), veterans (*n*=7), natural disaster survivors (*n*=2), terrorism survivors (*n*=1), and other (*n*=6). Roles of participants in their current work settings included clinical supervision (*n*=15), administration (*n*=10), teaching (*n*=6), research and/or evaluation (*n*=4), and other (*n*=4). A majority of participants (*n*=35) stated that they were currently providing trauma counseling. Four participants were not providing trauma counseling at the time of the current study.

Table 2

Years providing trauma counseling

Years	# of Participants
0-5 yrs.	8
5-10 yrs.	13
11-15 yr.	5
16-20 yrs.	10
21-25 yrs.	1
25 yrs. +	2

Participants were members of the following professional associations: American Counseling Association/Trauma Interest Network (*n*=10), National Board for Certified Clinical Hypnotherapists (*n*=7), EMDR International Association (*n*=9), International Association of Trauma Professionals (*n*=3), Association of Traumatic Stress Specialists (*n*=2), American Psychological Association/Division of Trauma Psychology (*n*=2), American Academy of Experts in Traumatic Stress (*n*=3), and other (*n*=3). All participants endorsed that they are currently certified trauma therapists in the following trauma certification organizations: EMDR International Association (*n*=10), American Academy of Experts in Traumatic Stress (*n*=3), National Board for Certified Clinical Hypnotherapists (*n*=7), Institute for Survivors of Sexual Violence (*n*=13), Board of Registered Nursing (*n*=1), and other (*n*=5).

Procedures

The primary researcher purposefully sampled a pool of experts among groups of nationally certified trauma counselors allowing for the inclusion of participants throughout the United States. Purposeful sampling strengthened this qualitative inquiry by including information-rich data less likely to be captured in a random selection process (Frey, 1994; Merriam, 1998). Participants were recruited from the following organizations: the American Counseling Association's Trauma Interest Network, International Society for Traumatic Stress

Studies, the Association of Traumatic Stress Specialists, EMDR International Association, and The American Academy of Experts in Traumatic Stress. In addition, published authors and graduate-level mental health faculty were invited to participate. Participants were also asked to forward the invitation to other trauma professionals. The rationale for including mental health professionals from a wide-variety of disciplines including social work, psychiatry, rehabilitation counseling and marriage and family counseling rather than limiting the participants to mental health counselors only was to allow for diverse perspectives surrounding the topic of trauma competency. Further justification for the inclusion of a broad range of trauma professionals serving traumatized individuals is the paucity trauma competency literature. Trauma competency as a construct does not currently exist nor does an operationalized definition for what it means to be trauma-competent as a mental health professional. Further, no measure exists in the trauma competency literature to quantify the term "trauma-competent counselor", therefore participants in this study self-identified as such based on their own constructions of the knowledge and skills inherent to the term.

The primary researcher emailed all prospective participants a structured interview questionnaire via Qualtrics, a confidential, electronic survey tool, as well as the Supervisee Levels Questionnaire-Revised (McNeill, Stoltenberg & Romans, 1992). Informed consent was collected from each prospective participant via Qualtrics. All questionnaires were collected prior to beginning the coding process.

After completing the on-line survey, participants were asked to provide their email addresses if they were interested in being contacted with follow-up questions regarding their responses. Seventeen participants provided their email addresses. The primary researcher followed-up with these seventeen participants via email asking for feedback about the categories

and subcategories that emerged from the data. Three participants responded and all concurred that the categories and subcategories captured in the analysis seemed to resonate with their understanding of the essential knowledge, skills and beliefs central to trauma-competent mental health practice.

Once the eligibility requirements listed above had been satisfied, participants were administered the Supervisee Levels Questionnaire (SLQ-R) via email to identify participants with advanced counseling skill (ie., levels 3 and 3i) since no measure of trauma competency currently exists. The Supervisee Levels Questionnaire-Revised (SLQ-R; McNeill, Stoltenberg, & Romans, 1992) is based on the Integrated Developmental Model (IDM; Stoltenberg, McNeill, & Delworth, 1998) and was used to quantify the construct, advanced counseling skill. The 3 and 3i (integrated) levels are indicators of advanced counseling skill and ability (McNeill, Stolenberg & Romans, 1992). Thirty-nine participant responses, those who scored in level 3 or 3i on the SLQ-R, were included in the data analysis.

In order to ascertain the number of participant responses to use in data analysis, we referenced Francis et al., (2010) who suggested that analysis continue until saturation is achieved rather than a predetermined sample size is reached. The number of participant responses used in the data analysis was determined according to a structured process (Francis et al., 2010) involving standards for specifying data saturation rather than the analysis of a fixed number of participant responses. This structured process continued throughout the analysis until the data reached saturation. According to Francis et al. (2010), data analysis begins with the identification of a predetermined quantity of participant responses to be coded then coding of additional data continues at specific intervals until no new codes emerge thereby reaching saturation. Prior to data collection, an initial analysis sample had been set at 20 and stopping criteria set at 5 (Francis

et al., 2010). Further, according to Schreier (2012), saturation is achieved when each subcategory is used at least once during the analysis. Therefore, in this study saturation was achieved when no new codes emerged (Francis et al., 2010) and each subcategory was represented at least once (Schreier, 2012) at response number 34. An additional five surveys were coded to ensure saturation and then coding was terminated after survey number 39.

Instruments

Supervisee Levels Questionnaire-Revised (McNeill, Stoltenberg & Romans, 1992). The SLQ-R is a 30 item inventory developed by Stoltenberg, Mc Neil, and Delworth (1998) based on the Integrated Developmental Model (IDM). The number of items per structure is: self and other awareness (12 items), motivation (8 items), and dependency-autonomy (10 items). For example, question 24 "I find I am able to understand my clients' view of the world, yet help them objectively evaluate alternatives." is a self-and-other awareness item. The response format is a 7-point Likert scale with never (1) and always (7) as polar response options. Cronbach alpha reliability coefficients were calculated and estimates were .83 for self and other awareness, .74 for motivation, and .64 for autonomy (McNeill et al., 1992). Construct validity tests indicated differences in subscale and total scores between the three groups: levels 1, 2, 3 and 3i (integrated). Further, significant correlation was found among the subscales, self and other awareness and dependency-autonomy, $r + .58$ $p < .001$, and motivation and dependency-autonomy, $r + .43$ $p < .001$.

Key precepts of the IDM are as follows: counselors will achieve diverse levels of competency across domains; client presenting concerns that are unique for therapists in training tend to elicit Level 1 responses; and therapists in training with greater experience with a specific client population are expected to demonstrate increased levels of counseling competency. Only

participants who score at a 3 or 3i (integrated) level equaling a minimum score of 142.5 on the SLQ-R were included in the study; confidence intervals of 95% will be determined on all levels of the SLQ-R (McNeill et al., 1992).

Data Sources

***Demographics and structured interview*.** Participants were asked to provide basic demographic information, current work setting, role in current work setting, years providing trauma counseling, population of survivors treated and respond to the following questions:

1. How do you define the term "trauma competency"?
2. What are some general guidelines you follow when working with trauma survivors?
3. What factors do you consider critical to trauma competency?
4. If you use different interventions with individuals who report a trauma history, what specific interventions do you use which you believe are unique to your work as a trauma therapist?
5. What are your beliefs about the process of trauma therapy and the counselor's role as a trauma therapist?

6. What should a competent trauma practitioner know? What knowledge should they have?
7. What should a competent trauma practitioner be able to do/demonstrate? What skills/ abilities should she have?
8. What attitudes should a competent trauma practitioner espouse?
9. Is there anything else that you think we should know about competent trauma practice that was not covered by the above questions?

Research team. Considering the limited literature available on trauma competency, questions one, two and three were designed to examine trauma competency as a construct since little is known about trauma counseling competency (Litz & Salters-Pedneault, 2008; Layne et al, 2014). Similarly, in questions four and five, we explored the advanced knowledge, intervention objectives and practice elements/behaviors of trauma-competent practice (Layne et al, 2014). In questions six through nine, we inquired about the knowledge, skills and attitudes inherent to competent trauma counselors as suggested by Sue et al., (1992). These questions were drawn from the counseling literature and developed collaboratively among all three researchers. The questions were developed with the intention of capturing the experiences of trauma therapists and to develop trauma competency as a measurable construct to support the training and professional development of trauma therapists.

