

**HOLISTIC TRAUMA-INFORMED TRAINING IN COUNSELING PSYCHOLOGY**

**DOCTORAL PROGRAMS**

**A DISSERTATION**

**SUBMITTED TO THE GRADUATE SCHOOL  
IN PARTIAL FULFILMENT OF THE REQUIREMENTS**

**FOR THE DEGREE**

**DOCTOR OF PHILOSOPHY**

**BY**

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**JULY 2023**

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### **Acknowledgements**

To my parents, Alex and Victoria Ambeau, there are not enough words to convey how much your support has meant to me as I worked towards fulfilling my dreams. Thank you to my brother, Alex, for always providing words of encouragement throughout the PhD journey! To Andre, thank you for your encouragement during the dissertation and PhD process and your support of me and my career goals. Thank you to my friends for your check-ins, calls, and texts and allowing me to vent throughout this journey.

To my chair, Dr. Bowman, thank you for taking on my dissertation and making sure I finished on time. Another thank you to my committee members, Drs. Davis, Phelps-Ward, and Tschopp, for your support with the quality of my dissertation. To Dr. Burkhart, thanks for all your encouragement, support, talks, and laughs on this journey to PhD! A special thank you to Dr. Hutchison for helping me organize, shape, and start my dissertation, and for supporting me from the very beginning of my BSU journey.

Huge thanks to Drs. Chambers and Hinnenkamp for giving time and energy to my dissertation and the data analysis processes. I would not have made it to this point without y'all! Thank you to Dr. Ibarra, who mentored me and provided me the opportunity to step my foot into the world of neuropsychology. Also, thank you to Dr. Schoener for your support throughout all the various processes and hoops we must jump through for neuropsychology! A special thank you to my cousin, Dr. Candace Grace for piquing my interest in psychology when I was just a freshman in college, and all our talks that supported and encouraged me along the way.

Though everyone who has helped me to get to this point could not be listed here, know I am appreciative and grateful for you all being on this journey with me.

**ABSTRACT**

**DISSERTATION:** Holistic Trauma-Informed Training in Counseling Psychology Doctoral Programs

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**DEGREE:** Ph.D.

**COLLEGE:** College of Health

**DATE:** July 2023

**PAGES:** 117

This study utilizes a phenomenological framework to better understand counseling psychology doctoral students' experiences of trauma training provided within their doctoral programs. Counseling psychologists are likely to encounter patients who have a history of trauma due to the high prevalence of trauma exposure within the United States. The lack of opportunities to learn foundational trauma psychological knowledge in counseling psychology doctoral programs has resulted in psychologists in-training seeking and engaging in trauma training outside of their programs (i.e., practicum, internship, workshops). Counseling doctoral students describe trauma training they have received within their programs (i.e., courses, didactics, seminars, clinical supervision, research). Twelve doctoral students currently enrolled in APA-accredited counseling psychology programs were interviewed and asked about their experience of trauma training within their program. Participants described their trauma-informed education occurred through a variety of settings including supervision, courses, research, and didactic/lectures. The majority of participants expressed wanting more treatment application when in addition to theoretical frameworks on trauma. The study's strengths and limitations are discussed.

### **Holistic Trauma-Informed Training in Counseling Psychology Doctoral Programs**

Individuals experience trauma in the United States at a remarkably excessive rate (U.S. Department of Veteran Affairs, 2023). Trauma, as defined by the American Psychological Association (APA, 2023), is “any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person’s attitudes, behavior, and other aspects of functioning” (Definition 1). The present study aims to understand counseling psychology doctoral students’ experience of trauma training within their program. Researchers continue to investigate the gap in trauma training among psychology doctoral programs, however, no studies have explored how counseling psychology doctoral students are gaining trauma training within their programs. The current study examined this concern using phenomenology, a qualitative research design, to structure the study and guide data collection and analysis.

### **Prevalence of Trauma in the United States**

The prevalence of lifetime exposure to trauma in the United States suggests most individuals experience at least one traumatic experience in their lifetime (Forman-Hoffman et al., 2016; Kilpatrick et al., 2013). The occurrence and repercussions of trauma in the United States are noteworthy as approximately six out of every 100 people (6%) will develop posttraumatic stress disorder (PTSD) at some point in their lifetime (U.S. Department of Veteran Affairs, 2023). Of note, about 13 million Americans had PTSD in 2020 (U.S. Department of Veteran Affairs, 2023). Furthermore, individuals who experience prolonged exposure to traumatic conditions can possibly develop complex trauma as their traumatic experience(s) occur over time rather than a single event or several singular events (Courtois, 2008; Herman, 1992).

The likelihood psychologists will work with an individual who has experienced at least one traumatic event in their lifetime is high, if not guaranteed. Thus, psychologists must have a foundation in trauma-informed care to provide ethical, competent services to clients seeking therapy services for trauma. As such, it is important to consider various conceptual and empirical standards training programs should aspire to implement for trauma-informed education and training, followed by the current status of trauma-informed training in applied psychology programs.

### **Trauma Education and Training Guidelines**

The *Guidelines on Trauma Competencies for Education and Training* (APA, 2015; hereafter referred to in this section as simply the Guidelines) recognizes the biopsychosocial impact of trauma and includes this perspective within the listed competencies. Trauma-related competence is defined as the “minimal knowledge, attitudes, and skills” a psychologist should possess when working with trauma populations (APA, 2015, p. 15). The Guidelines provide recommendations to assist in translating this required knowledge into training and education. These competencies address biological and cognitive-affective bases of trauma (scientific knowledge), how legal, cultural, and policy issues impact trauma and trauma work (professionalism), and psychosocial interventions aimed at alleviating suffering and promoting the health and well-being of trauma-exposed individuals, groups, and communities (psychosocial intervention).

In addition, there is also the *APA Clinical Practice Guideline for the Treatment of PTSD* (APA, 2017a, 2017b). These guidelines provide best practice recommendations for the treatment of PTSD in adults. The *Clinical Practice Guideline for the Treatment of PTSD* is based on the best available evidence, at the time they were written, and addresses the efficacy of

psychological and medication treatments for adults with PTSD along with their comparative effectiveness, what treatments work best, and whether serious harms/adverse events of treatments (e.g., hospitalization secondary to risk for suicide or suicidal attempt) or patient preferences influence treatment recommendations (APA, 2017a, 2017b). Additionally, listed in the *Clinical Practice Guideline for the Treatment of PTSD* (APA, 2017a, 2017b) are trauma psychotherapy and psychopharmacology treatment recommendations along with the strength of these recommendations (e.g., strong, conditional, insufficient).

Furthermore, the APA's *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017) expounds upon psychologists practicing within the boundaries of their competence. In the *APA Ethics Code* (Principle D, Justice, 2017, p. 4), psychologists are to ensure the "boundaries of their competence and the limitations of their expertise" do not result in wrongful practices. Additionally, the *APA Ethics Code* (Standard 2.01, Boundaries of Competence, 2017, p. 5) emphasizes psychologists' competence boundaries are derived from their "training, supervised experience, consultation, study, or professional experience." Counseling psychologists who lack training, or have no training, in trauma-informed care may fail to recognize trauma-related symptoms, properly assess trauma history, develop inaccurate conceptualizations, or misdiagnose clients (Kumar et al., 2019). Subsequently, psychologists who are ill-equipped to treat trauma populations risk providing misdirected or harmful treatment to clients which can run the risk of retraumatizing them (Cook et al., 2011; Dorahy et al., 2016).

Conclusively, the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015), *APA Clinical Practice Guideline for the Treatment of PTSD* (2017a, 2017b), and *APA's Ethical Principles of Psychologists and Code of Conduct* (2017) all provide an in-depth illustration of what it means to be an ethical, trauma-informed psychologist and the foundational

knowledge one should possess and continue to build upon. In utilizing multiple guidelines and the ethics code, both psychologists and academics can provide inclusive, evidence-based training and education in trauma for psychologists in-training to utilize when learning to work with trauma populations. Focusing education and training on these guidelines would provide doctoral students with the foundational knowledge in trauma-informed care to build upon in the future, thereby maintaining competency across the professional lifespan (Principle 2.03, Maintaining Competence, APA, 2017).

### **Current Status of Trauma-Informed Training**

The most updated survey to examine trauma education and training within clinical and counseling psychology doctoral programs was conducted by the Education and Training Committee of Division 56 of the APA (APA, 2021). The trauma education and training data was cross-referenced with the APA's directory of accredited counseling psychology programs by the current researcher (APA, 2023). The directory listed 75 APA-accredited counseling psychology programs as of April 2023. Of those accredited counseling psychology programs, only 4, or approximately 5%, were on Division 56's list of programs with either courses, faculty interest, or program emphasis in trauma education and training. Though researchers continue to acknowledge that psychology doctoral programs lack trauma-informed education and training (Cook et al., 2019; Cook et al., 2017; Courtois & Gold, 2009), there has been little examination into why this phenomenon occurs or recommendations to assist programs in integrating trauma-informed education and training into their curriculum.

Regarding trauma-informed education and training within broader applied psychology programs, including clinical, counseling, school, and combined psychology doctoral programs, Cook and colleagues (2017) examined trauma psychology courses and practicum experiences

offered in psychology doctoral programs to determine the status of training in trauma. Specifically, Cook and colleagues (2017) contacted 414 training directors from both APA-accredited and non-APA-accredited programs. Of the training directors who responded with adequate information (151; a response rate of approximately 36%), 1 in 5 psychology doctoral programs were identified as trauma-focused, meaning they offered trauma courses or practicums for students and most of these experiences occurred in optional practicum settings (i.e., learning trauma specific interventions like PE, CPT, TF-CBT) or didactics on trauma. Additionally, it should be noted, of the training directors who responded, 98 of the 151 programs (65%) were from clinical psychology programs; the researchers did not provide specific data for counseling psychology. Cook and colleagues (2017) also identified barriers in providing trauma-informed education and training, with the most cited barriers being the limited availability of elective courses and resources. (Cook et al., 2017).

Comparable studies have examined trauma training within psychology doctoral programs, practicum sites, and pre-doctoral internship sites over the years (Sigel & Silovsky, 2011a; Sigel & Silovsky, 2011b; Simiola et al., 2018). Research suggests trauma training is occurring in some programs for doctoral psychology students. However, research on the depth, content, and quality of the trauma training is lacking, as there are few descriptions of the content utilized within these training programs. Additionally, the available research has only assessed trauma education and training experiences from the perspective of graduate and predoctoral internship training directors. While this point of view is helpful in gauging where trauma training is occurring, there is no available data to date from students' perspectives. Examining the trauma-based education and training experiences of doctoral students in counseling psychology

programs to understand how this training is implemented is imperative. In the following sections, the foundations of trauma-informed care and additional relevant training standards are discussed.

### **Foundations of Trauma-Informed Care**

As noted, to conceptualize and appropriately treat clients who have experienced trauma, it is imperative to understand how traumatic experiences can impact them (i.e., somatic, cognitive, psychological). Psychologists often use the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (*DSM-5-TR*, APA, 2022) to classify and diagnose clients' reported symptomology which further assists with determining appropriate assessments, interventions, and other services. Though the *DSM-5-TR* (APA, 2022) can be helpful in identifying and diagnosing psychological disorders associated with trauma, it limits psychologists' ability to consider additional aspects of trauma that contribute to posttraumatic stress responses and traumatic experiences not meeting *DSM-5-TR* criteria.

Trauma manifests in many forms including insidious trauma, microaggressions, intergenerational trauma, betrayal trauma, complex trauma, and race-based trauma (Brown, 2020; Carter et al., 2017). When considering the diversity in types of traumas, psychologists should be wary of what they consider to be a "normal" traumatic event, or "typical" response to a traumatic event, as individual differences can influence what one considers traumatic and one's response to a traumatic exposure (Brown, 2020). To further understand the rationale for why foundational clinical training and education in assessing and treating trauma are important, an overview of the effects of traumatic experiences is provided from a holistic perspective which includes the neurological, socio-cultural, and psychological impacts of trauma.

### *Neurological Perspectives*

Researchers have linked several structural and functional alterations to trauma including parts of the amygdala, hippocampus, cingulate cortex, and the dorsolateral and ventromedial regions of the prefrontal cortex (Bremner et al., 1995; Morey et al., 2009; Rauch et al., 2006). The amygdala, hippocampus, and prefrontal cortex are involved in emotion processing and memory formation, including learning what fear is and assigning emotional valence for memories (Etkin & Wagner, 2007; Lezak et al., 2012). When an individual experiences a traumatic event, communication among these areas of the brain is disrupted, resulting in long-term changes in brain circuitry and how individuals may later respond to stressful encounters (Vermetten & Bremner, 2002). Additionally, individuals are at risk for misinterpreting and possibly having an inappropriate response to their environment due to the lack of communication between the prefrontal cortex and amygdala (Herrington, 2017; McGaugh, 2004). Though these functional adaptations have been associated with PTSD, available research also supports these changes in brain regions are also associated with depression (Bremner et al., 2000), borderline personality disorder (Schmahl et al., 2003), and dissociative identity disorder (Vermetten et al., 2006). This is important to consider for differential diagnosis and emphasizes the importance of psychologists having the skill set to appropriately assess trauma as trauma symptoms significantly overlap with multiple diagnoses. The diagnosis given to clients ultimately determines what or how treatment is implemented.

### *Psychological Perspectives*

In addition to APA's definition of trauma, the *DSM-5-TR* (APA, 2022) lists criteria individuals must endorse for their symptoms to be classified as a trauma- and stressor-related disorder. The *DSM-5-TR* acknowledges the psychological distress individuals experience

following trauma exposure is variable (APA, 2022). This variability relies on multiple factors such as how one responds to a trauma, the severity of the trauma (i.e., magnitude, frequency, duration, severity, and timing of the event), presence of interpersonal betrayal, vulnerability, or resilience factors, and one's ability to control the traumatic experience and/or subsequent reactions (Wilson, 1995).