The use of a coding team can assist in creating a richer set of codes and increase coding reliability (Saldana, 2009). Weston, Gandell, Beauchamp, McAlpine, Wiseman, and Beauchamp (2001) emphasized the importance of considering the structure of the research team and the influence each member brings to the study. Accordingly, the present study utilized a coding team comprised of three counselors, one of whom is the first author. All three researchers have clinical

experience with trauma survivors. All three researchers are doctoral students in a CACREP accredited counselor education program. One is dual-licensed as a professional counselor and a licensed mental health counselor and is a national certified counselor, one is a school counselor and one is a national certified counselor. The external auditor is a trauma therapist with over twenty years of experience providing trauma treatment. She is a licensed psychologist and professor of traumatology. The primary researcher is a certified trauma counselor with fifteen years of clinical experience with individuals surviving trauma. Two team members were female and one was male. Two self-identified as White and one as Montenegrian. The age of the coders was 44, 40 and 27 at the time of the study. Researchers placed particular emphasis on minimizing the power differential between researcher and participant while fostering authentic and connected researcher-participant relationships.

Ethical Considerations. An ethical concern for the researchers is whether or not this research adds value to the community of trauma therapists they studied. Throughout the research process, the research team was mindful to contribute equally and provide opportunities for the participants to engage in the research process. The researchers assume that when therapists' experiences serving those who have recovered from trauma are valued rather than subjugated by researchers, these experiences can contribute to the literature and inform standards of care. The researchers also posit that the healing experiences of agency and inclusion are the antithesis of the disempowering and violating traumatic experiences trauma therapists' witness, therefore the research benefits these therapists as well as the researchers. The researchers share the position that involving trauma therapists in research broadens their potentials while raising the standards of mental health care. Researchers placed particular emphasis on minimizing the power differential between researcher and participant while fostering connected researcher-participant

relationships. Finally, this research was approved by the IRB at Georgia State University prior to data collection. Participants received an IRB approved informed consent and were invited to participate in member-checking by providing their email addresses for follow-up questions and/or clarification. Participants will also receive a final copy of the manuscript for their review prior to publication.

Data Analysis

SLQ-R. A total of 45 certified trauma counselors participated in this study. However, six participants did not meet criteria for inclusion therefore their responses were not used in data analysis. The range of SLQ-R scores for the remaining 39 responses was 145 to 183, with a mean score of 175.6 and a standard deviation of 9.39 (Table 3). Cronbach's alpha for the 39 SLQ-R items was .671 (Table 4).

Table 3

Scale Statistics for SLQ-R Responses

Mean	Variance	Std. Deviation	N of Items
175.6000	87.045	9.39072	39

Table 4

Cronbach's Alpha for SLQ-R Responses

Cronbach's Alpha	N of Items
.671	39

Qualitative content analysis. This study addressed gaps in the current literature by using Qualitative Content Analysis (Schreier, 2012) to examine the experiences of trauma-competent practitioners. The authors developed core trauma concepts which include intervention objectives and practice elements (Layne et al, 2014) based on the derived categories and subcategories emerging from the data. Qualitative content analysis is an inductive qualitative method especially useful for summarizing key codes and concepts and recommended when the research question is descriptive in nature (e.g., what is a certain group of people saying about a given topic?) (Schreier, 2012). This interpretive method of qualitative analysis is recommended when a formal theory about a research category is unavailable or the current knowledge base is lacking (Hsieh & Shannon, 2005). Therefore, the primary goal of qualitative content analysis is to "systemically describe the meaning of your material" (Scheier, 2012, p. 3) thereby reducing data and only focusing on select aspects. Qualitative content analysis recommends that “the main categories of your coding frame are the aspects on which you want to focus your analysis organized within a coding frame which structures relevant meanings concerning specific aspects of the data (Schreier, 2012, p. 59).

Data analysis in this study followed guidelines for qualitative content analysis as illustrated by Scheier (2012). The present study involved coding of latent content which is a salient characteristic of qualitative content analysis (Schreier, 2012). This process of qualitative content analysis can be described as a means of deriving categories and subcategories from symbolic material that requires interpretation (Elo & Kyngas, 2008).

The process of qualitative content analysis began with independent coding of the first completed questionnaire by all three members of the research team. Next, the research team convened to compare their codes and discuss the initial coding frame (Scheier, 2012). This

coding frame is data-driven such that the categories and subcategories emerged from the data rather than from pre-existing theory (Scheier, 2012). At the time of development of the initial coding frame, preliminary categories, subcategories, definitions and examples were established and organized according to hierarchical levels within the coding frame. Data set number one was then recoded with the initial coding frame to ensure its accuracy, and a second set of data was subjected to an initial test of the coding frame. This is referred to by Scheier (2012) as the pilot phase which involves three stages: the trial coding, consistency check, and adjustment of the coding frame. The coding team met again during this pilot phase to revise the coding frame and become familiar with each category and subcategory. This research meeting following trial coding created a consensus understanding of the coding frame and eliminated overlap between categories. Next, during the main analysis phase, subsequent data sets two through thirty-six were coded independently by two research team members using the coding frame and verified by a third research team member. During this phase, the main analysis phase, comparing codes serves two purposes. First, summary measures improve the quality of the coding frame. Second, "you have to compare in order to identify units that were coded differently" (Scheier, 2012, p. 203). When there was disagreement about the code, dialogue continued until agreement was reached amongst all three researchers. This verification process involved three, two hour research team meetings to insure that coding accurately represented the operationalized definitions set forth in the coding frame and agreed upon by team members. The coding frame was then updated to reflect emerging codes from the remaining surveys. Finally, all thirty-nine surveys were recoded with the final coding frame.

The coding team then convened for a final meeting to review the final coding frame and code book to determine if any categories or subcategories should be condensed. It was

determined during this meeting that the categories *beliefs* and *attitudes*, once separate categories, should be condensed into one category entitled *attitude and beliefs*. Team members also agreed that the subcategories *contextual/systemic factors* should be located under the *knowledge* category rather than under the *attitude and belief* category as discussed earlier in the research process. Members also concurred that the definition for the subcategory *non–judgment* should be extended to include the idea expressed by participants that a neutral attitude is also required of trauma-competent clinicians in order to avoid overreacting to the client's trauma narrative. Several participants emphasized the idea that not reacting with surprise or disgust to the trauma narrative is critical to trauma competency in addition to maintaining a nonjudgmental attitude. Research team members also concurred that the subcategory *demonstrate professional competence* should be moved from the *attitudes and beliefs* category to the *skill* category. Next, members agreed that the subcategory *collaborative,* previously located under the *beliefs and attitude* category, should be renamed *establish collaborative therapeutic alliance* and located under the *skill* category. The team agreed that collaboration with clients is an activity engaged in by trauma-competent counselors rather than a belief or attitude held by trauma-competent counselors. All research team members unanimously agreed that the subcategory *competence* should be renamed *develop professional competence* and relocated from the *belief and attitude* category to the *skill* category since maintaining professional competency is a behavioral skill rather than an attitude endorsed by trauma-competent counselors. Also, the subcategory *strengths-based and positive*, originally considered a subcategory under *beliefs and skills*, was renamed *demonstrate a strengths-based approach with affirmative language* and relocated under the *skill* category. Once again it was determined by team members that a strengths-based approach is demonstrated through the use of affirmative language rather than a belief or attitude

held by trauma-competent counselors. The exact language used by participants was reviewed carefully as consensus was established among research team members.

During the final meeting the research team also discussed interpretation of the results. Implications for training and practice were discussed at length since feminist researchers operate from the perspective that research should involve advocacy and create social change. Specifically, the team discussed highlighting the recommendation that trauma competent skills are built on a firm foundation of client-centered counseling skills and that the development of the therapeutic relationship is critical to the process of trauma counseling. A final topic of discussion by the team involved the recommendation that the subcategories that occurred in the data with the greatest frequency, *maintain client safety* under skill (51), *neurobiology of trauma* (43) under knowledge and *reprocess traumatic memory* under skill (40) should be highlighted when discussing implications for clinical practice in order to represent the voices of the participants. Lastly, in this meeting the team echoed participants in this study in their agreement that trauma-competent clinicians' prioritize client safety by using least invasive methods of reprocessing emotional/traumatic memory during trauma therapy therefore they agreed to incorporate this perspective in the discussion section as well.