When an individual has a collection of symptoms classified under the broad symptomology above, a formal diagnosis can be made. The most frequent diagnoses given to individuals who have experienced trauma are posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorder (Abram et al., 2007; Brown, 2020; Courtois & Ford, 2009; Jakovljevic et al., 2006). Additional formal diagnoses associated and observed with trauma populations are mood disorders, personality disorders, and substance disorders; however, these disorders have high comorbidity rates with PTSD (Abram et al., 2007; Courtois & Ford, 2009; Jakovljevic et al., 2006). For clients who present to treatment with trauma- or stressor-related symptoms after a trauma but do not meet criteria for a PTSD diagnosis, the *DSM-5-TR* offers the diagnoses of other specified trauma- and stressor-related disorder and unspecified trauma- and stressor-related disorder (Brown, 2020; APA, 2022). Furthermore, these diagnoses allow psychologists to acknowledge any of the previously mentioned forms of trauma (i.e., betrayal trauma, race-based trauma, complex trauma) that cause trauma and stress responses for clients but do not meet the *DSM-5-TR*'s criterion for a diagnosis of PTSD (Brown, 2020).

### ***Sociocultural Perspectives***

The *Guidelines on Trauma Competencies for Education and Training* (APA, 2015), *APA Standards of Accreditation for Health Service Psychology and Accreditation Operating Procedures* (2018), and the APA's *Ethical Principles of Psychologists and Code of Conduct*

(2017) all note the importance of attending to clients' sociocultural contexts when providing services. It is not only imperative for clinicians to be competent in trauma-informed care, but it is equally, if not more important, for clinicians to understand how an individual's cultural background can impact their presenting problem(s). Through understanding culturally specific values, group norms, and the contexts that shape these traumatic experiences, more accurate and culturally competent psychological treatment can be administered.

As a starting point to becoming culturally informed in trauma, the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017) provide psychologists with a framework for understanding the experiences of clients through their intersecting identities to provide culturally competent care. As counseling psychologists, multiculturalism, diversity, and social justice are at the center of the profession (Vera & Speight, 2003) as well as a focus on strengths-based approaches to problem solving (Hill, 1977). The *APA Multicultural Guidelines* (2017) encourage psychologists to utilize a strengths-based approach to acknowledge challenges while also identifying positive, resilient ways individuals from diverse backgrounds address life experiences (Guideline 10). From an educational and training perspective, Fouad and Arredondo (2007) suggest faculty in psychology programs should integrate inclusive contextual realities of marginalized populations throughout course content and engage in research opportunities centered on multicultural education and training (e.g., publish research, facilitate workshops/training) to create a more culturally competent curriculum.

Taken together, when practitioners do not possess a foundational knowledge in trauma-informed care, they may fail to understand and neglect the multitude of traumatic responses and experiences clients bring to therapy. Understanding traumatic experiences and responses on

several levels (i.e., neurologically, psychologically, and socioculturally) is necessary for psychologists to engage in accurate diagnosing (as relevant) and effective treatment (Brown, 2020). Given the extensive knowledge needed to provide competent trauma-informed care, foundational training and education in trauma seems warranted as a required training experience in counseling psychology doctoral programs. Yet, prior research (Cook et al., 2017) clearly demonstrates the field is missing this mark, and much is still unknown. Additionally, available research (Cook et al., 2017; Sigel & Silvosky, 2011a; Simiola et al., 2018) largely concludes the current level of trauma focused training and education is insufficient yet does not explore in more depth the content of *how* to address this training gap. The following sections provide a theoretical grounding for a need to require foundational trauma knowledge for *all* trainees. These theoretical arguments are then linked to existing training competencies, demonstrating alignment with current training standards.

### **The New Theory of Disuse and Cognitive Overloading**

Constructivist theories view learning as a constructive process where individuals connect new information to previously learned information (Mayer & Moreno, 2003). More specifically, the new theory of disuse (Bjork & Bjork, 1992) and the concept of cognitive overloading (Kirschner, 2002; Mayer & Moreno, 2003) provide a deeper understanding of the importance of acquiring foundational trauma psychology knowledge throughout counseling psychology doctoral programs. According to Bjork and Bjork (1992) the new theory of disuse asserts newly learned information is stored into an individual's memory through the lens of, or linkages to, previously acquired knowledge. Further, learning about a phenomenon is dependent upon prior, stored knowledge an individual possesses that can be connected to newly presented information (Mayer, 2010), also known as a generative learning process (Wittrock, 1989). Through a

generative learning process, newly presented information is integrated with information stored in memory to construct new associations and expand relationships upon the previously stored information.

In the context of trauma-based training, the more foundational knowledge psychologists have regarding trauma-informed care, the more building blocks available to them to add and store new additional information. The new theory of disuse described by Bjork and Bjork (1992) suggests information stored in memory is modified over time to only include the relevant, frequently retrieved details. The frequent retrieval of stored information allows the pertinent details of this information to be remembered and built upon, which permits the development of new associations to this stored information and newly presented information (Bjork & Bjork, 1992). For example, if a psychologist in-training were required to take several courses or engage in multiple trainings related to trauma-informed care throughout the course of their doctoral program, they would have the opportunity to retrieve the learned information on trauma regularly.

Contrarily, if trauma-informed care is only learned about in one course or training, and there is no engagement in frequent retrieval, the information is less retrievable in the future (Bjork & Bjork, 1992). Put in the context of training, psychologists in-training can take one intense course or training where trauma-based information is thoroughly learned and frequently retrieved through testing, practice, assignments, or discussion. However, once this course or training ends, if the trainee does not use the trauma information learned, it eventually becomes unretrievable. Additionally, when there is no prior information stored to assist with conceptualizing newly presented information, cognitive overloading is inevitable (Mayer & Moreno, 2003). Cognitive overloading occurs when an individual's potential for cognitive

processing exceeds the learner's available cognitive capacity (Mayer & Moreno, 2003). In the context of trauma education and training, if foundational trauma-based information is un retrievable during a lecture or presentation on trauma-informed care, the trainee would not have the necessary information to make sense of the newly presented material. Cognitive overloading may occur in this situation because the individual would receive information they are unable to integrate with previously learned concepts, and ultimately are unable to store the newly learned information into memory. A visual representation of this would be like trying to file paperwork away in a filing cabinet that has no file folder for the paperwork you are trying to store. A folder must first be created to house the paperwork and then, over time, additional paperwork can be added to the folder.

### **Connecting Foundational Knowledge to Training Standards and Guidelines**

In addition to theory, there are a host of professional documents to support the need for required, foundational knowledge in trauma-informed care. The *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) provide an initial roadmap for integrating trauma-informed care into education and training and are designed to assess the clinical development of psychologists through benchmarks as they grow professionally from trainee to independent practitioner. Similarly, Fouad and colleagues (2009) identify and outline foundational and functional competency benchmarks for professional psychologists. Both the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) and the foundational competencies outlined by Fouad and colleagues (2009) emphasize the utilization of benchmarks for training, signaling a supervising practitioner of the trainee's developmental level, and when the trainee can advance to more complex clinical work (APA, 2015; Fouad et al., 2009; Kaslow, 2004).

Additionally, APA's *Standards of Accreditation for Health Service Psychology and Accreditation Operating Procedures* (SoA's; APA, 2018) distinguish between minimal levels of achievement needed between the doctoral, internship, and post-doctoral levels of training which also coincide with the benchmarks outlined by Fouad and colleagues (2009). These standards reinforce the concept that trainees (should) progress in the complexity of their knowledge and skills from the doctoral level through post-doctoral. This developmental progression further highlights the need for trainees to be exposed to trauma-informed care basics during their doctoral program for them to continue advancing in their knowledge and skills sets for later stages of professional training (Bjork & Bjork, 1992). However, the accreditation standards do not reference trauma education specifically. This lack of specificity in the standards leaves room for faculty members of APA-accredited counseling psychology programs to integrate foundational trauma-based information into the core curriculum. In doing so, all students in the program would receive foundational knowledge in trauma as all students would be required to take the core courses in the program. This would allow for frequent retrieval of trauma information which would result in the trauma-based information being more accessible in the future to utilize and build upon (Bjork & Bjork, 1992).

Utilization of the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) give counseling psychology doctoral programs a blueprint on what information regarding trauma psychology should be integrated into the curriculum to ensure psychologists in-training develop a foundational, holistic understanding of trauma. Additionally, these guidelines provide an illustration of what skills, attitudes, and knowledge are needed for psychologists in-training to advance to the next level of their training and build upon the foundational knowledge initially learned (APA, 2015; Fouad et al., 2009). For this reason, trauma-specific knowledge

should be integrated throughout the SoA's various professional-wide competencies (PWC's, e.g., intervention, supervision, consultation) to help develop the foundational trauma knowledge needed to practice ethically (APA, 2017) and competently (APA, 2015, 2017a, 2017b).

### **The Present Study**

Given the previously mentioned prevalence rates of trauma in the United States, counseling psychologists are likely to encounter clients with a history of trauma (U.S. Department of Veteran Affairs, 2023). A foundational understanding of trauma, its manifestation, impacts, and cultural implications are essential to ensure accurate client conceptualization, diagnosis, and treatment. The lack of opportunities to learn foundational trauma psychological knowledge within counseling psychology doctoral programs has resulted in psychologists in-training seeking and engaging in trauma training outside of and in addition to their program (e.g., practicum, internship; Simiola et al., 2018). Though psychologists in-training must begin somewhere with their trauma education and practice, this should not be at the expense of clients who present to practicum or internship sites for services. Moreover, practicing without a foundational understanding of cultural trauma psychology is questionable at minimum as psychologists in-training are treating clients outside the scope of their competence (Standard 2.01, Boundaries of Competence; APA, 2017) due to the limited opportunities to engage in any prerequisite in-depth trauma training (APA, 2018). This author seeks to investigate the current trauma training practices and doctoral students' experiences of this training within counseling psychology programs that are successfully implementing trauma-based training.

The present study seeks to answer the following questions using phenomenological inquiry:

1. What are doctoral students' experiences of trauma education and training who are enrolled in counseling psychology programs?

2. What trauma-informed education and training could be helpful within counseling psychology doctoral programs, by doctoral students' report?

## **Methods**

### **Philosophical Assumptions of Qualitative Research**

Philosophical assumptions are necessary to appropriately understand qualitative research as studies are conceptualized, created, conducted, and understood through a researcher's philosophical perspective (Creswell & Poth, 2018). A constructivist-interpretivist perspective (Ponterotto, 2005) will be used to investigate how counseling psychology doctoral programs are implementing trauma training and counseling psychology doctoral students' experiences with said trauma training. A constructivist-interpretivist approach believes there are multiple realities that are influenced and constructed by the context of participants' experiences, perceptions, and social environment (Moustakas, 1994). The purpose of constructivist-interpretivist research is to unveil participants' reality and experience of a phenomenon under study through deep reflection (Moustakas, 1994). This deep reflection allows for a full description of the individual's conscious experience including thoughts, feelings, examples, ideas, and situations that comprise a phenomenon (Moustakas, 1994). The underlying belief of the researcher is that to understand the experience of trauma training in counseling psychology doctoral programs, researchers must know the meaning psychologists in-training make of this experience to provide the basis for further research and training recommendations (Moustakas, 1994).

### **Research Design**

The phenomenological approach to this study developed comprehensive descriptions of trauma training in counseling psychology doctoral programs and participants' experiences of this training (Creswell et al., 2007). Phenomenological qualitative research allows participants to

describe, thoroughly, their lived experiences of a phenomenon (Creswell et al., 2007). In providing an in-depth description of their experiences, participants are allowed the opportunity to highlight what they consider imperative about the phenomenon (Moustakas, 1994).

In phenomenological research, the researcher focuses on constructing meanings and essences of a phenomenon, based on the participants' experiences, and abstains from making suppositions or assumptions (Moustakas, 1994). It is imperative to gain unprejudiced descriptions of a phenomenon not influenced by biases from the researcher (Zahavi, 2019). To acknowledge personal biases and preconceived beliefs of trauma training, the process of bracketing can be used. Bracketing is a methodological device used in phenomenological research that requires the researcher to intentionally set aside their beliefs and knowledge about the phenomenon under study prior to and throughout the entirety of the investigation to gain a more objective perspective of the phenomenon (Carpenter, 2007; Chan et al., 2013). Including statements of bracketing that identify any prejudgments and preconceived ideas allows readers to understand the biases that may have inadvertently influenced the conceptualization and interpretation of participants' experiences and brings awareness to the researcher's biases so they can bracket off any assumptions (Chan et al 2013, Moustakas, 1994). Appropriately engaging in bracketing adds to the validity of the data collection and analysis process (Chan et al., 2013).

### **Researcher-as-Instrument**

In the present study, phenomenological reflection (i.e., journaling) was utilized to identify personal experiences with the phenomenon under study in order to be transparent about any biases and aim to put them aside (Creswell et al, 2007; Creswell & Poth, 2018; Moustakas, 1994). The research team included the primary researcher and two psychologists, one counseling psychologist and one school psychologist, also described as peer debriefers. The use of peer

debriefers in qualitative research serves several purposes, including (1) encouraging the primary researcher to examine biases and deeper meaning, (2) testing the research question(s), (3) developing and testing steps in the research design, and (4) providing support and encouragement (Lincoln & Guba, 1985). The peer debriefers were allowed to interrogate and question the primary researcher's findings to ensure there were no biases in the interpretations of the data and make sure the audit trail makes sense. Feedback provided by peer debriefers was taken into consideration and added where appropriate.

Both peer debriefers had some prior experience in qualitative research and qualitative data analysis prior to this study. Information on phenomenology was sent to both peer debriefers to read and study. The research team was encouraged to discuss and ask questions throughout the data analysis the process. After discussing the phenomenological research process, the peer debriefers were presented the proposal for the current study. The primary researcher then described the concept of reflexivity and bracketing within phenomenological research. The primary researcher provided the peer debriefers with her own writings on reflexivity and bracketing as a model. The research team discussed the primary researcher's reflection including how previous experiences were the driving forces behind the current study and the impact on the interpretation of results. The peer debriefers were encouraged to engage in reflexivity and bracketing, and to be as open as possible in their reflections, which have been deidentified in the current study (see below).

### ***Reflection***

The process of phenomenological research asks the researcher to identify their personal experiences with the phenomenon being studied to be transparent about their biases and to be intentional with setting them aside (Moustakas, 1994; Creswell & Poth, 2018). The following

reflections come from the primary investigator and both peer debriefers. The reflections were shared with one another to hold all researchers accountable, consistent with the bracketing process.

**Primary Researcher.** I became interested in studying trauma due to my previous work with clients who have experienced trauma and my personal experiences with trauma (both myself and close relationships). Hearing clients' stories of their previous encounters with mental health professionals who were unable to help them process their trauma, or even being reluctant to talk about trauma in sessions, frustrated me. Though I was able to take trauma courses in my master's program, complete my master's practicum at a trauma agency, work for a trauma agency post-master's degree, and had the opportunity to attend trauma-related trainings, I knew everyone was not afforded the same opportunity. Despite this knowledge, I feel strongly that there should be basic, foundational training on trauma taught to psychologists in-training regardless of their personal clinical or research interests. I believe clinicians without formal, foundational trauma-focused training may potentially cause clients harm through various means (e.g., misdiagnosis, dismissing presenting concerns, demonstrating discomfort with trauma content). As a clinician, I am also aware it takes additional time and money to attend conferences and workshops where trauma training is frequently available, which can deter them from obtaining these "optional" experiences. As I prepared for this study, I noted my cynical perspective on how much exposure to trauma-informed care psychologists in-training have prior to beginning work with clients who have a trauma history. I am also aware this belief, for me, extends beyond clinicians and directly to counseling psychology programs, as there are no universal, foundational training opportunities in trauma for doctoral-level counseling psychology students. Throughout the study, I had to make sure I was not influencing participants'

descriptions of the phenomenon negatively during the data collection process, as well as during data analysis. Instead, I allowed the participants to lead me into their own subjective experiences.

**Peer Debrief 1. In their own words, this debriefer stated:** “Inasmuch as to demonstrate how my personal experiences may have impacted my role with the current study, I shared reflections from my trauma education and training across my degree programs. The bulk of my trauma education and training occurred outside my degree departments. I chose to pursue trauma-related opportunities outside my departments (e.g., sexual assault advocate training as an undergraduate; master’s internship at a community violence intervention center, etc.), in part, due to exposures with sexual violence. I completed Trauma-Focused CBT training online as a master’s student. Across my doctoral training, I continued providing therapy for folks with presenting concerns related to interpersonal violence, although my clinical focus was less focused upon trauma than during my masters training. At times, I incorporated trauma treatment into doctoral class projects (e.g., outcome assessment and associated presentation from work with a client whose presenting concern was sexual trauma).

Informed by my training experiences, I noticed an assumption that trauma education and training would be loosely integrated into coursework, rather than a foundational competency. I also assumed participants would be motivated to seek trauma training outside their department due to an interest in treating trauma in psychotherapy. Also, I wondered how varied the topics of trauma training and education would be (e.g., physiological trauma responses, evidence-based psychotherapy practice, pharmacological treatments for trauma, etc.). More broadly, I observed some internal skepticism towards how often the phrase “trauma” is used in common vernacular, and wondered about any secondary-gain for some individuals (e.g., social media influencers) to

profit from the increased use of trauma language. I was curious if the aforementioned skepticism I experience would be relevant to any of the current study's participants."

**Peer Debrief Two. In their own words, this debriefer stated:** "When tasked with identifying themes surrounding trauma, I pulled upon my experiences working with clients in settings where childhood trauma was prevalent. I recognized my disassociation, realizing that I, at times, "separated" from their traumas by informing them of psychoeducation, coping strategies, and referring them to individuals with a focus on trauma informed practice. Why? Not only because my own training program rarely focused on trauma informed practice, but also because I navigate the world as a Black woman, I too carry trauma whether by my Blackness and/or by being a woman. This has caused me to be an expert at hiding my traumas to put on a "brave face" and be the "strong, Black woman" and persevere through difficulties. Through identifying themes, I saw not only myself in the clinicians, but also their clients. I realized in moments of transcribing that trauma has infiltrated our everyday lives whereas the word "trauma" is very familiar, yet still unknown. In believing this, I think we take away from the lived experience of those who have and are victims of trauma.

As a professional who works predominantly with children in K-12 settings, I initially felt slighted that I was not explicitly taught trauma-informed practices, rather, it was gained by working within rural, urban, and suburban communities. It made me question, "was I expected to know what to do when exposed to clients who have experienced trauma?" In the back of my mind, I thought of all of the clients I served without the addition of a trauma-informed lens and having to pull from my experiences with my own trauma and treatment. By recognizing these biases, moving forward, I will be intentional about researching and informing myself of trauma informed practices and how I can implement the work not only in my personal life and healing,

but also with my clients. To do this, I must be knowledgeable about systemic issues surrounding access to mental health care, and the disproportionate effect this has on minoritized people. In doing this, I hope to challenge training norms and attitudes surrounding trauma and be an advocate for those suffering from trauma in their lives. I hope to challenge my own dissociative thoughts and feelings, to be a culturally responsive, trauma-informed clinician.”

### **Participants**

The sample included 12 counseling psychology doctoral students. To be included, participants had to be currently enrolled in an APA-accredited counseling psychology doctoral program and have completed a trauma course or trauma training offered by their program (e.g., supervision, research, didactic/seminar, etc.). The researcher had contact with five other potential participants who either a) did not respond to follow-up emails after expressing interest; b) did not meet full eligibility for participation; or c) responded to the recruitment message after data collection was completed. Participants' ages ranged from 24 to 33. Eight participants identified as White, three participants identified as Asian/Asian American, and one participant identified as Black/African American. Ten participants identified as Cisgender Women, one participant identified as non-Binary, and one participant identified as a Cisgender Man. Participants ranged from first to fifth year doctoral students in their program. One participant's program required trauma training, while 11 participants' programs did not require trauma training (see Table 1). There was a total of 10 counseling psychology doctoral programs represented by participants.

**Table 1***Participant Demographic Information*

Participant	Age	Race	Gender	Year in Program	Required Trauma Training
AC	27	White	Woman	5th	No
AD	28	White	Woman	4th	No
AE	26	Asian	Woman	1st	No
AF	27	White	Woman	4th	No
AG	25	White	Woman	2nd	No
AH	31	Asian	Woman	5th	No
AJ	31	White	Non-Binary	3rd	No
AK	27	Black	Woman	3rd	No
AL	25	White	Woman	1st	Yes
AP	33	White	Woman	4th	No
AQ	24	Asian	Woman	3rd	No
AS	26	White	Man	3rd	No

**Procedures***Initial Participant Identification and Screening*

To obtain interviews from counseling psychology doctoral students enrolled in programs implementing trauma-based training, these programs had to first be identified. According to the APA Commission on Accreditation's (2023) website when searching for accredited programs, there are 75 accredited counseling psychology programs. Of the 75 programs, three programs were listed as "Accredited - Inactive" and thus were not contacted due to their programs being phased out. The remaining 72 APA-accredited counseling doctoral programs' training directors were contacted via email and asked if their program requires foundational training in trauma-informed care for all students (e.g., interventions to work with trauma populations,

biopsychosocial perspective of trauma; see Appendix B), and, if yes, how this training is implemented (e.g., didactics, course, clinical experience, seminars, supervision). One program training director's email address was invalid, and an alternative email was not found to contact the program. Of the remaining 71 program training directors contacted, 37 (52%) responded. Only one of the 37 training directors responded stating their program requires a course in trauma psychology. The training director of this program was sent a recruitment email to disseminate to their students (see Appendix C). 17 program training directors voluntarily provided information that their programs offered an optional elective trauma psychology course or had trauma-related didactics/modules within other courses. The remaining program training directors who responded did not indicate whether there were optional trauma training opportunities at their program.

Since there was only one counseling psychology program requiring trauma training for all students represented in the pool, initial recruitment screening was expanded to include students who completed trauma training (i.e., course, supervision, didactic, seminar, research, etc.) within their program not including external practicum or internship experiences. With the expanded criteria, all 71 training directors were contacted a second time via email with the student recruitment message (see Appendix D) to be disseminated to doctoral students enrolled in their programs. The recruitment message included a brief explanation of the study, IRB approval indication, researcher's contact information, and supervising faculty's contact information. Doctoral students interested in participating were instructed through the recruitment message to email the researcher to confirm they completed or received a form of trauma training through their program to be eligible to participate. Doctoral students who met eligibility criteria

were assigned a code to ensure confidentiality and sent a Qualtrics hyperlink to review and sign informed consent and provide demographic information (see Appendices E and F).

### ***Interview Procedures***

Prior to beginning the interview, participants were given the opportunity to ask questions of the researcher via email and again at the start and end of the interview. Each participant was interviewed by the researcher. All interviews were conducted over Zoom (a video-conferencing platform) and recorded, as indicated in the informed consent. Interviews were semi-structured and consisted of a series of questions regarding demographics, trauma training experience, and trauma training suggestions (see Appendix G). The questions chosen for the semi-structured interview were short interview questions that allowed participants to answer openly, and were more likely to result in longer, more meaningful responses to questions for a richer description of a phenomenon (Kvale, 1996; Morrow, 2005). The researcher supplemented the questions with comments, clarifications, reflections, and probes to demonstrate understanding of participants' responses and followed up as needed to gather additional information (Moustakas, 1994). Interviews were scheduled to last 30 to 45 minutes. Participants were compensated with a \$20 Tango gift card for their time.

### **Data Analysis**

After each interview was completed, audio recordings were saved on a password protected computer. To ensure accuracy, transcripts were transcribed verbatim using transcription software (Descript). After transcription was completed, the researcher reviewed the transcription against the audio file for accuracy and completed edits as necessary. All identifying information was removed from transcripts. Participants did not see the transcripts once they were completed.

Next, the researcher engaged in the process of horizontalization, a process where statements are given equal significance to one another and repetitive statements are removed (Moustakas, 1994). Horizontalization was used to check the transcript for accuracy, bracket out expressions (e.g., “chunk” sentences or paragraphs that express one idea), and remove filler words (e.g., umm, like, really, etc.) and statements unrelated to the research question (e.g., calling out to pets to be quiet, mention of a phone call coming in). Through bracketing out expressions, the researcher highlighted any significant statements, sentences, or quotes that provided an understanding of participants’ experiences, or textual statements (Moustakas, 1994). This process is known as the transcendental-phenomenological reduction process, and through this process, the researcher was able to immerse in the data to encapsulate the full descriptions of participants’ experiences. This process continued until all expressions were listed for each transcript, indicating saturation was reached (Moustakas, 1994).

Following the process of horizontalization, the textural statements were reduced into broader themes to develop a structural description of participants’ experiences of the phenomenon (Moustakas, 1994). All concepts, themes, or categories from the expressions of textural descriptions were listed without discrimination. By this point, the researcher had listened to each interview once and read each transcript twice. If an expression did not fit within an existing theme or category, a new one was created. For any expressions experienced by all participants, those expressions were considered invariant constituents (Moustakas, 1994). Invariant constituents describe a core theme of the experience and is a description necessary and sufficient for understanding the phenomenon.

Finally, using both the textural and structural descriptions, a combined statement was developed to convey the overall essence of participants’ experience (Moustakas, 1994). The

essence of any experience is never an exhaustive description. Rather, the synthesis of the textural and structural descriptions constructed represents the essence of an experience at a particular time and place, after an exhaustive imaginative and reflective interview of the phenomenon, and the researcher's perspective at the time of the study (Moustakas, 1994). In synthesizing the textural and structural descriptions, a holistic statement was formed on the essences of the common, or universal, experiences of the phenomenon. Once completed, peer debriefers were sent the audit trail which consisted of documentation of all data collection and analysis procedures, data categorization materials, and research findings to review and read over for accuracy and provide feedback (Morrow, 2005; Akkerman et al., 2008).

### **Results**

There were twelve semi-structured interview questions; one was used to gather demographic information and was not used for analysis. Four of the questions were used to gain detailed information about the participants' experience(s) with trauma-based training within their counseling psychology program. A sixth question was used to gain information on how participants' trauma training influenced their provision of trauma-informed care. Another question was used to gather information on the types of traumatic exposure(s) participants' clients have experienced. Two questions were used to gain information on participants' perceived level of competence when working with trauma clients. Another two questions were used to understand participants' experiences of providing trauma therapy. The last question was used to provide participants an opportunity to express what information they believe is important for working with trauma clients. Following data analysis, the two questions associated with participants' experiences providing trauma services were removed as they did not provide data related to the research questions. Therefore, nine questions were utilized for the coding process

and were categorized as follows: (1) share a story about your trauma-based training, (2) how was the training organized, (3) what did you learn, (4) what do you wish you would have learned, (5) what kinds of traumatic experiences have your clients been exposed to, (6) tell me about a time when your training influenced your provision of trauma-informed practice, (7) how competent would you say you feel when working with trauma clients, (8) what makes you feel that way about your level of competence, and (9) tell me what information/skills you believe would be helpful in working with trauma clients. These nine categories were used to organize themes found during the coding process. Table 2 displays the categories, themes, and frequencies for the results.

**Table 2***List of Categories and Themes*

Categories	Themes	Frequency
Share a story about your trauma-based training.	Individual supervision	2
	Practicum group supervision	2
	Course	6
	Research assistant	4
	Diversity group with students	1
	Didactic/Lecture	3
How was the training organized?	Discussions	3
	Readings	7
	Outside training	3
	Coursework	7
What did you learn?	Trauma psychoeducation	12
	Trauma intervention	9
	Therapeutic relationship	2
	Trauma assessment	1
What do you wish you would have learned?	Trauma psychoeducation	5
	Trauma intervention and application	8
What kinds of traumatic experiences have your clients been exposed to?	Sexual trauma	10
	Childhood abuse/trauma/neglect	9
	Emotional/Verbal abuse	5
	Physical abuse	4
	Grief	4
	Victim of perceived life-threatening situation	1
	Homelessness	1
	Involvement with legal system	2
	Vehicle accident	2
	Domestic violence	8
	Systemic marginalization/Racial trauma/stress	5

Categories	Themes	Frequency
	Health trauma	6
	Community/Gang violence	2
	Financial trauma/Poverty	2
	Family trauma	1
	Religious trauma	1
	Combat trauma	1
	Gun Violence	4
	Traumatic brain injury	1
Tell me about a time when your training influenced your provision of trauma-informed practice.	Client autonomy	2
	Trauma psychoeducation	4
	Research on trauma	2
	Trauma interventions and theories	7
How competent would you say you feel when working with trauma clients?	Developmentally appropriate	4
	Dependent on trauma severity	1
	Moderately	6
	Mild to moderately	1
What makes you feel that way about your level of competence?	Diversity of trauma clients seen	2
	Client self-report/Outcome measures	2
	Assessing trauma	3
	Psychoeducation of trauma/therapies/research	7
	Supervisor feedback/support	2
Tell me what information/skills you believe would be helpful in working with trauma clients.	Trauma education throughout program	4
	Trauma assessment	1
	Trauma manifestations	5
	Trauma treatment and application	11
	Humility	2
	Trauma Psychoeducation	4
	Mental health resources for providers	1

**Share a Story About Your Trauma-Based Training.**

Six themes were identified in the trauma-based training categories. Themes in this category included: (1) individual supervision, (2) practicum group supervision, (3) course, (4) research assistant, (5) diversity group, and (6) didactic/lecture.