Coding and analysis procedures in this study were designed to minimize researcher bias since the primary researcher employs a feminist epistemology thereby privileging equalitarian relationship and an ethic of care (Gilligan, 1982). Throughout the coding process consensus was reached by providing equal time for each coding team member to state his or her position after which the verifying team member verbally demonstrated his or her understanding of coding team members' perspectives prior to verifying the final coding frame. Consensus was determined when agreement was reached amongst all three researchers.

Trustworthiness. Trustworthiness was intentional in the design in the current study. One such aspect of the research design was the double coding process, an ongoing coding frame developed and continually revised by the coding team. "In qualitative content analysis, reliability by double-coding is the most important quality criterion" (Schreier, 2012, p. 16). Also, the final coding frame and analysis was externally audited which involved auditor review of categories and subcategories for "unidimensionality" and "mutual exclusivity." According to Scheier (2012), unidimensionality implies that each category and subcategory summarize one facet of the data. Secondly, mutual exclusivity means that each category and subcategory should reflect ideas that are separate from the others without overlap (Scheier, 2012). Consistent with the process of inductive qualitative content analysis, this analysis was compared to relevant literature (Scheier, 2012) and divergence from the literature was highlighted and reassessed. Despite the low number of participant endorsement in some subcategories, these researchers, including the external auditor, unanimously decided to include them in the final coding frame since these subcategories resonated with existing literature. Several other measures were also taken to increase the trustworthiness of this study. Reflexivity in data interpretation was accomplished through a research journal continually updated by the researcher; the research journal functions as a means of documentation and reflection including interpretation of data and personal reactions throughout the research process (Creswell, 2007).

Results

Qualitative content analysis of the data yielded three categories and thirty-three supporting subcategories (Table 4). These categories and subcategories were not exclusive. A single participant response may include multiple statements that were coded into different categories or subcategories (Table 4). The number of times that a subcategory was coded

(frequency count) will be presented along with the number of participants who endorsed each subcategory (Table 5) indicated by participant identification number (ID).

Table 4

Categories, Subcategories, Frequency Counts, and Definitions

Category	Subcategory/Frequency	Definitions
Attitude and Beliefs	Respect (*f*=14)	Participants state that trauma-competent counselors demonstrate respect for clients as experts of their own unique experience and individualized treatment needs.
	Acceptance (*f*=8)	Participants state that trauma-competent counselors demonstrate acceptance of the survivor and her experience.
	Non-judgment (*f*=17)	Participants state that trauma-competent counselors demonstrate a non-judgmental and neutral attitude.

	Openness to new knowledge and experience (*f*=30)	Participants state that trauma-competent counselors are open to broadening their knowledge and clinical experience and therefore maintain active involvement in professional development and consultation.
	Confidence (*f*=32)	Participants state that trauma-competent counselors demonstrate confidence in their clients' ability to recover from the effects of trauma.
	Clients are in control (*f*=14)	Participants state that trauma-competent counselors demonstrate that the survivor is in control of his/her recovery experience.

	Self-care is a priority (*f*=15)	Participants state that trauma-competent counselors are aware that counselor well-being is critical and focus on maintaining their own psychological health by prioritizing self-care.
Knowledge	Demonstrate foundational trauma knowledge including prevalence, trauma theory, and principles of trauma-informed-care. (*f*=29)	Participants state that trauma-competent counselors demonstrate knowledge about common elements of evidence-based interventions, core trauma concepts and trauma-competent practice.
	Current trauma literature (*f*=6)	Participants state that trauma-competent counselors demonstrate an understanding of current trauma literature and evidence-based practice.

	Contextual/Systemic factors (*f*=6)	Participants state that trauma-competent counselors demonstrate an understanding of contextual and systemic factors.
	Neurobiology of trauma (*f*=43)	Participants state that trauma-competent counselors demonstrate an understanding of the neurobiology of trauma and how the brain processes traumatic experience.
	Effects of trauma on functioning (*f*=18)	Participants state that trauma-competent counselors demonstrate an understanding of the effects of trauma on individual domains of functioning (cognitive, emotional, physical, spiritual, relational and identity).

	Trauma symptomology varies (*f*=8)	Participants state that trauma-competent counselors demonstrate an understanding that trauma symptoms vary and are adaptations for survival.
	Practice within limits of clinical competency (*f*=6)	Participants state that since trauma-competent counselors are responsible for providing effective treatment, they must know the limits of their clinical competence and seek clinical supervision or appropriate referral when necessary.
Skill	Demonstrate professional competence (*f*=5)	Participants state that trauma-competent counselors are trauma-informed and demonstrate professional competence in core trauma knowledge and trauma-focused intervention and treatment.

	Demonstrate a strengths-based approach with affirmative language (*f*=25)	Participants state that trauma-competent counselors empower the survivor through affirming language and interventions that emphasize her strength and positive attributes.
	Demonstrate lightness and humor (*f*=5)	Participants state that trauma-competent counselors demonstrate lightness and humor where appropriate without minimizing the client's trauma experience.
	Establish collaborative therapeutic alliance (*f*=33)	Participants state that trauma-competent counselors establish a collaborative therapeutic alliance and mutually agreed upon treatment goals.

	Develop therapeutic relationship (*f*=13)	Participants state that trauma-competent counselors are aware of the importance of the therapeutic relationship to trauma work and demonstrate skill in developing this critical relationship.
	Demonstrate trauma-focused clinical skills (*f*=13)	Participants state that trauma-competent counselors demonstrate trauma-focused clinical skills and evidence-based interventions.
	Demonstrate client-centered counseling skills (*f*=21)	Participants state that trauma-competent counselors demonstrate client-centered counseling skills.
	Demonstrate assessment skills (*f*=10)	Participants state that trauma-competent counselors demonstrate competency in clinical assessment and complete assessment prior to reprocessing emotional memory.

	Demonstrate diagnostic skills (*f*=7)	Participants state that trauma-competent counselors demonstrate competency in the diagnosis of posttraumatic stress as well as provide differential diagnoses.
	Demonstrate intentionality (*f*=39)	Participants state that trauma-competent counselors demonstrate intentionality by guiding clients toward mutually agreed upon treatment goals.
	Provide psychoeducation about the neurobiology of trauma and trauma treatment. (*f*=27)	Participants state that trauma-competent counselors provide psychoeducation about the neurobiology of trauma and trauma treatment to normalize client experience.
	Address traumatic beliefs (*f*=10)	Participants state that trauma-competent counselors address traumatic beliefs and negative meanings attached to self, other and the world.

	Teach coping and emotional regulation strategies (*f*=14)	Participants state that trauma-competent counselors teach coping and emotional regulation strategies for managing trauma related symptoms.
	Reprocess traumatic memory (*f*=40)	Participants state that trauma-competent counselors demonstrate competency in reprocessing traumatic memory and developing a coherent trauma narrative.
	Keep client emotionally present (*f*=28)	Participants state that trauma-competent counselors are able to maintain connection by keeping the client emotionally present while reprocessing traumatic memory.

	Therapist remains emotionally present (*f*=18)	Participants state that trauma-competent counselors are able to maintain connection with the client by remaining emotionally present while reprocessing traumatic memory.
	Maintain client safety (*f*=51)	Participants state that trauma-competent counselors do no harm by using minimally invasive interventions while maintaining physical and emotional safety.
	Facilitate reconnection (*f*=7)	Participants state that trauma-competent counselors facilitate reconnection to others including teaching relational and communication skills.

Table 5

Response Exclusiveness and Inclusiveness

Category/Number of participants	Subcategories	Participant ID
Attitude and Beliefs (*n*=33)	Respect	102, 106, 117, 121, 129, 135, 138, 141
	Acceptance	104, 105, 129, 130, 132, 133, 135, 138
	Non-judgment	103, 105, 115, 116, 126, 130, 133, 136, 138, 139, 143
	Openness to new knowledge and experience	101, 103, 104, 105, 106, 116, 118, 119, 122, 123, 128, 130, 131, 135, 137, 138, 139, 141, 143
	Confidence	101, 105, 106, 112, 116, 117, 118, 120, 121, 122, 123, 126, 130, 134, 138, 140, 141, 142
	Clients are in control	115, 122, 130, 133, 135, 137, 138, 142
	Self-care is a priority	102, 105, 115, 121, 130, 132, 133, 134, 138, 139, 140, 142
Knowledge (*n*=38)	Demonstrate foundational trauma knowledge including prevalence, trauma theory, and principles of trauma-informed care	102, 105, 106, 111, 118, 119, 120, 123, 127, 128, 129, 130

	Demonstrate foundational knowledge about trauma-competent clinical skills	101, 102, 103, 104, 105, 106, 112, 115, 116, 119, 122, 124, 129, 131, 137, 138, 142, 143
	Current trauma literature	103, 130, 131, 34, 139
	Contextual/Systemic factors	101, 102, 110, 121, 138, 142
	Neurobiology of trauma	101, 102, 103, 104, 106, 107, 111, 115, 117, 119, 120, 123, 125, 126, 127, 129, 131, 133, 134, 136, 140, 142
	Effects of trauma on functioning	102, 104, 106, 115, 117, 122, 129, 133, 135, 142
	Trauma symptomology varies	102, 129, 130, 135, 137
	Practice within limits of clinical competency	105, 117, 124, 126, 134
Skill (*n*=39)	Demonstrate professional competence	101, 112, 123, 130
	Demonstrate a strengths-based approach with affirmative language	112, 115, 117, 120, 121, 123, 125, 130, 134, 136, 138, 141, 142
	Demonstrate lightness and humor	119, 125, 126, 134, 141

	Establish collaborative therapeutic alliance	101, 103, 106, 115, 116, 117, 119, 120, 121, 122, 123, 125, 127, 131, 133, 134, 138, 140, 141
	Develop therapeutic relationship	101, 102, 103, 105, 116, 123, 128, 138, 140
	Demonstrate trauma-focused clinical skills	112, 115, 120, 124, 125, 126, 135, 139, 141, 142
	Demonstrate client-centered counseling skills	112, 115, 116, 121, 122, 132, 133, 135, 136, 137, 138, 139, 142
	Demonstrate assessment skills	103, 105, 116, 118, 121, 128, 139
	Demonstrate diagnostic skills	106, 111, 118, 122, 133, 135, 142
	Demonstrate intentionality	101, 104, 105, 106, 112, 116, 117, 119, 120, 121, 123, 125, 126, 131, 137, 140, 141, 142, 143
	Provide psychoeducation about the neurobiology of trauma and trauma treatment	102, 104, 106, 112, 115, 119, 120, 121, 122, 127, 130, 132, 133, 134, 139, 140
	Address traumatic beliefs	101, 104, 122, 130, 133, 140, 141, 142
	Teach coping and emotional regulation strategies	102, 104, 105, 116, 120, 122, 137, 139, 140, 142

	Reprocess traumatic memory	101, 103, 104, 105, 106, 110, 112, 115, 118, 119, 120, 122, 125, 126, 131, 133, 134, 136, 137, 139, 140, 141, 143
	Keep client emotionally present	103, 107, 115, 117, 118, 120, 121, 122, 123, 124, 125, 126, 127, 133, 134, 136, 141, 143
	Therapist remains emotionally present	101, 107, 118, 119, 120, 125, 130, 131, 132, 133, 134, 141, 143
	Maintain client safety	101, 103, 104, 105, 106, 112, 117, 118, 119, 120, 121, 122, 124, 125, 126, 128, 129, 132, 136, 137, 138, 139, 141, 142, 143
	Facilitate reconnection	101, 115, 117, 118, 122, 137

Attitudes and Beliefs

The first category *attitudes and beliefs* (frequency=130/*n*=33) includes codes that speak to participants' ideas regarding the attitudes, beliefs and trauma-specific values held by trauma-competent counselors and contains seven subcategories. The following is an excerpt from participant narratives demonstrating these attitudes and beliefs endorsed by trauma-competent counselors:

> Trauma competency is when one has the ability to address the needs of the client that has been traumatized with respect, connection and an ability to help them resolve the trauma without reliving it. Create safety and connection with respect and compassion. Listening

to the trauma narrative without judgment or overreacting is critical to trauma competency.

The category *attitudes and beliefs* includes the subcategories *respect, acceptance, non-judgment, openness to new knowledge and experience***,** *confidence, clients are in control and self-care is a priority.* The first subcategory *respect* (*n*=8; frequency=14) is defined as participants state that trauma-competent counselors demonstrate respect for clients as experts of their own unique experience and individualized treatment needs. Examples of this subcategory include "Survivor as expert on their own adaptations and experiences." "Don't make assumptions about how the trauma has affected the client." "Respect for the varied experiences of survivors." "Modulate the therapy to fit client's needs." "Survivors are the experts and know best how to heal themselves." "I believe the client is the best authority on knowing what he/she needs and that the trauma work should be very interactive and highly personalized for each individual's situation." "Recognizing that only survivors truly know what is right and healing for themselves." "Trauma competency is when one has the ability to address the needs of the client that has been traumatized with respect, connection and an ability to help them resolve the trauma without reliving it." "Create safety and connection with respect and compassion." Some participants expressed ideas relevant to this category more than once.

Coding within the subcategory *acceptance* (*n*=8; frequency=8) required that participants state that trauma-competent counselors demonstrate acceptance of the survivor and her experience. Examples of relevant codes include "Willingness to extend humanity and acceptance to someone who feels outcast or shunned." "Demonstrate acceptance of the client's experience of the trauma." "Even if the memory/trauma sounds bizarre to us, what matters is that the client was affected by it, and that's ALL that matters. Searching out facts to see if it really happened is

not useful, and can make the client feel like you don't believe them thereby adding to the trauma." "Willingness to go off road to support client's exploration and understanding of his experiences." "The counselor needs to be ready to explore off-map with the client to understand and witness their experience." "Be where the patient is, not where you are." "Acceptance of the client's experience. Meet clients where they are." "Calm acceptance of where the client is."

The third subcategory *non-judgment* (*n*=11; frequency=17) is defined as participants state that that trauma-competent counselors demonstrate a non-judgmental and neutral attitude. Examples of this subcategory include "Ability to listen and hear without judgment and 'pity' but rather emphasizing the positive aspects of surviving the experience and moving on with life." "Broad, expansive view of life and the world. So big that there is no room for judgmental thinking." "Maintaining a neutral but empathetic stance, rather than reinforcing how horrible the trauma was." "Being able to hear stories without surprise or disgust." "An extensive awareness of how impactful his /her reaction to the client's trauma experience can be." "The ability to sit with the client, without judgment or over-reacting, as they tell their story." Therapist needs to be able to bear witness to the client's trauma without adding to it." "Be able to keep one's own feelings about the trauma out of the treatment room. I've had clients tell me they were afraid to talk about their trauma for fear it would then traumatize the listener. They had been trying to protect the previous therapist." Some participants expressed ideas relevant to this category more than once.

The fourth subcategory *openness to new knowledge and experience* is the second largest subcategory in this category (*n*=11; frequency=30) and is defined as participants state that trauma-competent counselors are open to broadening their knowledge and clinical experience and therefore maintain active involvement in professional development and consultation.

Examples of this subcategory include “It requires a personal dedication to reach out to academic professionals to gain as much knowledge as possible.” “Continued education towards mastery of skills.” “Eager to learn and improve one's skills.” “Continual training and practicing, learning.” “Training and supervised experience with competent providers who are getting consistent results.” “Good clinical supervision while learning to treat trauma.” “Continuing training/education, consulting with peers/mentors.” “Obtaining ongoing training to treat the traumatized population. Fine-tuned with ongoing education and support.” “Ongoing specialized training is important.” Some participants expressed ideas relevant to this category more than once.

Coding within the subcategory *confidence* (*n*=18; frequency=32), the largest subcategory in this category, required that participants state that trauma-competent counselors demonstrate confidence in their clients’ ability to recover from the effects of trauma. Examples of relevant codes include “Demonstrate absolute confidence, backed by competency, that the client will recover.” “Therapist needs to convey absolute confidence that the client can heal from the trauma.” “Confidence, a calm that can be like a beacon to the client.” “Stuff happens to people and in trauma therapy you happen to people by creating experiences of resolution, engagement, and hope.” “Maintaining confidence that they will be able to heal from the trauma and imparting that confidence to the client.” “Belief in ability to survive overcome and thrive after trauma.” “The therapist's own belief that a person can really heal from trauma.” “Remember they have made it this far in their life therefore making it to counseling with a trauma specialist is a step towards a healthier life.” “For one, I think it's helpful to know that, yes, people can survive, overcome, and thrive after a traumatic event.” “We need to communicate our confidence that they can recover from the effects of the trauma, feel better about themselves, and no longer have

to define themselves by their trauma." "Believe that their brain will heal; this belief is contagious."