***Individual Supervision***

Two participants discussed learning about trauma-informed care through individual supervision. One participant reported their supervisor provided psychoeducation on the impact of trauma and how to incorporate trauma-informed care in their clinical work. A common discussion point for both participants was learning about countertransference they experienced when working with trauma clients and how to view what was happening in the therapeutic relationship from a clinical lens rather than a personal lens. For example, participant AL stated, “she [supervisor] would challenge us [students] to look at it from different perspectives and how what we’re bringing into the room might affect how we work with the client.”

***Practicum Group Supervision***

Two participants discussed learning about trauma-informed care through practicum group supervision. Participant AP reported “it seems like we talk about trauma there a lot because we haven’t talked about it as much in other courses.” Participant AF discussed learning “different steps in what you would do in a more manualized approach” and ways to individualize treatment while using a manual as guidance.

***Course***

There were six participants who discussed taking at least one course with a trauma focus. Four participants reported taking a trauma specific course for at least one semester and the courses were delivered online. Additionally, the four participants noted their trauma course was

an elective. Participant AJ noted “It was a good class, but it was also an elective...The trauma and counseling course doesn’t really fit anywhere in our plan of study.” One participant, AK, reported learning about trauma-informed care in two evidence-based therapies classes, with one class being children-focused therapies, and both courses being required. Another participant, AQ, discussed a prevention and outreach course where the entire class participated in a community-based project of their choosing and their class chose gender-based violence which focused class discussions on “dating violence and intimate partner violence.”

### ***Research Assistantship***

Four participants discussed learning about trauma-informed care as a research assistant. Participant AG reported during their research assistantship, “we did a bunch of training on the CAPS-5 (Clinician-Administered PTSD Scale for DSM-5)” for a research project examining “community members with trauma exposure.” Another participant, AH, discussed “getting training in the ARC Model (Attachment, Regulation and Competency)” to “help families work better with how to support child clients who have trauma.” Participant AQ reported learning about trauma-informed care during their research assistant experience, with an emphasis on “topics related to intimate partner violence.” Participant AC commented their experience as a research assistant “was my first exposure to even understanding what trauma-focused care was, or trauma-informed care, and the difference between trauma-centered and trauma-informed.”

### ***Diversity Group With Students***

There was one participant who discussed their experience in a student-led group discussion about trauma. Participant AE reported that once a month they attended the “diversity dialogue” group where students in their program gathered in breakout groups to talk about

certain topics amongst one another. Participant AE stated the group they participated in focused on racial trauma.

### *Didactic/Lecture*

Three participants talked about their experience in didactics or lectures with a focus on trauma-informed practice. Participant AF discussed attending a lecture from a faculty member in their program who provided psychoeducation on “what racial trauma looks like, what it is.” Participant AG reported their program offers a voluntary meeting, periodically, where faculty present on topics “they’re an expert in” and one faculty member presented on the “basics of understanding PTSD conceptually and what the treatment looks like.” Another participant, AK, talked about frequent didactic presentations from professionals in the community who lecture on various therapies, and stated, “we did have someone come in from the VA and they talked to us about prolonged exposure therapy.”

### **How was the Training Organized?**

In the category pertaining to trauma training organization, there were four themes identified. These themes included: (1) discussion, (2) readings, (3) outside training, and (4) coursework.

### *Discussions*

There were three participants who engaged in conversations to learn about trauma-informed care. Participants talked about having open discussions in individual or group supervision. For example, participant AC discussed having “exploratory conversations” with their faculty clinical supervisor that provided “psychoeducation for me on the impact of trauma.” Another participant, AP, reported in their group supervision “it seems like we talk about trauma there a lot” because their peers had clients who had experienced various types of traumas.

### ***Readings***

Seven participants talked about reading being a component of their trauma-based training. Participant AE reported the members of the student-led group would “read a few chapters of the book [*My Grandmother’s Hands*] and then come back to have discussions” about racial trauma due to the book’s focus. Participant AH talked about meeting biweekly with their research team where they would “read certain chapters [of the ARC manual] and we’ll come back to the meeting and discuss.” Six participants discussed reading required textbooks, books, articles, and manuals throughout their trauma-focused course. For example, participant AJ reported reading “*The Body Keeps the Score* as a grounding text” and “a lot of Judith Hermann’s work on the three-stage model of trauma processing.”

### ***Outside Training***

Three participants reported receiving trauma-based training from an outside party while enrolled in a course or supervision. Participant AF talked about taking “the trauma-focused CBT training out of the University of South Carolina (different university than where the participant was enrolled).” Two participants were required to do training through the U.S. Department of Veterans Affairs (VA). Participant AG reported a lot of the training they received during the research assistantship on the CAPS-5 was “online through the VA.” Participant AS stated “we were required” to watch a certain set of publicly available “standard video trainings” through the VA.

### ***Coursework***

There were seven participants who described how their trauma course was structured. Coursework discussed by participants included: research paper, discussion post, case conceptualization, mock session, exam, reflection assignments, presentation, and projects. Five

participants reported they completed a research paper as part of their trauma course. For example, Participant AK reported they were required to complete a research paper on a trauma treatment of their choosing and decided to take “a deeper dive into trauma-focused CBT” which they believe helped them “understand better the different stages of therapy.” One participant, AJ, stated they were required to give a presentation in their course where they “had to provide an overview of a world event that could be understood as traumatizing” and talk about the impact from a local, community, and national level, as well as “what could have been done differently or better.” Another participant, AD, “formulated a treatment plan” and “did a mock session” using a trauma intervention of their choosing during their trauma course.

### **What did You Learn?**

For the category of learned information through trauma-based training, four themes were identified. These themes included: (1) trauma psychoeducation, (2) trauma intervention, (3) therapeutic relationship, and (4) trauma assessment.

#### ***Trauma Psychoeducation***

All 12 participants reported receiving trauma psychoeducation during their trauma-based training. This included psychoeducation on the impact of trauma, types of traumas, and trauma manifestations. For example, participant AF described gaining “psychoeducation about what PTSD looks like.” Another participant, AE, reported they learned about the “definition of what is trauma, and in particular racial trauma” during their trauma-based training. Participant AP reported having “discussions about folks whose clients have repeated trauma, complex trauma, interpersonal trauma” during their group supervision. Participant AJ described “it was helpful to see all the different kinds of trauma that exist” and “what trauma can involve and how it can show up in so many different ways.” Participant AC discussed through their research

assistantship they became “familiar with some of the language or the concepts” related to “the difference between trauma-centered and trauma-informed care.”

### ***Trauma Intervention***

Nine participants described learning about trauma intervention during their course, research assistantship, supervision, or didactic/lecture. Three participants talked specifically about learning evidence-based therapies (EBTs). Participant AK reported learning about trauma-focused-CBT in their trauma course. Another participant, AS, described learning “the basics of theory” on trauma and stated, “we did a lot of narrative exposure and CPT and EMDR overviews.” Participant AJ discussed learning about a “three-stage model of trauma processing” and reported “it was helpful to provide me a conceptual framework to work with clients.” Additionally, participant AF described learning to “develop early coping skills before digging into anything” when work with trauma clients. Participant AG talked about learning “which treatments are helpful, broadly, what do they look like, where I can get resources to actually treatment plan, and what that’s going to look like” during didactics. Participant AD discussed “the most helpful piece for me was comparing EMDR, DBT, and psychodynamic” when learning about trauma interventions “so that you could in the future, pursue it on your own.”

### ***Therapeutic Relationship***

Two participants discussed learning about the role the therapeutic relationship has in trauma treatment. Particularly, participant AL described their supervisor helping them to look at the therapeutic relationship from a ‘clinical lens’ and helped them to look at “what are the possible reasons she [the client] could be responding this way, and what is your role?”

Participant AS described the “biggest lesson” from their trauma-based training was “to be very

transparent with clients” about the process of trauma therapy, and that the “dropout rates of a lot of these therapies are quite high” with the intention of trying to “reduce that dropout rate.”

### ***Trauma Assessment***

There was one participant who discussed learning about assessing trauma as a research assistant. Participant AG described the CAPS-5 training as “it started off with basic psychoed about PTSD conceptually and then it walked through how the interview was set up.”

Additionally, participant AG stated the training had videotaped role plays which they watched and “then you do the interview alongside the video” which they found helpful.

### **What do You Wish You Would Have Learned?**

Two themes were identified for the category pertaining to what participants wanted to learn in their trauma-based training. These themes included: (1) trauma psychoeducation and (2) trauma intervention and application.

### ***Trauma Psychoeducation***

Five participants endorsed they wanted to learn more psychoeducation on trauma including manifestations of trauma, types of traumas, and generally more resources on trauma. For example, participant AP described wanting their trauma course to have “a week dedicated to trauma and then from there to other manifestations, other things that can come from trauma.” Another participant, AC, reported, “I think if somebody had suggested a book or something, or a manual on that, that could have been helpful” when they discussed wanting to know more about manifestations of trauma.

### ***Trauma Intervention and Application***

There were eight participants who discussed wanting to learn more information about trauma interventions and technique application. Participant AL reported wanting to learn “more

specific techniques” during their individual supervision. Another participant, AK, expressed “I would’ve liked to go more into depth as to how we would have treated a particular client with trauma or actually learning the specific steps of a specific trauma-based therapy.” Participant AG described wanting to have an “opportunity to have specific training on the nitty gritty of it all would’ve been really nice” when reflecting on their trauma-based training experience.

### **What Kinds of Traumatic Experiences Have Your Clients Been Exposed to?**

When asked about traumatic experiences their clients have experienced, 19 categories were identified. The types of traumas identified include: (1) sexual trauma, (2) childhood abuse/trauma/neglect, (3) emotional/verbal abuse, (4) physical abuse, (5) grief, (6) victim of perceived life-threatening situation, (7) homelessness, (8) involvement with legal system, (9) vehicle accident, (10) domestic violence, including intimate partner violence, (11) systemic marginalization/racial trauma/stress, (12) health trauma (i.e., medical, life-threatening illness, abortion, Covid), (13) community/gang violence, (14) financial trauma/poverty, (15) family trauma, (16) religious trauma, (17) combat trauma, (18) gun violence, and (19) traumatic brain injury.

### **Tell Me About a Time When Your Training Influenced Your Provision of Trauma-Informed Practice.**

There were four themes identified when participants were asked how their training influenced their provision of trauma-informed practice: (1) client autonomy, (2) trauma psychoeducation, (3) research on trauma, and (4) trauma interventions and theories.

#### ***Client Autonomy***

There were two participants who discussed how learning about client autonomy influenced their work with trauma clients. First, participant AD discussed a “fundamental and

foundational” aspect of their trauma-based training was learning to create “rapport and safety and letting the client progress on their own schedule instead of any kind of schedule I have for them.” Another participant, AQ, talked about working with clients from an “empowerment-based model” and how it has allowed them to “consistently give my clients choice in what they want to do” and “set boundaries about things they want to talk about versus don’t” in therapy.

### ***Trauma Psychoeducation***

Four participants described the role trauma psychoeducation played in their provision of trauma-informed practice. Participant AC discussed previous training on “the potential impact of neglect” and “feeling loyal to people who have mistreated you” were helpful during one of their complex trauma cases. Participant AH talked about the ARC model and how it helped them to provide psychoeducation during family consultations and being able to “incorporate the attunement part” to teach parents about emotional regulation with their children. Another participant, AE, reported how their research paper on traumatic grief helped them to connect a client’s inability to process or cope with their father’s loss to “when she started relapsing.”

### ***Research on Trauma***

Two participants identified the trauma information learned from their research assistantship impacted their provision of trauma work with clients. Participant AG described how the CAPS-5 training helped them to realize they only needed to “understand the nature of the problem” and not to “rehash details that were unnecessary and triggering.”

### ***Trauma Interventions and Theories***

There were seven participants who discussed their trauma-informed practice was influenced by their knowledge of trauma interventions and theories. One participant, AS, discussed how learning about “different trauma theory has helped me be very organized with

how I work” and particularly feels learning about CPT “helped me have that blueprint” to keep clients on “an appropriate path” with trauma therapy. Another participant, AL, reported drawing from “the trauma narrative aspect of TF-CBT” they learned in practicum group supervision to help process a client’s trauma. Participant AK stated the training they received on TF-CBT has “helped me to be mindful of different signs and symptoms of trauma”, particularly with children because “kids cannot always vocalize or elaborate upon trauma that they may have experienced.” Similarly, other participants noted how they utilized previous trauma-based training as a guide when working with clients. For example, participant AJ discussed using “different grounding techniques” and “somatic approaches” they learned in their trauma course with clients such as “bilateral stimulation.”

### **How Competent Would You Say You Feel When Working With Trauma Clients, and What Makes You Feel That Way About Your Level of Competence?**

Participants were asked to rate their level of competence when working with trauma clients and why they felt that way about their level of competence. Four themes were identified for participants’ perceived level of competence and include: (1) developmentally appropriate, (2) dependent on trauma severity, (3) moderately, and (4) mild to moderately. Five themes were identified as reasons for participants’ perceived level of competence which include: (1) diversity of trauma clients seen, (2) client self-report/outcome measures, (3) assessing trauma, (4) psychoeducation of trauma/therapies/research, and (5) supervisor feedback/support.