The sixth subcategory *clients are in control* (*n*=8; frequency=14) is defined as Participants state that trauma-competent counselors demonstrate that the survivor is in control of his/her recovery experience. Examples of this subcategory include "Process must be client directed." "Defer power and control to the client." "Letting the client know that they are in control at all times." "Allow them to maintain control during treatment in terms of duration, the ability to stop treatment during a session, disclosing only so much as they are comfortable with." "Asking before making any physical contact." "Provide them with as much power and control in the counseling relationship as I can helping them to understand the boundaries and their ability to engage/disengage at will."

The seventh and final subcategory *self-care is a priority* (*n*=12; frequency=15) is defined as participants state that trauma-competent counselors are aware that counselor well-being is critical and focus on maintaining their own psychological health by prioritizing self-care. Examples of this subcategory include "The stability and well-being of the therapist is critical to trauma competency." "And, last but possibly most important for a clinical professional to have sought treatment for any traumas they have been through so they can stay present and healthy themselves while working with their clients." "Have one's own traumas resolved so they don't leak out in the therapy room." "Being clear enough yourself to not get immersed in the difficulties of the client." "SELF CARE for the therapist and minimizing vicarious trauma and burnout." "It is essential that in order to provide excellent care for trauma clients that the clinician engage in consistent self-care (as well as supervision, consultation, and/or therapy for

themselves when necessary) to avoid vicarious trauma reactions and burn out as a therapist in general."

Knowledge

The category *knowledge* (frequency=140/ *n*=38) describes the trauma-focused knowledge and core trauma concepts essential to the trauma-competent counselor and is composed of eight subcategories. An excerpt below demonstrates this trauma-specific knowledge:

> The competent practitioner should know what occurs in the brain and body with trauma, some basic neurophysiology. Knowing the physiological and psychological effects of trauma and how it can affect the responses and behaviors of individuals. Knowing the basic framework of recovery and techniques of treatment as well as what current research finds on trauma treatment techniques. Understanding the effects of various overlapping layers of oppression on survival of traumatic events.

Subcategories include *demonstrate foundational trauma knowledge including prevalence, trauma theory, and principles of trauma-informed-care*, *demonstrate foundational knowledge about trauma-competent clinical skills, current trauma literature, contextual/systemic factors, neurobiology of trauma, effects of trauma on functioning, trauma symptomology varies, and practice within limits of clinical competency.*

The subcategory *demonstrate foundational trauma knowledge including prevalence, trauma theory* (*n*=20; frequency=29) is defined as participants state that trauma-competent counselors demonstrate knowledge about common elements of evidence-based interventions, core trauma concepts and trauma-competent practice. This subcategory includes statements such as "A professional who has been competently trained to work with clients presenting with trauma issues and/or provide these clients with trauma-informed care." "Using Herman's 3 stages of

trauma recovery as a guide conceptually and clinically." "Use of some of Briere's ideas/techniques in treating trauma. Overall, helping the client communicate a more coherent narrative on their trauma as therapy progresses." "Judith Herman's model for phases of trauma therapy 1. Safety, 2. Exploring the abyss, 3. Making new meaning of the experience." "Understanding what defines trauma and the 3-stage model of effective trauma treatment." "An overarching understanding of the 3 stages of trauma recovery." "Formal training in the treatment of trauma."

The subcategory*, demonstrate foundational knowledge about trauma-competent clinical skills* (*n*=18; frequency=24) is similar, but speaks more generally to the knowledge about trauma-focused intervention and treatment. The definition for this subcategory is participants state that trauma-competent counselors demonstrate knowledge about common elements of trauma-focused intervention and treatment. Examples include "I have found that knowing the theory behind what is being done has allowed me to adapt and individualize the techniques." "Knowing relevant appropriate interventions for use with survivors of traumatic events." "Specialized training in treating trauma." "Knowing the basic framework of recovery and techniques of treatment as well as what current research finds on trauma treatment techniques."

The third subcategory *current trauma literature* (*n*=5; frequency=6) is defined as participants state that trauma-competent counselors demonstrate an understanding of current trauma literature and evidence-based practice. Examples of this subcategory include "An understanding of best practices/empirically validated theories and interventions." "They should also be informed about the most effective evidenced base practices when working with a trauma client." "Understanding of the research related to effects of trauma." "Staying up to date on

current research on trauma treatment." "I try to keep as up to date as possible on the research on trauma and its effects on the human mind and emotions."

The fourth subcategory *contextual/systemic factors* (*n*=11; frequency=30) is defined as participants state that trauma-competent counselors demonstrate an understanding of contextual and systemic factors. Examples of this subcategory include "The context of where and how they live is important to me." "Multicultural issues that need to be considered when treating trauma." "Be familiar with the definition(s) of trauma and cultural differences in how trauma might be defined and experienced." "Multicultural competence might sound cliché, yet I find that it is crucial when working with my clients." "Understanding their world helps me grasp how the traumatic event was coded and how it colors their life." "Understanding the effects of various overlapping layers of oppression on survival of traumatic events."

Coding within the subcategory *neurobiology of trauma* (*n*=22; frequency=43), the largest subcategory in this category, required that participants state that trauma-competent counselors demonstrate an understanding of the neurobiology of trauma and how the brain processes traumatic experience. Examples of relevant codes include "I believe it is the responsibility of the clinician to understand the nature of trauma from a neuropsychological perspective." "Keep learning about how the brain works as new information is available." "Current information on how trauma effects different parts of the brain and behavior through neuroscience and neuropsychology." "So much new is emerging on how the brain works and the neuroplasticity. It is exciting to know the scientific work that shows the brain can change." "The competent practitioner should know what occurs in the brain and body with trauma, some basic neurophysiology." "Knowledge of how trauma affects the brain, most specifically the memory."

The sixth subcategory *effects of trauma on functioning* (*n*=10; frequency=18) is defined as participants state that trauma-competent counselors demonstrate an understanding of the effects of trauma on individual domains of functioning (cognitive, emotional, physical, spiritual, relational and identity). Examples include “Trauma competency includes having a general framework for how trauma occurs, its overt and covert manifestations, and a sensibility to its impact on the person's life.” “Be mindful of the multiple ways that trauma may have affected this client’s life, vocational, physical, and mental well-being.” “Knowing the physiological and psychological effects of trauma and how it can affect the responses and behaviors of individuals.” “Understanding the nature of trauma from the standpoint of how it effects the person mentally, emotionally and physically and knowing how to treat it effectively.”

The seventh subcategory *trauma symptomology varies* (*n*=5; frequency=8) is defined as participants state that trauma-competent counselors demonstrate an understanding that trauma symptoms vary and are adaptations for survival. Examples of this subcategory include “I am conscious of the varied ways people can present after experiencing trauma.” “Understanding of psychological symptoms as adaptations to traumatic experiences.” “Everyone doesn't respond to trauma the same way. There are various trauma responses.” “Knowledge regarding typical and atypical reactions to trauma.”

The eighth and final subcategory *practice within limits of clinical competency* (*n*=5; frequency=6) is defined as participants state that since trauma-competent counselors are responsible for providing effective treatment, they must know the limits of their clinical competence and seek clinical supervision or appropriate referral when necessary. Examples of this subcategory include “Knowing one's limitations and collegially collaborating with other professionals.” “To know what the trauma practitioner's strengths and limitations are when

working with a client." "Acceptance of one's limitations." "Know when to refer." "Counselor responsible for providing effective treatment."

Skills

Contributing factors to practice elements inherent to trauma-focused intervention and treatment emerged in the *skills* category (frequency=366/ *n*=39). This category is the largest with eighteen subcategories and involves the trauma-focused skills and interventions utilized by trauma-competent counselors as demonstrated by the participant below:

> I have found that my ability to stay present with my clients while they tell their stories of trauma has made major strides with clients feeling safe to work with me as well as helping them get healthier. Being able to explain the science behind why they are having the emotional and physical reactions they have had since the traumatic event(s) has made a world of difference for them as well. Another skill/ability that I have found helpful is being able to help my clients stay emotionally present during their session(s).

The subcategories are *demonstrate professional competence, demonstrate a strengths-based approach with affirmative language, demonstrate lightness and humor, establish collaborative therapeutic alliance, develop therapeutic relationship, demonstrate trauma-focused clinical skills, demonstrate client-centered counseling skills, demonstrate assessment skills, demonstrate diagnostic skills, demonstrate intentionality, provide psychoeducation about the neurobiology of trauma and trauma treatment, address traumatic beliefs*, *teach coping and emotional regulation strategies, reprocess traumatic memory, keep client emotionally present, therapist remains emotionally present, maintain client safety,* and *facilitate reconnection.*

The subcategory *demonstrate professional competence* (*n*=4; frequency=5) is defined as participants state that trauma-competent counselors are trauma-informed and demonstrate

professional competence in core trauma knowledge and trauma-focused intervention and treatment. Responses include, for example, “Demonstrates professionalism and competency in knowledge and skills.” “Knowledgeable, understanding, an ability to connect with a client while still remaining professional.” “To assume a student's role with the client yet also communicate humbly counselor's training, experience, and knowledge of trauma and its implications” “I make sure to comment on the fact that I know what to do to reassure them of my intentions and competence.” “They should be able to reference clients whom they have been successful with whereby the client is able to discuss the traumatic event or look back on it with neutral affect.” “Demonstrate mastery of a proven trauma treatment.” “Display competency and professionalism.”

The definition for *demonstrate a strengths-based approach with affirmative language* (*n*=13; frequency=25) is participants state that trauma-competent counselors empower the survivor through affirming language and interventions that emphasize her strength and positive attributes. Examples include “Convey belief that the most difficult part was already done by client by surviving the trauma.” “Uplifting the client to understand their own feelings, biologically with anxiety, anger and trauma symptoms and empowering them that they're inner strength is stronger than their symptoms.” “How to take whatever the client brings to the situation as a valuable resource in helping the client move forward.” “As soon as possible compliment or find something positive to attribute to the client/situation.” “Help them accept the positive side of trauma in that they survived it.” “Reframing the trauma by naming the clients strengths and coping skills.” “Finding ways to use the client's worldview in positive, affirming ways.” “Ability to listen and hear without judgment or pity but rather emphasizing the positive aspects of surviving the experience and moving on with life.” “I also use a strength based,

positive psychology approach. Most of my clients are asked to compile a list of their strengths that we apply in new ways while working through the trauma." "Being committed to helping survivors regain a sense of personal power." "Use affirmative language."

Responses coded into *demonstrate lightness and humor* (*n*=5; frequency=5) included those in which participants state that trauma-competent counselors demonstrate lightness and humor where appropriate without minimizing the client's trauma experience. Examples include "Create an experience that counters the original trauma experience." "Laughter and lightness in the session." "Use humor and playfulness. "Use humor where appropriate." "Have a sense of humor."

The fourth subcategory under *skill* is *establish collaborative therapeutic alliance* (*n*=19; frequency=33) within which participants state that trauma-competent counselors establish a collaborative therapeutic alliance and mutually agreed upon treatment goals. Examples include "The client and the therapist are a team that works together for the benefit of the client." "Get a clear agreement on alleviating those effects, and explain the process in language that is understandable and helpful to the client." "Collaborating is critical." "Establish a reciprocal, supportive relationship with clients." "Focus agreed on by both clinician and client."

The subcategory *develop therapeutic relationship* (*n*=9; frequency=13) is defined as participants state that trauma-competent counselors are aware of the importance of the therapeutic relationship to trauma work and demonstrate skill in developing this critical relationship. Example codes are "Relationship between survivor and clinician is key to process of resolving symptoms and building the ability to relate with new schema." "Clinical relationship as a holding environment and one focus of the intervention." "Solid relationship and rapport are needed to provide safe environment for trauma processing." "Make sure I connect well first."

Coding within the subcategory *demonstrate trauma-focused clinical skills* (*n*=10; frequency=13) required that participants state that trauma-competent counselors demonstrate trauma-focused clinical skills and evidence-based interventions. Examples of relevant codes include "I believe that to be competent, it is important to use empirically validated, trauma-focused interventions to help the client move towards their desired state." "Possessing specific skills to assist clients overcome the residual pain of trauma."

The seventh subcategory *demonstrate client-centered counseling skills* (*n*=13; frequency=21) is defined as participants state that trauma-competent counselors demonstrate client-centered counseling skills. Examples of this subcategory include "The basic Rogerian principles are applicable unconditional positive regard, genuineness, and empathy." "Practitioner should be able to offer hope (regarding healing) to client, demonstrate understanding of client issues even when client does not hold hope." "Safety, warmth, genuineness, positive regard, empathy, and congruency." "It is critical to have a strong foundation of basic listening/counseling skills."

The eight subcategory is *demonstrate assessment skill* (*n*=8; frequency=10) and is defined as participants state that trauma-competent counselors demonstrate competency in clinical assessment/measurement completed prior to reprocessing emotional memory. Examples of this subcategory include "Having the knowledge and skills to assess and serve the specialized needs of clients with a history of traumatic or disturbing life events." "I assess for the capability of the client to benefit from treatment based on previous treatment history, level of functioning from a psychiatric perspective (e.g., presence of psychosis or BPD), substance abuse, etc." "They should be able to demonstrate (by valid and reliable measures) that their clients are displaying improvement in their trauma symptoms." "Trauma pre-test and post-test." "Assessment/re-

assessment of aspects of the trauma that client finds most distressful." "The trauma practitioner should also know how to gauge readiness for processing through the trauma." "Do not take them to the memory of traumatic incident until they are ready."

Coding within the subcategory *demonstrate diagnostic skills* (*n*=7; frequency=7), required that participants state that trauma-competent counselors demonstrate competency in the diagnosis of posttraumatic stress as well as provide differential diagnosis. Examples of relevant codes include "Understand the diagnostic criteria for PTSD vs. chronic distress perpetuated by developmental, attachment, and complex trauma." "Awareness of traumatic symptoms, their interaction with other disorders and daily interactions." "Look for interactions with other disorders or daily functioning." 'Promote shared understanding of what is going on with regard to symptoms." "Assess for depersonalization/derealization/dissociation." "An understanding that the world of trauma is far greater than the DSM's description alone."

The tenth subcategory *demonstrate intentionality* (*n*=19; frequency=39) is the third largest in the *skill* category and is defined as participants state that trauma-competent counselors demonstrate intentionality by guiding clients toward mutually agreed upon treatment goals. Examples of this subcategory include "I believe that if the client sees the therapist focusing on moving towards healing, the client feels a renewed sense of hope and trust that the movement can happen." "Be intentional. Set an intention and keep moving toward it." "Have a clear intention." "Ally by their side as they walk through the trauma but who also has enough of a sense of direction that can help the person find their way through it." "The counselor's role as a trauma therapist is to safely guide."

The tenth category *provide psychoeducation about the neurobiology of trauma and trauma treatment***.** (*n*=16; frequency=27) is defined as participants state that trauma-competent

counselors provide psychoeducation about the neurobiology of trauma and trauma treatment to normalize client experience. Examples of this subcategory include “Helping the client understand traumatic symptoms and why they are experiencing these symptoms.” “Psychoeducation about trauma and reactions to it are important so clients understand cognitively what is happening symptomatically and what they may expect as they continue in treatment.” “Providing psychoeducational and informational materials to client to normalize their experiences.” “I work toward normalizing their responses to the trauma as a normal response to an abnormal situation. Many survivors blame themselves for their actions or reactions.” “Normalize what they are experiencing.” “Normalizing reactions to trauma and trauma treatment.” “They should know how to convey this information to the client in order to demystify trauma and give the client an understanding of what has been occurring for them and why.” “Explaining the temporary reduction of their brain's ability to use their frontal lobe for logic and reasoning with active symptoms of trauma explaining trauma and their current symptoms of trauma with relations to memories being stuck in the amygdala.”

The subcategory *address traumatic beliefs* (*n*=8; frequency=10) is defined as participants state that trauma-competent counselors address traumatic beliefs and negative meanings attached to self, other and the world. Responses include, for example, “Another role that may be helpful is to help the client eliminate distorted meanings that are attached to the event/trauma.” “Trauma does not define them.” “It’s a problem with learning and memory not one’s identity, value, worth, morality or any other meaning.” “Curiosity about survivors’ experience of their sense of self.” “Eventually help client make meaning of the experience.” “Updating thoughts about self, other and the world.”