#### ***Developmentally Appropriate***

There were four participants who described their level of competence as developmentally appropriate and reasons for self-reported level of competence include: psychoeducation of trauma, diversity of trauma clients seen, and assessing trauma. Participant AE reported their

competency as developmentally appropriate because they can “identify trauma, symptoms of trauma, and how to help clients talk about it” but feel less competent in techniques for working with trauma. Another participant, AP, described feeling many of the clients they have seen had “significant trauma” and the diversity of trauma they have worked with make them feel “competent for my training level.”

### ***Dependent on Trauma Severity***

One participant, AF, reported their level of competence is dependent on the “type of trauma and the frequency” and felt this way due to the variety of trauma clients they have seen. Participant AF explained, “for someone with a history of multiple traumas, I think I would feel much less competent versus no other trauma history except this time when this thing occurred.” They also acknowledged “certain things are more challenging, both for personal reasons, and objectively speaking, they feel more interconnected with other experiences” and feel the client may not fit the “mold of trauma training (i.e., “textbook example”).”

### ***Moderate Competence***

There were six participants who endorsed feeling moderately competent when working with trauma clients; their identified reasons for their level of competence include: client self-report/outcome measures, diversity of trauma clients seen, trauma class, and supervisor feedback/support. Participant AD reported feeling moderately competent due to “seeing treatment success both in client report and on the C-CAPS measure and some different scales to measure outcomes.” On the other hand, participant AC described feeling moderately competent because “I’ve seen so much trauma across a wide range of scenarios, client demographics, settings, different levels of healing, progressing.” Two participants discussed the trauma class they completed contributed to their perceived moderate level of competence. For example,

participant AS reported feeling “average or maybe a little above average because I’ve had the course” Another participant, AL described their level of competence stemmed from “the feedback that I have received” and “my support systems here at school.”

### ***Mild to Moderately Competent***

One participant, AK, described their level of competence as mild to moderate. AK explained, “I feel having knowledge of the trauma therapies helps” but stated “I would probably have to get supervision to really make sure I feel comfortable in what I’m doing” if a client wanted to solely work on trauma.

### **Tell Me What Information/Skills You Believe Would Be Helpful in Working With Trauma Clients.**

There were seven themes discussed by participants when asked about information or skills they believe were helpful for working with trauma clients. The themes include: (1) trauma education throughout program, (2) trauma assessment, (3) trauma manifestations, (4) trauma treatment and application, (5) humility, (6) trauma psychoeducation, and (7) mental health resources for providers.

### ***Trauma Education Throughout Program***

Of the 12 participants, four reported integrating trauma education throughout courses in counseling psychology programs would be helpful for working with trauma clients. For example, participant AC stated education on trauma “needs to be integrated into all classes” because elective trauma course may not be possible if you “have to take a class that’s pertinent” to students’ other academic goals. Another participant, AJ, reported, “I wish trauma informed care was integrated throughout all of the things we do because it’s so important.”

### ***Trauma Assessment***

One participant discussed knowledge of trauma assessment would be helpful when working with trauma clients. Participant AC talked about “taking pieces of trauma assessments that could be incorporated into an intake” to get “some basic information that we need to know about trauma history or adverse experienced history” prior to meeting with clients to better understand their presenting concerns.

### ***Trauma Manifestations***

There were five out of the 12 participants who discussed why learning about manifestations of trauma would be helpful when working with trauma clients. One participant, AD, reported “more information on dissociation” would be helpful and knowing “when to switch from processing to grounding” with clients who dissociate. Participant AK discussed “knowing more about how trauma can manifest itself into other diagnoses like dissociative identity disorder, personality disorders” and “knowing how to navigate that when there’s both trauma and a personality disorder” would be helpful when working with trauma clients.

### ***Trauma Treatment and Application***

Eleven out of 12 participants reported knowing more information and skills about trauma treatments and intervention application would be helpful. Participant AC discussed the opportunity for “young clinicians to get more exposure earlier on” so they can be “comfortable planning interventions and treatment plans.” Participant AF discussed more information about “differences between different types of traumas and differential treatments” would be helpful. Participant AJ stated “I think everyone would benefit from having some basic awareness of how to do trauma treatment because it’s going to come up” with clients. More specifically, AJ stated “having empirically validated trauma informed treatment approaches embedded in our

discussions of multicultural competency and career counseling” would be helpful. Other participants talked about having more application-based training for trauma. For example, participant AK discussed “having roleplaying or actually practicing some of those skills, even if it was with classmates “would be “helpful because it’s hard to envision yourself doing more trauma work without actually doing it.”

### ***Humility***

Two participants endorsed humility as a skill clinicians should emphasize when working with trauma clients. For example, participant AD stated, “I feel like having a strong multicultural background that’s rooted in cultural humility goes a long way in doing trauma work,” and “understanding that deeper cultural component makes all the difference in structuring the actual treatment of the trauma processing.” Another participant, AQ, discussed “being able to have that humility to know sometimes my way is not always gonna be the best way” when working with trauma clients and “being able to work in the room in the way that fits best for them.”

### ***Trauma Psychoeducation***

There were four participant who discussed various types of trauma education they believed would be beneficial when working with trauma clients. Participant AE talked about clients being “aware of how they feel, their body, especially body sensations” related to trauma and being able to provide psychoeducation on this to clients. Participant AF noted “more of an understanding around the biological aspect of trauma” can be helpful to “contextualize” that the “brain is doing this because it’s keeping you safe in this way.” Participant AJ discussed “expanding the selection criteria for those who get seen as traumatized” as important when working with trauma clients because “there’s so much more trauma than those who have PTSD” such as “traumatization within the system.”

### *Mental Health Resources for Providers*

One participant noted having resources for mental health practitioners who are providing trauma therapy as helpful when working with trauma clients. Specifically, participant AJ stated, “I think there needs to be more mental health support for mental health professionals because the stuff we hold space for and bear witness to can itself cause trauma.”

### **Discussion**

The present study examined doctoral students’ experiences of trauma education and training within counseling psychology programs. Twelve participants responded to semi-structured interview questions which provided insight into their personal experiences. The results of this study expand upon the current literature on trauma education and training within psychology programs, specifically counseling psychology. Through analyzing participants’ responses, themes were identified to provide further knowledge on how trauma-based training is being implemented in counseling psychology doctoral programs from the students’ perspective as well as information on what students believe they should be learning regarding trauma education and training. Through these identified themes four broader categories of themes were found to describe the essence of trauma education and training within counseling psychology programs, including (1) accessibility, (2) advocacy, (3) humility, and (4) self-efficacy.

There were two research questions for the current study: (1) what are doctoral students’ experiences of trauma education and training who are enrolled in counseling psychology programs, and (2) what trauma-informed education and training could be helpful within counseling psychology doctoral programs, by doctoral students’ report? The second research question was included to elaborate on aspects of trauma education and training doctoral students felt most important to their clinical practice and knowledge. The responses to the two research

questions provide an in-depth description of what is and should be included in counseling psychology programs related to trauma education and training.

### **What Are Doctoral Students' Experiences of Trauma Education and Training Who Are Enrolled in Counseling Psychology Programs?**

#### *Accessibility*

All 12 participants endorsed learning trauma psychoeducation within their counseling psychology programs. Most participants in the current study expressed feeling that all students should have access to the trauma education and training they received, but also acknowledged this is not always possible given degree plans and requirements within psychology programs. Though the majority of participants were enrolled in counseling psychology programs that do not require trauma education or training within the curriculum, they noted seeking out opportunities within their programs to receive this training. Consider Participant AJ talked about being one of two doctoral students enrolled an elective trauma course that is rarely offered. They expressed the importance of receiving trauma education and training in their program due to the many symptoms and manifestations of trauma, and felt concern about their peers who did not have the space in their degree plan to take the elective trauma course.

Amongst the participants, half endorsed receiving trauma education and training through information they learned in a trauma course offered by their program. Additional settings discussed by students were individual and group supervision, research assistantship, student-led diversity group, and didactic/lecture. The majority of participants reported that within these settings, readings (i.e., assigned texts, journal articles, treatment manuals) and coursework (i.e., research paper, reflection assignments, presentations) were the primary structures involved in their trauma education and training. Additionally, there were three participants who completed

trauma training through an outside agency (e.g., U.S. Department of Veterans Affairs) as part of a requirement for their training setting (i.e., course, supervision, research).

### *Self-Efficacy*

Despite highly reported experiences of trauma psychoeducation and trauma treatment and application within their trauma training, all participants expressed wanting either more trauma psychoeducation and/or experience with trauma treatment and application. When asked about perceived level of competence, half the participants felt moderately competent in working with trauma clients, with the second most reported competency level being “developmentally appropriate.” The most cited reason participants reported for identifying themselves as competent was due to receiving psychoeducation on trauma, trauma therapies, or trauma-focused research. However, most of the participants noted feeling they would still need supervision or additional resources when working with trauma clients. Though these participants have received some form of trauma education and training, they still expressed feeling there could be more learned when it comes to working with trauma populations. Specifically, they desired more resources on trauma and how it manifests, and more education on how to apply trauma interventions and techniques with various trauma presentations. This makes sense as several participants reported feeling they learned more about the theory behind trauma treatments or frameworks, which they found helpful, but also expressed wanting more education on how to apply the information to client cases. From a psychoeducational viewpoint, some participants described wanting to learn about types of traumas not included in a PTSD diagnosis (i.e., racial trauma, systemic trauma) and how trauma symptoms or responses can present as other mental health disorders (i.e., personality disorders).

## **What Trauma-Informed Education and Training Could Be Helpful Within Counseling Psychology Doctoral Programs, by Doctoral Students' Report?**

### *Advocacy*

The majority of participants expressed a desire for more information on a variety of trauma interventions and treatments, as well as the opportunity to practice engaging in implementing the treatments. They believed this would be beneficial to psychologists in-training prior to working with trauma clients. Additionally, most participants discussed wishing trauma education and training had occurred throughout their program or in earlier courses as a way to prepare them to better provide trauma-informed care to clients. Other participants noted the need for and importance of trauma psychoeducation in understanding trauma, trauma assessment, and how trauma manifests.

Participants endorsed trauma psychoeducation and trauma treatment and application as being a primary influence in their provision of trauma-informed services. This included the impact of trauma, types of traumas, manifestations of trauma, and neurological aspects of trauma. These areas of trauma psychoeducation also coincide with the holistic trauma perspective described previously which includes the neurological, social-cultural, and psychological impacts of trauma. Notably, participants talked about being able to provide psychoeducation to clients when engaging in trauma therapy and being able to utilize all or aspects of trauma treatment manuals or guidelines to guide their provision of trauma care. They believed this education and training also provided them with the tools and knowledge needed to be able to advocate for their client in various clinical settings.

### *Humility*

Several participants noted themes focused more on provider specific education and resources. This included things like the therapist having their own mental health resources (i.e., access to individual therapy) when working with trauma clients to assist with any vicarious trauma or possible burnout due to the nature and content of discussion in the therapy space. Essentially, psychologists in-training should not only have access to mental health providers for themselves, but also know the signs and be able to acknowledge when they need personal assistance. From an ethics perspective, psychologists are required to take “appropriate measures” to obtain professional help, which can include personal therapy, when they “become aware of personal problems that may interfere” with work-related responsibilities (APA, 2017, Standard 2.06(b), Personal Problems and Conflict). However, it was noted that psychologists in-training often do not have time to attend personal therapy due to the time commitment for other doctoral student related roles and assignments, cannot afford therapy, or are referred for therapy at their university counseling centers which can come with personal risks or discomfort (i.e., as a practicum or internship site for other psychology students). Though some universities do provide psychologists in-training with a list of outside therapists who have sliding scale fees; however, the price over time to keep a therapist can add up quickly for doctoral students who are typically on a fixed income.

Additionally, participants expressed the need for humility in regard for both clients and practitioners as an important aspect of trauma-informed care. Utilizing cultural humility in the provision of trauma services not only aligns with the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) and *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017), but it also ensures practitioners are

conceptualizing and diagnosing clients accurately. This would assure client concerns are being understood and treated appropriately without causing more trauma or harm (Brown, 2020; Jakovljevic et al., 2006). From the perspective of the practitioner, humility can bring awareness and reassurance to therapy not always being linear in trauma treatment. In remembering this, psychologists can acknowledge that, even though a client has experienced trauma and has stressor-related symptoms, it does not mean trauma is necessarily their focus in treatment.

The results of the present study indicate counseling psychology doctoral students are exposed to trauma-informed education and training within their programs; however, who receives this education and training is largely dependent upon students' personal interest and motivation to seek it. Like Cook and colleagues (2017), most of the trauma education and training provided to participants within their program is through elective courses and didactics. Furthermore, consistent with Sigel and Silvosky's (2011a) research, several participants noted learning evidence-based treatment(s) for trauma in their program at some point. Though the current study only examined trauma education within counseling psychology doctoral programs, participants noted wanting to receive more breadth and depth in their trauma training (i.e., frequency and range of topics, training opportunities), a finding like that of Simiola and colleagues' (2018) investigation of trauma training in pre-doctoral internship programs.

Taken together, trauma training is available to some extent in counseling psychology programs, but the individuals who are receiving it are self-selected. This indicates there are students who are not receiving the same education within the program. The required curriculum for a psychology doctoral degree leaves little room for additional courses, so students may not have the option to add another course. This does not consider that students may be receiving trauma education and training through other avenues, such as conferences, online trainings, or

during practicum and internship experiences. As noted by Cook and colleagues (2011), psychologists, including psychologists in-training, can certainly expect to have trauma survivors among their caseload, making it critical that ALL students have some formal training in trauma work. It would appear that a regularly offered trauma-focused course would be a welcome addition to most counseling psychology doctoral programs, perhaps even as a requirement, so all enrolled students receive trauma education and training rather than a select few. Taken a step further, truly integrating trauma-focused psychoeducation and treatment intervention and application throughout the core curriculum could be an option for counseling psychology programs. This would ensure all students receive trauma-focused education and training without having to take an additional elective course. Finally, this would also build trainees' self-efficacy in their provision of trauma services; participants noted the importance of receiving trauma education and training and their confidence in their clinical abilities during in the current study.

### **Strengths and Limitations**

Several strengths were present in this study. First, the primary researcher's prior experience with trauma education and training may have provided more insight into participants' experiences. The researcher's insider knowledge and awareness of trauma training and education could have shaped the type of follow-up questions asked to expand upon participants' responses, which may have been excluded by a researcher without such education and training.

Confirmability was another strength of this study through the use of reflexivity and peer debriefers to ensure the results of the study were based in and can be connected back to the data collected and the data analyses (Morrow, 2005). The researcher engaged in reflexivity throughout the study to monitor biases and assure participants' experiences were their own. The researcher's reflexivity process consisted of (1) not asking leading questions about themes

previously identified with other participants, (2) reflecting on the research questions before each interview, and (3) intentionally approaching each participant's interview as their own, and not affiliated with prior participant interviews (Kvale, 1996). The two doctoral peer debriefers, who had no personal interest in the research study, were consulted during data analyses and engaged in the process of reflexivity. The peer debriefers were sent participants' raw data along with the researcher's analysis of the data to review, critique, and provide feedback on findings and any possible biases present in the data analysis. Finally, the researcher kept an audit trail with detailed notes of all research procedures, including notes of how data categories and themes emerged and any possible influences that may have impacted data collection or analysis (Akkerman et al., 2008; Morrow, 2005). The audit trail was then sent to the peer debriefers for review and feedback.

There were several limitations in the present study, mostly due to the qualitative design. First, the transferability of the current findings is limited as this was a small sample size and no statistical analyses were conducted (Lincoln & Guba, 1982; Morrow, 2005). Each theme presented in the results notes the number of participants who endorsed each theme. Themes expressed by more participants would be considered more transferable than those discussed by few participants. For example, all participants reported learning some trauma psychoeducation within their respective trauma training settings. This theme is deemed highly transferable. However, the sample primarily identified as women (83%) and white (67%), therefore, the transferability of themes pertaining to these participants' experiences receiving trauma-focused education and training, and the influence of said training on their clinical provision of mental health services, may be different than counseling psychology doctoral students who do not identify as women and white. Another limitation of the present study is the participants were

only interviewed once for data collection rather than over a series of interviews and they were not contacted following the interview. Since participants were not contacted after the researcher transcribed their interviews, they were not given the opportunity to provide feedback as to whether the interviews were interpreted correctly or rectify any responses to ensure there was no misinterpretation (Chan et al., 2013). The current study is also dependent within two larger systems, each respective counseling psychology doctoral program and the APA Commission on Accreditation, as there are specific requirements students must obtain to complete their doctoral degree.

The current results suggest if counseling psychology programs continue trauma education and training as is, these same results would be expected. However, should counseling psychology doctoral programs integrate and provide more trauma education and training, the results of a similar study could be different. Finally, both peer debriefers held doctoral degrees in psychology, one counseling psychology and one school psychology, within the same region of the United States. This could have skewed the data analysis process, as many critical thinking skills and opinions are culturally bound within psychology training and geographic location.

### **Implications for Training Programs**

From a training perspective, based on the findings from the present study and past research, trauma training is occurring in psychology programs (Cook et al., 2019; Cook et al., 2017; Courtois & Gold, 2009). However, since all programs do not offer or require trauma-specific education and training, the students that receive this education and training are self-selected as they must seek out these opportunities on their own, typically through practicum and internship placements. Though APA's *Standards of Accreditation for Health Service Psychology and Accreditation Operating Procedures* (SoA, 2018) provide psychology programs with

guidelines for the minimum levels of achievement needed throughout practicum, internship, and post-doctoral levels of training, there are no specific references to trauma education within the accreditation standards. Given the lack of specificity in the standards, programs have the option to integrate trauma education throughout their core curriculum as it would provide doctoral students with frequent exposure to trauma education and training and allow them to continue advancing their knowledge in this area (Bjork & Bjork, 1992). This approach would be consistent with the concept that trainees SHOULD be progressing in the complexity of their knowledge and skills throughout the program (APA, 2018; Fouad et al., 2009).

The current study provides insight into how trauma training and education within counseling psychology programs is implemented, with noted modalities being classes, supervision, research, and didactic or lectures. Additionally, participants in the current study indicated the more experiences of trauma education and training they received, the more competent they felt providing trauma treatment and intervention to clients. To foster and increase psychology doctoral students' self-efficacy in their provision of trauma services, counseling psychology programs should look for opportunities to integrate trauma education and training. Based on the current findings, this could be done in several ways, including incorporating trauma education, interventions, and application throughout core curriculum, through supervisory experiences, or a lecture/didactic series. In this way, students would receive repeated exposure to trauma education and training over the course of the program. Additionally, several students mentioned completing trauma training through an outside agency (e.g., U. S. Department of Veterans Affairs) as part of a requirement for a course, practicum supervision, or research lab. This could be an option for faculty to utilize in tandem with lectures, didactics, or discussions so more students are able to take advantage of such opportunities.

Through continuous trauma learning and practice opportunities in counseling psychology programs, students would not only feel more confident in their knowledge and ability to provide trauma-informed care to clients, but they would be engaging in ethically appropriate practice. Additionally, they would be able to progress in the complexity of their trauma knowledge and skills throughout their program rather than only receiving education and training at the beginning or end of their program or in practicum or internship. This would be in line with the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015), *APA Clinical Practice Guideline for the Treatment of PTSD* (APA, 2017a, 2017b), and the APA Ethics Code (2017), as well as Bjork and Bjork's (1992) new theory of disuse and generative learning (Wittrock, 1989; Mayer, 2010).

### **Implications for Research**

There are several research implications to note for next steps in the literature on trauma education and training in psychology doctoral programs. Future research on trauma education and training within counseling psychology doctoral programs could include a larger sample size and quantitative methods to increase generalizability of the findings, as well as the exploration of other factors impacting or contributing to engagement in trauma education and training. By increasing generalizability, future research findings could provide more insight and understanding on how to better integrate trauma education and training in counseling psychology programs.

Given participants' experiences providing trauma-informed care and what makes them feel competent and confident, future research should examine what aspects of trauma education and training students believe increase self-efficacy in their provision of trauma services. Factors to examine in future research could focus on themes discussed in the current study such as the

use of outcome measures with clients, being able to assess trauma symptoms, trauma psychoeducation, supervisor feedback and support, and working with a variety of trauma clients.

### **Implications for Clinical Training**

Incorporating holistic trauma training and education withing counseling psychology doctoral programs' curricula would provide all psychologists in-training with the foundational knowledge needed to work with trauma populations ethically and appropriately. The high prevalence rates of trauma in the population (U.S. Department of Veteran Affairs, 2023), ensures psychologists will provide clinical service to someone either directly or indirectly impacted by trauma. Increased understanding of the biological, neurological, psychological, and social repercussions of trauma can assist psychologists in assessing and identifying trauma responses, DSM diagnosing, and providing appropriate treatment (Brown, 2020). In acknowledging the multifaceted presentation of trauma, psychologists would be practicing within their competence and in accordance with the *APA Clinical Practice Guideline for the Treatment of PTSD* (2017a, 2017b) and APA's *Ethical Principles of Psychologists and Code of Conduct* (2017). Additionally, all psychologists should regularly participate in continuing education related to trauma treatment to make certain they are not only refreshing themselves on the content, but also guarantee they are staying up-to-date on the best practices and treatments for trauma clients.

### **Conclusion**

The high prevalence of trauma throughout the U. S. population guarantees psychologists will regularly encounter and work with clients who have experienced a form of trauma or been impacted by trauma. Despite high rates of trauma, existing research suggests trauma education and training within psychology programs is limited. The present study aimed to understand trauma education and training experiences within counseling psychology doctoral programs

through a qualitative approach. Counseling psychology doctoral students who had completed trauma education or training within their program were interviewed and to describe their experiences learning about trauma-informed care and what information or skills they believed to be important when working with trauma clients. The current findings indicate trauma education and training is occurring in counseling psychology doctoral programs, however, which students receive this education and training is dependent upon their own personal interest, if there is room in the degree plan for an elective course, research focus (personal or research assistantship), or possible discussions in supervision. This suggests trauma education and training within counseling psychology programs is reliant on personal interest rather than a foundational component and standard of the doctoral degree in psychology. Overall, this study shows counseling psychology doctoral students want more trauma education and training within their programs prior to providing trauma services to clients. Implications of this research are highly relevant to psychologists in-training, counseling psychology faculty, and APA's *Standards of Accreditation for Health Service Psychology and Accreditation Operating Procedures* (APA, 2018).

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## APPENDIX A: Extended Literature Review

### Holistic Trauma-Informed Training in Counseling Psychology Doctoral Programs

Individuals in the United States experience trauma at a remarkably excessive rate (U.S. Department of Veteran Affairs, 2023). As defined by the American Psychological Association (APA; 2020), trauma is “any disturbing experience that results in significant fear, helplessness, dissociation, confusion, or other disruptive feelings intense enough to have a long-lasting negative effect on a person’s attitudes, behavior, and other aspects of functioning” (Definition 1). Traumatic experiences can include, but are not limited to, war, rape, accidents, and natural disasters (APA, 2020). Additionally, within the last 50 years, the field of psychology has expanded the definition of trauma to also include verbal and emotional abuse (Shepard & Campbell, 1992; Straus, 1979). The encompassing, and ever evolving, definition of trauma provides individuals with a more diverse perspective of the many ways in which one can experience trauma.

Though the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition, text revision (*DSM-5- TR*; APA, 2022) provides psychologists with criteria for what constitutes a traumatic stress response, the etiology of the response is limited. Currently, the *DSM-5- TR* notes an individual must have been exposed to “actual or threatened death, serious injury, or sexual violence” (APA, 2022, pg. 271) by (1) directly experiencing traumatic event(s), (2) witnessing the event(s) occur, (3) learning the event(s) happened to a close friend or family member / learning a violent or accidental, actual or threatened death of a friend or family member occurred, (4) or repeated exposure to aversive details of the event(s) for a diagnosis of posttraumatic stress disorder (PTSD) to be given. While this criterion is beneficial in identifying more traditional etiologies for traumatic events, it is not inclusive of the more current, expanded

descriptions of traumatic experiences such as betrayal trauma (Freyd, 1996), racial trauma (Carter, 2007), and complex trauma (Herman, 1992). Research has shown “nontraditional” forms of trauma (i.e., racial trauma) have physiological and psychological symptoms similar to those experienced by individuals diagnosed with PTSD (Brown, 2020). This becomes concerning for psychologists as they must determine appropriate treatment based on the presenting concern, and if the etiology of a client’s stressor symptoms does not align with the *DSM-5-TR*, the appropriate treatment may not be implemented.

To ensure clients are receiving the best care possible, it is imperative psychologists receive appropriate trauma training prior to working with individuals from trauma populations. Taken a step further, doctoral psychology programs should integrate the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) into their curriculum to ensure psychologists in-training are equipped to work with trauma populations and are able to develop foundational knowledge in trauma-informed care. However, this is not always the case as research has shown few psychology programs offer opportunities for trauma-related course work or training (Bruce et al, 2018; Cook et al., 2017). Furthermore, research has shown psychologists will still provide some form of trauma therapy with clients despite a lack of sufficient training in trauma-informed care (Cook et al., 2011). It is possible this type of work borders on working outside one’s scope of competence. Not only does working outside of one’s scope of competence put clients at risk, but it is also a direct violation of the APA’s *Ethics Code* (Standard 2.01 Boundaries of Competencies; 2017). At minimum, psychologists providing trauma services should utilize the *APA Clinical Practice Guideline for the Treatment of PTSD* (APA, 2017a, 2017b) to assure they are providing accurate and competent care. Without an adequate

foundation to trauma-informed care, psychologists, both fully licensed and in training, risk the chance of harming their clients (APA, 2017a, 2017b).

To better understand how psychology programs are training their students in trauma-informed care, this study examines the experiences of current doctoral students who are enrolled in counseling psychology programs implementing trauma-informed training. Counseling psychology doctoral students were interviewed and asked about their experiences and training in trauma-informed care within their respective programs. Based on the data collected from students' interviews, recommendations were made for counseling psychology programs who lack similar opportunities for trauma-informed training and education. Following is a review of the literature on traumatic experiences among individuals in the US.

### **Prevalence of Trauma in the United States**

The occurrence and repercussions of trauma in the United States are noteworthy as approximately 50% of women and 60% of men experience at least one trauma in their lifetime (U.S. Department of Veteran Affairs, 2023). Additionally, about 8 million individuals develop PTSD each year in the United States after experiencing a traumatic event (U.S. Department of Veteran Affairs, 2023). The prevalence of lifetime exposure to trauma in the United States was examined by Forman-Hoffman and colleagues (2016) using mental health surveillance studies with participants ( $N = 5,653$ ). For their analysis, the researchers utilized the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, APA, 1994)* criteria to assess posttraumatic stress symptoms. Additionally, they used four measures of traumatic event exposure and posttraumatic stress including, (1) lifetime exposure to one or more potentially traumatic events, (2) lifetime exposure to one or more potentially traumatic events followed by recurrent flashbacks, (3) experience of posttraumatic stress symptoms in the past year, and (4) if a PTSD

diagnosis was given in the past year. They found individuals ages 26 and older were more likely to have been exposed to one or more potentially traumatic event(s) in their lifetime when compared to individuals ages 25 and younger. More specifically, 43% of individuals ages 26 to 49 and 45% of individuals ages 50 and older, had experienced at least one potentially traumatic event in their lifetime. Taken together, 88% of the participants reported at least one lifetime traumatic experience (Forman-Hoffman et al., 2016).

Similarly, Kilpatrick and colleagues (2013) assessed exposure to traumatic events and posttraumatic stress symptoms with the *DSM-IV* and *DSM-V* criteria. The survey consisted of 25 closed-ended questions and measured exposure to traumatic events. Additionally, there were three follow-up questions about other traumatic events not asked in the questionnaire and a written description of their traumatic experience(s) (Kilpatrick et al., 2013). They found 89% of their participants ( $N = 2,963$ ) reported exposure to at least one previous traumatic event in their lifetime with multiple traumatic events being the norm (Kilpatrick et al., 2013).