The definition for *teach coping and emotional regulation strategies* (*n*=10; frequency=14) is participants state that trauma-competent counselors teach coping and emotional regulation strategies for managing trauma related symptoms. Examples include "Skills geared towards containment of difficult emotions and experiences, helping survivors to regulate arousal. Grounding and resourcing techniques, mindfulness-based techniques." "Demonstrate experientially how to reach and run emotional brain." "Help clients practice affect modulation/emotional containment to help prepare them to process trauma." "Be trained in teaching grounding and other coping strategies." "Teach coping strategies for managing trauma related symptoms." "Teach coping strategies for on-going stress/anxious responses to life." "Develop a new pattern of coping skills."

Responses coded into the second largest subcategory, *reprocess traumatic memory* (*n*=23; frequency=40), included those in which participants state that trauma-competent counselors demonstrate competency in reprocessing traumatic memory and developing a coherent trauma narrative. Examples include "Memory reconsolidation through neuroplasticity." "Use of memory reconsolidation steps when reprocessing trauma material." "Process trauma." "Get them to be able to talk about the trauma experience without re-experiencing the emotions attached to the traumatic experience." "The provider should have a clear understanding of how to keep the person present and not reliving the event(s) and re-traumatizing them and actually know how to resolve the effect of the trauma(s)." "My goal is to wring the angst from the memory and turn it to useful information." "Follow the client's lead into connecting to the emotions bound to the trauma." "Developing a more coherent account of the trauma with better emotional regulation and decreased distress over time." "Different techniques to aid with memory reconsolidation."

The next subcategory under *skill* is *keep the client emotionally present* (*n*=18; frequency=28) within which participants state that trauma-competent counselors are able to maintain connection by keeping the client emotionally present while reprocessing traumatic memory." Examples include "I work to have the person relate the experience while remaining in the present and not re-experiencing the trauma emotions." "Keep the client grounded with what is going on in the room and in the connection with the therapist." "Keeping them present and in window of tolerance." "Keeping the survivor present with me in the here and now. Keep the client grounded and present."

Coding within the subcategory *therapist remains emotionally present* (*n*=13; frequency=18) required that participants state that trauma-competent counselors are able to maintain connection with the client by remaining emotionally present while reprocessing traumatic memory. Examples of relevant codes include "Peaceful awareness of the intended outcome as well as a mind firmly rooted in the knowledge that the traumatic event is finished." "While I am seeing a traumatized client in front of me, I am also seeing them cleared of the trauma." "The role of the therapist is to stay in the light and understand that it is not the stuff that happened, but rather the brain's continuing to be effected that requires therapeutic intervention." "To stay present and not get taken in by the story." "The therapist MUST stay emotionally present to the task at hand versus getting caught up in the client's history."

The subcategory *maintain client safety* (*n*=25; frequency=51) is the largest subcategory and is defined as participants state that trauma-competent counselors do no harm by using minimally invasive interventions while ensuring physical and emotional safety. Examples of this subcategory include "The counselor creates the container (safety, rapport, shared language) to encourage the client to explore and reconnect with the trauma." "The counselor's role is to

provide support, structure, emotional safety." "I believe that it is important to do everything possible to create a soothing, safety-enhancing experience because it is not easy for the clients to face and work through their trauma." "Use minimally invasive techniques to work through the issue." "Avoid re-experiencing the trauma." "First, do no harm." "The importance of protecting vulnerable populations, and ways to protect safety for the client so that the therapy process does not further harm or victimize the client." "Creating safety with respect and compassion." "It's my job to make a safe space in which to allow that healing to begin." "Competent also refers to knowing what not to do and at all times assessing the effect of interventions so as not to regress or make client worse." "Providing a safe space for the survivor to realize that the trauma is no longer happening." Maintain a safe space, ability to bring a client back from the abyss of trauma." "Create a space in which survivors feel safe to tell their stories."

The final subcategory is *facilitate reconnection* (*n*=6; frequency=7) and is defined as participants state that trauma-competent counselors facilitate reconnection to others including teaching relational and communication skills. Examples of this subcategory include "More thinking into how to get client transitioned into community involvement and other relationships besides with therapist." "Develop a new pattern of communication and relationship skills." "Teach relational skills." "Teach boundary-setting." "Teach assertiveness."

Discussion

What has emerged from these qualitative data are the essential attitudes, knowledge and skills of trauma-competent practitioners from a variety of disciplines including counseling, social work, marriage and family therapy, rehabilitative counseling, medicine and nursing. The emergent categories suggest that certain attitudes and beliefs inform competent trauma counseling supported by core trauma knowledge and trauma-focused practice elements. Further,

participant responses suggest that these trauma-competent attitudes, knowledge and skills rest on a solid foundation of client-centered counseling skills including common factors. Their responses articulate their competence as experienced trauma counselors along with their respect for and acceptance of survivors as experts of their own highly individualized trauma symptoms and experiences. These data also resonate with hallmark trauma-informed principles (Fallot, 2008; Harris & Fallot, 2001) in that participants endorsed a trauma-informed and strengths-based perspective which includes a belief in survivors' rights to be in full control of their unique recovery experiences, and awareness that trauma symptoms are adaptive attempts to cope and survive.

In many ways, the results of this study mirror the existing literature on trauma-specific mental health care (Cook & Newman, 2014; Fallot, 2008; Harris & Fallot, 2001) grounded in common factors contributing to positive therapeutic outcome (Defife & Hilsenroth, 2011; Messer & Wampold, 2002; Wampold, et al., 2010). The finding that trauma-competent counselors relate to trauma-related material with non-judgment, respect and a belief in recovery as opposed to pity and disdain is supported by the literature (Cook & Newman, 2014). Consistent with the New Haven cross-cutting trauma-focused competencies (Cook & Newman, 2014), the participants in this study stated that trauma-competent counselors establish a collaborative therapeutic alliance and mutually agreed upon goals. Collaborative goal formation is also identified in the common factors literature as a necessary component in effective clinical outcomes across treatment modalities (Defife & Hilsenroth, 2011). According to Defife and Hilsenroth (2011), therapists should be confident when discussing their credibility and treatment experience. Participants mirrored this idea when describing the subcategory *demonstrate professional competence.* Another common factor to positive therapeutic outcome is fostering positive expectancy by

developing a rationale for symptoms, identifying a specific treatment course developed to ameliorate symptomology, and normalizing presenting issues (Defife & Hilsenroth, 2011). Fostering positive expectancy emerged as the subcategory *provide psychoeducation about the neurobiology of trauma and trauma treatment* which was described by participants as essential to trauma competency. Participant responses suggest that the trauma-competent counselor should know how to educate the survivor about both the neurobiology of trauma and what to expect during the course of trauma treatment. This information not only increases positive expectancy but also provides survivors a sense of control over their own treatment.

Participants stated that psychoeducation about trauma and effective trauma treatment is critical to trauma competency and creates positive therapeutic outcomes. They also indicated in their responses that *demonstrating foundational trauma knowledge* and *demonstrating trauma-competent clinical skills* are both critical components of trauma-competent mental health care.

Participants also shared that trauma-competent counselors demonstrate an understanding of contextual and systemic factors while respecting the varied experiences and trauma responses of survivors (Cook & Newman, 2014; Fallot, 2008; Harris & Fallot, 2001; Weine, 2002). Further, participants echoed the New Haven cross-cutting trauma-focused assessment competencies (Cook & Newman, 2014) in the importance that trauma-competent counselors place on an understanding of current trauma literature, evidence-based practice, and research-supported intervention.

Study participants also highlighted the criticality of self-care for trauma counselors, which reinforces tenets found in the trauma therapist development and competency literature (Logeran, 2004; Turkus, 2013; Cook & Newman, 2014). The subcategory *self-care is a priority* suggests that trauma-competent counselors are aware that counselor well-being is foremost and,

therefore, focus on maintaining their own psychological health by prioritizing self-care. Additionally, participants' responses echoed the New Haven trauma-informed professionalism competencies in their assertion that trauma competent counselors appreciate trauma survivors' strengths and incorporate a strengths-based approach that emphasizes resilience and growth (Cook & Newman, 2014; Fallot, 2008; Harris & Fallot, 2001). Further, this study mirrors the trauma-informed professionalism competencies mandate that trauma counselors minimize the risk of iatrogenic harm to the client when reprocessing the trauma narrative (Cook & Newman, 2014). The largest subcategory in the current study was *maintain client safety* in which participants state that trauma-competent counselors do no harm by using minimally invasive interventions while maintaining physical and emotional safety.