As demonstrated in these prevalence studies, there are a significant number of individuals in the United States who have experienced a traumatic event in their lives. Furthermore, individuals who experience prolonged exposure to traumatic conditions can possibly develop complex trauma as their traumatic experience(s) occur over time rather than a single event or several singular events (Courtois, 2008; Herman, 1992). Based on the cited prevalence rates, the likelihood psychologists will work with an individual who has experienced at least one traumatic event in their lifetime is high, if not guaranteed. Thus, psychologists must have a foundation in trauma-informed care to provide ethical, competent services to clients seeking therapy services for trauma. As such, the next section considers various conceptual and empirical standards

training programs should aspire to implement for trauma-informed education and training, followed by the current status of trauma-informed training in applied psychology programs.

### **Trauma Education and Training Guidelines**

As discussed, it is highly likely, and nearly certain, counseling psychologists will provide services to someone with a history of trauma across their professional career. Given this likelihood, it is imperative psychologists receive training and education in trauma-informed care to provide competent services. More specifically, a holistic understanding of trauma, its manifestation, and best treatment practices may be considered a foundational component of training within psychology doctoral programs. For the purposes of this study, a holistic understanding of trauma is defined as an understanding of how trauma impacts an individual from a biopsychosocial approach. Acknowledging how trauma affects individuals from a multifaceted perspective provides psychologists with the necessary knowledge to make appropriate diagnoses and give competent treatment to clients who present with trauma symptomology (Kumar et al., 2019). Thus, a holistic understanding of trauma recognizes the biological, cognitive, psychological, and sociocultural manifestations of trauma and uses this information in conceptualization and treatment (Kumar et al., 2019).

Similarly, the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) recognizes the biopsychosocial impact of trauma and includes this perspective within the listed competencies. Trauma-related competence is defined as the “minimal knowledge, attitudes, and skills” a psychologist should possess when working with trauma populations (APA, 2015). The *Guidelines on Trauma Competencies for Education and Training* (APA, 2015; hereafter referred to in this section as simply the Guidelines) provide guidelines to assist in translating this required knowledge into training and education. These competencies address

biological and cognitive-affective bases of trauma (scientific knowledge), how legal, cultural, and policy issues impact trauma and trauma work (professionalism), and psychosocial interventions aimed at alleviating suffering and promoting the health and well-being of trauma-exposed individuals, groups, and communities (psychosocial intervention). The essential components of these Guidelines and competencies are listed in detail below.

To begin, the Guidelines provide nine cross-cutting competencies in the areas of knowledge, attitudes, and skills that are considered foundational to broader competencies including concerns with individual and cultural diversity, developmental factors, and self-reflective practice (APA, 2015). The cross-cutting or foundational competencies include: 1) understanding the impact of trauma on health outcomes, 2) understanding trauma responses in relation to intersecting identities, 3) recognizing individual and systemic impacts of trauma, 4) adapting assessment and interventions to account for developmental lifespan factors, 5) addressing complex trauma, 6) incorporating client's strengths into interventions and collaborating (i.e., share power in decision-making) when appropriate, 7) psychologist engagement in self-reflection, self-care, and awareness of biases, 8) applying research-based interventions and assessment strategies, and 9) engaging in interprofessional collaboration (APA, 2015). These competencies were developed to be applied across trauma-exposed groups, disciplines, and theoretical orientations (APA, 2015).

The nine cross-cutting competencies are foundational components upon which broader competency areas are based. The broader trauma-related competencies span across five areas: 1) scientific knowledge about trauma, 2) psychosocial trauma-focused assessment, 3) psychosocial trauma-focused intervention, 4) trauma-informed professionalism, and 5) trauma-informed rationale and systems (APA, 2015). Scientific knowledge includes knowledge about the

prevalence, incidence, risk and resilience factors, trajectories, subpopulations, and settings regarding trauma. Psychosocial trauma-focused assessment requires clinicians to possess knowledge of, and skills in, applying up-to-date assessment measures determined to be suitable for trauma survivors. Psychosocial trauma-focused intervention emphasizes the importance of using research supported interventions to foster a sense of safety, trust, and openness to address trauma-focused material. Trauma-informed professionalism requires clinicians to work ethically on behalf of trauma survivors in both therapy and organizations and/or systems. Finally, trauma-informed rationale and systems refers to clinicians' ability to interact with trauma populations effectively and consciously, and recognize the effects of trauma at the individual and systemic levels to ultimately promote resiliency, recovery, and prevention (APA, 2015). Within these five trauma-related competencies, benchmarks are provided to evaluate psychologists in-training and their readiness to advance in their education and training or for independent practice (APA, 2015). These benchmarks help distinguish psychologists' levels of experience (e.g., beginner, intermediate, expert) and can be adjusted as necessary throughout one's training.

In addition to the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015), there is also the *APA Clinical Practice Guideline for the Treatment of PTSD* (APA, 2017a, 2017b). These sets of guidelines provide best practice recommendations for the treatment of PTSD in adults. The *Clinical Practice Guideline for the Treatment of PTSD* is based on the best available evidence, at the time they were written, and answers these questions: 1) What is the efficacy of psychological and medication treatments for adults with PTSD? 2) What is their comparative effectiveness? 3) Which treatments work best for which patients? and 4) Do serious harms/adverse events of treatments (e.g., hospitalization secondary to risk for suicide or suicidal attempt) or patient preferences influence treatment recommendations? (APA, 2017a,

2017b). Listed in the *APA Clinical Practice Guideline for the Treatment of PTSD* (APA, 2017a, 2017b) are psychotherapy and psychopharmacology treatments for trauma as well as recommendations along with the strength of these recommendations (e.g., strong, conditional, insufficient).

Furthermore, the APA's *Ethical Principles of Psychologists and Code of Conduct* (APA, 2017) expounds upon psychologists practicing within the boundaries of their competence. In the *APA Ethics Code* (Principle D, Justice, 2017, p. 4), psychologists are to ensure the "boundaries of their competence and the limitations of their expertise" do not result in wrongful practices. Additionally, the *APA Ethics Code* (Standard 2.01, Boundaries of Competence, 2017, p. 5) emphasizes psychologists' competence boundaries are derived from their "training, supervised experience, consultation, study, or professional experience." Counseling psychologists who lack training, or have no training, in trauma-informed care may fail to recognize trauma-related symptoms, properly assess trauma history, develop inaccurate conceptualizations, or misdiagnose clients (Kumar et al., 2019). Further, psychologists providing trauma-related services to clients without proper training would be in direct violation of Principle D (Justice) and Standard 2.01 (Boundaries of Competence) of the *APA Ethics Code* (2017) as they would be offering services outside their scope of practice. Subsequently, psychologists who are ill-equipped to treat trauma populations risk providing misdirected or harmful treatment to clients which can run the risk of retraumatizing them (Cook et al., 2011; Dorahy et al., 2016). This includes being cognizant of individuals who may experience traumatic symptoms but do not recognize their experience(s) as traumatic (Brown, 2020). When psychologists understand the many ways in which trauma can manifest and be experienced by individuals, they become better able to comprehend clients' biological, social, psychological, and behavioral responses as trauma

responses. Lastly, by acknowledging the multifaceted presentation of trauma, psychologists can holistically conceptualize clients and gather the information needed to ensure appropriate assessment and treatment interventions are implemented (Brown, 2020).

Conclusively, the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015), *APA Clinical Practice Guideline for the Treatment of PTSD* (2017a, 2017b), and *APA's Ethical Principles of Psychologists and Code of Conduct* (2017) all provide an in-depth illustration of what it means to be an ethical, trauma-informed psychologist and the foundational knowledge one should possess and continue to build upon. In utilizing both guidelines and the ethics code, psychologists and academics can provide inclusive, evidence-based training and education in trauma for psychologists in-training to utilize when learning to work with trauma populations. Psychology programs' recognition and inclusion of these guidelines and principles would give students the comprehensive understanding of trauma-informed care needed to provide appropriate and ethical treatment to trauma populations. In summary, focusing education and training on these guidelines would provide students with the foundational knowledge in trauma-informed care to build upon in the future, thereby maintaining competency across the professional lifespan (Principle, 2.03, Maintaining Competence, APA, 2017). A better understanding of the current status of trauma-informed training and education is described below to illustrate what trauma education and training psychology students receive and gaps in these areas examined in prior literature.

### **Current Status of Trauma-Informed Training**

Given trauma prevalence rates, it is imperative psychologists acknowledge and understand basic foundations of trauma psychology and treatment to provide competent services. For this reason, counseling psychology doctoral programs should, at minimum, be integrating

trauma-informed education and training throughout training activities. This foundation should aim to provide students with beginning level knowledge to ensure strong conceptualization, diagnosis, and treatment skills in trauma-informed care (APA, 2015).

The current status of trauma-informed education and training in counseling psychology doctoral programs is unknown, as the last survey to examine trauma education and training within clinical and counseling psychology doctoral programs was in 2007 by the Education and Training Committee of Division 56 of the APA (APA, 2007). However, the current researcher cross-referenced the trauma education and training data provided by the Education and Training Committee of Division 56 with APA's directory of accredited counseling psychology programs (APA, 2023). The directory listed 75 APA-accredited counseling psychology programs as of April 2023. Of those accredited counseling psychology programs, only 4, or approximately 5%, were on Division 56's list of programs with either courses, faculty interest, or program emphasis in trauma education and training. Though researchers continue to acknowledge psychology doctoral programs lack trauma-informed education training (Cook et al., 2019; Cook et al., 2017; Courtois & Gold, 2009), there has been no examination into why this phenomenon occurs or recommendations to assist programs in integrating trauma-informed education and training into their curriculum.

The most recent available research regarding trauma-informed education and training within broader applied psychology programs, including clinical, counseling, school, and combined psychology doctoral programs, was conducted by Cook and colleagues (2017). They examined trauma psychology courses and practicum experiences offered in psychology doctoral programs to determine the status of training in trauma. The researchers retrieved training directors' contact information from the APPIC Academic Programs in Psychology Directory,

which included training directors from both APA-accredited and non-APA-accredited programs. Of the 414 programs they contacted, 151 responded and provided adequate information for the purposes of the study (a response rate of approximately 36%; Cook et al., 2017). Programs categorized as having trauma-focused education and training offered both trauma psychology courses and practicum experiences with trauma populations (Cook et al., 2017). For programs identified as trauma-focused, further inquiry was made on whether the trauma courses or practicums were required or optional for students. Cook and colleagues (2017) found among sampled programs, 1 in 5 psychology doctoral programs offered these opportunities for students to participate in trauma training, and most of these experiences occurred in optional practicum settings or didactics on trauma. Practicum sites were found to offer students opportunities to learn trauma specific interventions such as Prolonged Exposure Therapy, Cognitive Processing Therapy, and Trauma-Focused Cognitive Behavioral Therapy (Cook et al., 2017). In terms of didactics, programs offering some form of trauma education or training provided students with opportunities to attend workshops or seminars and focused training on diagnosing trauma-related disorders.

Cook and colleagues (2017) also identified barriers in providing trauma-informed education and training. The most cited barriers included the limited availability of elective courses and resources. Less common barriers were lack of student interest, and student and faculty concerns about safety when working with trauma populations (Cook et al., 2017). The researchers acknowledged the results from this survey study did not encompass a comprehensive reflection of trauma training in psychology doctoral programs due to the low response rate, and some degree of sampling bias from the training directors who responded due to their investment in trauma training (Cook et al., 2017). They also acknowledged the results of their study only

included trauma training from the perspective of the program training directors, with no input from programs' doctoral students. Additionally, it should be noted, of the training directors who responded, 98 of the 151 programs (65%) were clinical psychology programs. Additionally, the researchers only distinguished clinical psychology programs in their results and data tables and did not provide separate, specific data results for counseling psychology.

Comparable to Cook and colleagues (2017) examination of psychology doctoral programs' trauma education and training, Sigel and Silvosky (2011a) investigated graduate psychology programs' use of evidence-based treatment (EBTs) for child and family trauma. Of the 599 graduate program directors contacted, 201 (34% response rate) responded to the survey questionnaire. Of the 201 directors who responded, 89% provided training in at least one EBT (Sigel & Silovsky, 2011a). However, only 45% of graduate programs provided training in treatments with strong empirical support (e.g., Trauma-Focused Cognitive-Behavioral Therapy; Sigel & Silovsky, 2011a).

Similar to the findings of Cook and colleagues (2017) and Sigel and Silvosky (2011a) regarding trauma training opportunities in psychology programs, Simiola and colleagues (2018) examined the occurrence of trauma training within pre-doctoral internship programs. Because predoctoral internships are a requirement to obtain a doctoral degree in psychology, it is also important to understand what trauma training includes during internship, as this is one of the last training opportunities psychologists in-training have before independently practicing. Simiola and colleagues (2018) surveyed training directors of predoctoral internship sites. Of the 726 training directors they contacted, 259 (35.6% response rate) responded and answered the survey questionnaire. They found all 259 training programs offered at least one trauma training opportunity in the form of didactics or supervision, with 62% of sites offering one to three hours

of trauma didactics and 54.5% offering supervision-specific training opportunities (Simiola et al., 2018). However, the breadth and depth of this training was found to be low as the frequency and range of topics, and training opportunities, was limited due to the priority of other training program requirements (Simiola et al., 2018). Additionally, only 34.7% of these sites offered training in EBT for trauma (Simiola et al., 2018). Notably, 20% of the training directors in this study were from the Department of Veterans Affairs (VA) Medical Centers training programs, while 70% of the training programs were affiliated with an academic institution (Simiola et al., 2018). The researchers suggest the VA and academic institutions may be able to provide more training in trauma-informed care due to the resources available to them (Simiola et al., 2018). Comparable to Cook and colleagues (2017), data collection solely from the perspective of training directors and no students is a limitation of Simiola and colleagues' (2018) study.