The finding that trauma-competent counselors demonstrate knowledge about common elements of evidence-based interventions, core trauma concepts, trauma-competent practice elements, and the neurobiology of trauma is supported by the literature. Consistent with the New Haven scientific knowledge about trauma competencies (Cook & Newman, 2014), the participants in this study agreed that a thorough understanding of trauma-related models and theories as well as neurobiological factors are essential to trauma competency. Further, the importance of accurate clinical assessment and diagnosis to trauma-competent care emerged from these data and is likewise highlighted by the New Haven psychological trauma-focused assessment competencies (Cook & Newman, 2014).

Participants also suggested that there are factors inherent to successful trauma treatment. Possible factors indicated in participant responses and endorsed by Wampold et al. (2010) include the following: reprocessing traumatic memory; making meaning of the traumatic experience; teaching coping strategies; emphasizing strength and resiliency; teaching boundary-

setting; ensuring client safety; collaborative agreement about tasks and goals of therapy; development of a respectful therapeutic relationship; and demonstrating professional competence in effective treatment interventions.

Participants' narratives also supported the position of Messer and Wampold (2013) indicating that a strong therapeutic alliance has been found to be associated with better treatment outcomes, and that alliance requires agreement about the tasks of therapy, goals of therapy, and the emotional connection between client and counselor (Messer & Wampold, 2002). The importance of the therapeutic relationship as integral to the process of resolving symptoms was mentioned by several participants. Participants were clear that *establishing a collaborative therapeutic alliance* with mutually agreed upon treatment goals, among the largest of the subcategories emerging from the data, is an essential skill of the trauma competent counselor. Participants also stated that trauma-competent counselors are aware of the importance of the therapeutic relationship or "a holding environment" to trauma work and *demonstrate client-centered counseling skills* in developing this critical relationship. Further, participants were united in their belief that trauma-competent counselors demonstrate *confidence* in their clients' ability to recover from the effects of trauma, and that trauma-competent counselors *demonstrate professional competence*. These participant responses mirror the burgeoning literature on the critical task and bond components in trauma-focused treatment (Hoffart, Oktedalen, Langkaas & Wampold, 2013). Several participant responses also indicated a clear allegiance or belief in the efficacy of a particular trauma treatment such as EMDR or clinical hypnotherapy. According to Hoffart et al. (2013) the task and bond components are critical factors in treating posttraumatic stress disorder. Further, these researchers emphasize that mutually agreed upon treatment goals

and interventions along with a shared belief in the success of these strategies to ameliorate symptoms is key to positive treatment outcomes in trauma mental health care.

An unexpected finding was the absence of collaboration with medical professionals as an essential factor in trauma-competent mental health care. Given the established elevation of substance abuse and other comorbid mental health issues among clients who experience trauma (McHugo et al. 2005), the researchers expected to find a greater emphasis on the importance of collaboration with medical care providers. Again, this finding may be partially explained by the inclusion of only three mental health professionals with medical training in the analysis. However, lack of emphasis on collaboration with other medical professionals to treat comorbid disorders remains unexplained. An area of analysis in this study that has been largely overlooked in the literature addresses the need for on-going training and consultation for trauma counselors. Both Logeran (2004) and Turkus (2013) emphasized that trauma work is challenging and should not be conducted without on-going training, consultation, and supervision as long as the trauma therapist is in practice. Further, these researchers suggest that trauma therapists have access to trauma-sensitive supervision rather than clinical supervision with a therapist unfamiliar with trauma theory and practice.

Participants in this study shared their position that competent trauma counselors are *open to new knowledge and experience* and therefore broaden their knowledge and clinical experience through active involvement in professional development and consultation. Trauma counselors need a community of fellow trauma therapists for continued learning, collaboration and support. They also concurred that trauma counselors need specific training and supervised experience with trauma-sensitive supervisors. Trauma-specific supervision and training differs from generalist supervision and training in that trauma-sensitive counselor educators and supervisors

are familiar with trauma precepts and interventions and understand the particular risks involved in providing trauma counseling (Logeran et al.,2004).

Implications for Practice

The results of this study highlight some important considerations for professional counselors working with trauma clients. Considering the lack of graduate-level training in psychological trauma and established trauma counseling competencies, it is recommended that professional counselors seek supervision with trauma-sensitive supervisors skilled in providing trauma counseling and well-versed in psychological trauma theory and intervention. In addition, it is recommended that trauma counselors practice in collaborative communities of fellow trauma counselors for support and opportunities for on-going learning and skill development.

The importance of a strong, client-centered therapeutic alliance is highlighted in this study. Turkus (2013) referred to the therapeutic alliance in trauma work as "a *holding environment*" for both therapist and patient to contain the difficult work of processing the intolerable" (p.5). Professional counselors working with this client population may need to make special efforts to convey unconditional positive regard and acceptance. This can be particularly important to clients surviving trauma, as these clients tend to have histories of feeling marginalized, stigmatized, and silenced because of their trauma histories. Similarly, based on participant responses within the category *maintain client safety*, it is suggested that counseling interventions are tailored to the specific treatment needs of trauma clients particularly regarding pacing the processing of traumatic material and avoiding abreaction or emotional flooding by titrating the level of affect within the client's window of tolerance.

In addition, it is suggested that professional counselors remain attuned to ways in which their own unresolved trauma may interfere with their therapeutic work and seek trauma

counseling as needed. Self-care, while critical to all mental health professions, is particularly important when providing trauma-focused care. Since trauma counselors use their presence to ground survivors in the present moment during emotional processing, it is recommended that counselors developing their trauma competency become skilled in remaining present and mindful during trauma work. It is also recommended that counselors training in trauma learn mindfulness to prevent vicarious traumatization, especially during the reprocessing phase of trauma treatment.

The importance of professional training, trauma-sensitive supervision, and on-going consultation are highlighted. Finally, the abundance of core trauma concepts and practice elements discussed by these participants indicates a need for trauma-informed and trauma-focused interventions tailored to the unique needs of trauma clients. As such, it is recommended that counselors working with trauma clients immerse themselves in the available literature and become well-versed in the treatment interventions most endorsed for use with trauma clients.

Limitations and Implications for Further Research

One possible limitation of this study involves the lack of a measure to quantify trauma competent knowledge, skills and attitudes. The Supervisee Levels Questionnaire-Revised (SLQ-R; McNeill, Stoltenberg, & Romans, 1992) based on the Integrated Developmental Model (IDM; Stoltenberg, McNeill, & Delworth, 1998) was used in the current study but does not specifically measure trauma-related competencies. Furthermore, the trauma-competent counselors who participated in this study identified as such based on their own self-report rather than based on objective and measurable standards required by a certifying organization.

Implications for future research suggested by this study are in the areas of counselor education and supervision. Research should support the development of trauma counseling

competencies grounded in the experiences of trauma-competent counselors to support trauma counselor training and development during graduate training and beyond. Participants perceived a lack of trauma competencies to guide their education and support their clinical practice. Therefore, there is a need to continue to investigate effective ways to integrate trauma-specific, competency-based training into counseling curricula. Since the majority of individuals presenting to community mental health settings have a trauma history, research involving ways to integrate trauma-focused skills into basic counseling skills courses and core trauma knowledge into theory-based coursework is needed given the fact that many counselors will work in these treatment environments.

Participants in this study concurred that remaining present themselves while providing trauma treatment was a skill critical to trauma competency, therefore research is needed to investigate whether mindfulness training among counselors is a preventative factor in the development of secondary traumatization during the reprocessing phase of trauma treatment. Participants in this study also shared their position that trauma counselors need a professional community for continued learning and support including access to trauma-sensitive supervision. Therefore, research is needed to develop a model of trauma-sensitive supervision to support the development of trauma-competent counselors and trauma-specific supervision.

Finally, given the prevalence of trauma in the United States and the paucity of literature addressing trauma therapist development and trauma-specific training and competency, this study explored trauma counselors' experiences providing trauma-competent mental health care. This study confirmed that there are core knowledge, skills and attitudes essential to trauma competency that can be used to educate and support trauma counselors in training within a trauma-informed learning community. While the participants in this study represented a wide

variety of disciplines among the mental health professions, they were all united in their identification as trauma counselors and agreed that the privilege of participating in the recovery experiences of traumatized people is well worth the on-going commitment required to acquire and maintain trauma competency.

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