While Simiola and colleagues (2018) surveyed predoctoral internship training sites regarding trauma training and education for adult clients, Sigel and Silvosky (2011b) surveyed predoctoral psychology internship sites' use of EBTs for child maltreatment and their families. Of the 373 psychology predoctoral pediatric internship training directors that were contacted, 137 (37% response rate) answered the survey questionnaire (Sigel & Silvosky, 2011b). Based on the data collected, 82%, or 4 out of 5, internship sites provided at least one EBT training with the most taught treatments being Trauma-Focused Cognitive-Behavioral Therapy, Parent-Child Interaction Therapy, and Abuse-Focused Cognitive-Behavioral Therapy. Notably, the most taught EBTs were all identified as well-supported treatments by the Chadwick Center for Children and Families (2004) and labeled as best practice treatments (Saunders et al., 2004). However, 49% of all internship sites reported training in at least one treatment intervention not supported by research (Sigel & Silvosky, 2011b).

Taken together, research suggests trauma training is occurring in some programs for doctoral psychology students. However, research on the depth, content, and quality of the trauma training is lacking, as there are no descriptions of the content utilized within these training programs. Additionally, the available research has only assessed trauma education and training experiences from the perspective of graduate and predoctoral internship training directors. While this point of view is helpful in gauging where trauma training is occurring, there is no available data to date from students' perspectives. The completed study examined the trauma-based education and training experiences of doctoral students in counseling psychology programs to understand how this training is implemented. In the following sections, the foundations of trauma-informed care and additional relevant training standards are discussed to better understand the multifaceted perspective of trauma that should be included in trauma education and training.

### **Foundations of Trauma-Informed Care**

As noted, to conceptualize and appropriately treat clients who have experienced trauma, it is imperative to understand how traumatic experiences can impact them (i.e., somatic, cognitive, psychological). Psychologists often use the *DSM-5-TR* (APA, 2022) to classify and diagnose clients' reported symptomology which further assists with determining appropriate assessments, interventions, and other services. Though the *DSM-5-TR* (APA, 2022) can be helpful in identifying and diagnosing psychological disorders associated with trauma, it limits psychologists' ability to consider additional aspects of trauma that contribute to posttraumatic stress responses and traumatic experiences that do not meet *DSM-5-TR* criteria.

Trauma manifests in many forms including insidious trauma, microaggressions, intergenerational trauma, betrayal trauma, complex trauma, and race-based trauma (Brown,

2020; Carter et al., 2017). When considering the diversity in types of traumas, psychologists should be wary of what they consider to be a “normal” traumatic event, or “typical” response to a traumatic event, as individual differences can influence what one considers traumatic and one’s response to a traumatic exposure (Brown, 2020). To further understand the rationale for why foundational clinical training and education in assessing and treating trauma are important, I provide an overview of the effects of traumatic experiences from a holistic perspective which includes the neurological, socio-cultural, and psychological impacts of trauma.

### **Neurological Perspectives**

Following a traumatic encounter, individuals can be left with partial memory of their experience, have easily reactivated neurobiological responses, and experience sensorimotor reactions and symptoms (e.g., body sensations, images, smells, physical pain, numbing, etc.; Ogden et al., 2006). Although not an exhaustive list of what an individual can experience following a traumatic encounter, these provide insight as to why individuals may experience a disrupted sense of self. Furthermore, the trauma one has endured can impact how information processing on cognitive, emotional, and sensorimotor levels are integrated, leading to dysregulated arousal (Ogden et al., 2006). This can lead to escalated emotional reactions, uncontrollable thoughts, and misinterpretation of one’s present environmental cues as those of past trauma experiences (Ogden et al., 2006).

Researchers have linked several structural and functional brain alterations to trauma including parts of the amygdala, hippocampus, cingulate cortex, and the dorsolateral and ventromedial regions of the prefrontal cortex (Bremner et al., 1995; Morey et al., 2009; Rauch et al., 2006). The amygdala, hippocampus, and prefrontal cortex are involved in emotion processing and memory formation, including learning what fear is and assigning emotional

valence for memories (Etkin & Wagner, 2007; Lezak et al., 2012). When an individual experiences a traumatic event, communication among these areas of the brain is disrupted. This can result in long-term changes in brain circuitry and how individuals may later respond to stressful encounters (Vermetten & Bremner, 2002). Additionally, individuals are at risk for misinterpreting and possibly having an inappropriate response to their environment due to the lack of communication between the prefrontal cortex and amygdala (Herringa, 2017; McGaugh, 2004).

The above findings suggest exposure to trauma, or recall of traumatic experiences, causes dysfunction of the neurocircuitry involving the medial prefrontal cortex, hippocampus, and amygdala (Bremner, 2006). Though these functional adaptations have been associated with PTSD, available research also supports these changes in brain regions are also associated with depression (Bremner et al., 2000), borderline personality disorder (Schmahl et al., 2003), and dissociative identity disorder (Vermetten et al., 2006). This is important to consider for differential diagnosis and emphasizes the importance of psychologists having the skill set to appropriately assess trauma as trauma symptoms significantly overlap with multiple diagnoses. The diagnosis given to clients ultimately determines what or how treatment is implemented; certain DSM-5-TR diagnoses are often used for clients who have trauma histories.

### **Psychological Perspectives on Trauma**

In addition to APA's definition of trauma, the *DSM-5-TR* (APA, 2022) lists criteria individuals must endorse for their symptoms to be classified as a trauma- and stressor-related disorder. The *DSM-5-TR* acknowledges the psychological distress individuals experience following trauma exposure is variable (APA, 2022). This variability relies on multiple factors such as how one responds to a trauma, the severity of the trauma (i.e., magnitude, frequency,

duration, severity, and timing of the event), presence of interpersonal betrayal, vulnerability, or resilience factors, and one's ability to control the traumatic experience and/or subsequent reactions (Wilson, 1995). These factors impact whether individuals present symptoms within an anxiety- or fear-based context, a clinical presentation of anhedonic and dysphoric symptoms, externalizing angry and aggressive symptoms, dissociative symptoms, or a combined presentation (APA, 2022).

When an individual has a collection of symptoms that are classified under the broad symptomology above, a formal diagnosis can be made. The most frequent diagnoses given to individuals who have experienced trauma are posttraumatic stress disorder (PTSD), acute stress disorder, and adjustment disorder (Abram et al., 2007; Brown, 2020; Courtois & Ford, 2009; Jakovljevic et al., 2006). Additional formal diagnoses that are associated and observed with trauma populations are mood disorders, personality disorders, and substance disorders; however, these disorders have high comorbidity rates with PTSD (Abram et al., 2007; Courtois & Ford, 2009; Jakovljevic et al., 2006). These additional disorders can also be present when individuals have experienced trauma but do not meet criteria for PTSD. For clients who present to treatment with trauma- or stressor-related symptoms after a trauma but do not meet criteria for a PTSD diagnosis, the *DSM-5-TR* offers the diagnoses of *other specified trauma- and stressor-related disorder* and *unspecified trauma- and stressor-related disorder* (Brown, 2020; APA, 2022). Furthermore, these diagnoses allow psychologists to acknowledge any of the previously mentioned forms of trauma (i.e., betrayal trauma, race-based trauma, complex trauma) that cause trauma and stress responses for clients but do not meet the *DSM-5-TR*'s criterion for a diagnosis of PTSD (Brown, 2020). When examining trauma diagnoses, it is important to explore how sociocultural factors can impact trauma responses for individuals.

### **Sociocultural Perspectives**

The *Guidelines on Trauma Competencies for Education and Training* (APA, 2015), *APA Standards of Accreditation for Health Service Psychology and Accreditation Operating Procedures* (2018), and the APA's *Ethical Principles of Psychologists and Code of Conduct* (2017) note the importance of attending to clients' sociocultural contexts when providing services. It is not only imperative for clinicians to be competent in trauma-informed care, but it is equally, if not more important, for clinicians to understand how an individual's cultural background can impact their presenting problem(s). Through understanding culturally specific values, group norms, and the contexts that shape these traumatic experiences, more accurate and culturally competent psychological treatment can be administered.

An individual's cultural background (e.g., individualism vs. collectivism, religion, social roles, race/ethnicity, etc.) can influence their reaction to a traumatic event (Buse et al., 2013; Wilson, 2007). While this review precludes an extensive review of all sociocultural variables, a few examples will be provided. To start, Black women are often perceived as "strong Black women" who persevere through all encountered challenges or obstacles (Woods-Giscombé, 2010). However, this mindset has not been proven beneficial, as Black women who embrace this identity have been shown to be at a greater risk for developing psychological disorders such as anxiety and depression (Stanton et al., 2017). This belief, at the extreme end, prevents Black women from expressing psychological concerns that may arise because they are expected to be emotionally resistant individuals who need little to no assistance from others (Collins, 2009). As a result, in a clinical setting, clients who identify as Black women may minimize their traumatic experience(s) or hesitate to express emotional vulnerability. Psychologists who lack awareness or knowledge in culturally informed trauma psychology may fail to recognize these presenting

concerns as responses to trauma, can further traumatize or harm clients, provide inappropriate treatment, or misdiagnose their presenting concerns (APA, 2015; Dorahy et al., 2016).

As a starting point to becoming culturally informed in trauma, the *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017) provide psychologists with a framework for understanding the experiences of clients through their intersecting identities to provide culturally competent care. As counseling psychologists, multiculturalism, diversity, and social justice are at the center of the profession (Vera & Speight, 2003) as well as a focus on strengths-based approaches to problem solving (Hill, 1977). The *APA Multicultural Guidelines* (2017) encourage psychologists to utilize a strengths-based approach to acknowledge challenges while also identifying positive, resilient ways individuals from diverse backgrounds address life experiences (Guideline 10). From an educational and training perspective, Fouad and Arredondo (2007) suggest faculty in psychology programs should integrate inclusive contextual realities of marginalized populations throughout course content and engage in research opportunities centered on multicultural education and training (e.g., publish research, facilitate workshops/training) to create a more culturally competent curriculum.

Taken together, when practitioners do not possess a foundational knowledge in trauma-informed care, they may fail to understand and neglect the multitude of traumatic responses and experiences clients bring to therapy. Understanding traumatic experiences and responses on several levels (i.e., neurologically, psychologically, and socioculturally) is necessary for psychologists to engage in accurate diagnosing (as relevant) and effective treatment (Brown, 2020). Given the extensive knowledge needed to provide competent trauma-informed care, foundational training and education in trauma seems warranted as a required training experience

in counseling psychology doctoral programs. Yet, prior research (Cook et al., 2017) clearly demonstrates the field is missing this mark, and much is still unknown. Additionally, available research (Cook et al., 2017; Sigel & Silvosky, 2011a; Simiola et al., 2018) largely concludes the current level of trauma focused training and education is insufficient yet does not explore in more depth the content of *how* to address this training gap. One approach that may assist with this gap is identifying and describing counseling psychology training programs – and their practices - that are currently providing trauma training and education. The focus on training programs that provide trauma-informed training (or better yet, excel at such training) was the goal of this research study. To further demonstrate the need for such a study, the following sections provide a theoretical grounding for a need to require foundational trauma knowledge for *all* trainees. These theoretical arguments are then linked to existing training competencies, demonstrating alignment with current training standards.

### **Theoretical Rationale for Trauma-Informed Education and Training**

As mentioned, researchers have not examined counseling psychology doctoral programs that are engaging in trauma-informed education and training. As such, learning theories supporting the importance of obtaining foundational trauma-informed knowledge throughout doctoral training are explored. Specifically, constructivist theories including the new theory of disuse and the concept of cognitive overloading are discussed in relation to the current study.

### **The New Theory of Disuse and Cognitive Overloading**

Constructivist theories view learning as a constructive process where individuals connect new information to previously learned information (Mayer & Moreno, 2003). More specifically, the new theory of disuse (Bjork & Bjork, 1992) and the concept of cognitive overloading

(Kirschner, 2002; Mayer & Moreno, 2003) provide a deeper understanding of the importance of acquiring foundational knowledge in counseling doctoral programs.

According to Bjork and Bjork (1992), the new theory of disuse asserts that newly learned information is stored into an individual's memory through the lens of, or linkages to, previously acquired knowledge. For example, how an individual interprets newly presented information depends on what connections they can form between the new information and previously learned (and thus stored in memory) information. Essentially, initial information becomes the foundation for additional or more advanced knowledge to be built upon. In the context of trauma-based training, the more foundational knowledge psychologists have regarding trauma-informed care, the more building blocks available to them to add and store new additional information. For example, a psychologist must first know how trauma affects various regions of the brain, and their functioning, before they can conceptualize clients' trauma responses from a neurological perspective. Bjork and Bjork (1992) argue storing information into long-term storage is a skilled task; they also acknowledge the process of retrieving stored information from memory is variable and dependent on environmental, interpersonal, emotional, or physical cues present when an individual is attempting to recall information. Stated another way, when an individual is attempting to recall information stored in their memory, the right cue(s) must be present at the time of retrieval (Bjork & Bjork, 1992).

Additionally, the new theory of disuse described by Bjork and Bjork (1992) suggests information stored in memory is modified over time to only include the relevant, frequently retrieved details. The frequent retrieval of stored information allows the pertinent details of this information to be remembered and built upon, which permits the development of new associations to this stored information and newly presented information (Bjork & Bjork, 1992).

For example, if a psychologist in-training were required to take several courses or engage in multiple trainings related to trauma-informed care throughout the course of their doctoral program, they would have the opportunity to retrieve the learned information on trauma regularly. According to Bjork and Bjork (1992), the trauma information learned during the doctoral program would be more accessible in the future because of the frequent retrieval throughout different courses or trainings and the creation of new associations. The retrieval of information, and the act of studying information, contribute to the storage strength, or how well the information is learned (Bjork & Bjork, 1992). Trauma information that is well learned and frequently retrieved would have high storage strength and high retrieval strength (i.e., increasing ease and accessibility in retrieving the information from memory; Bjork & Bjork, 1992).

Contrarily, if trauma-informed care is only learned about in one course or training, and there is no engagement in frequent retrieval, the information is less retrievable in the future. Bjork and Bjork's (1992) new theory of disuse suggests even the most highly overlearned, and frequently accessed information can become inaccessible over time if not regularly used. Put in the context of training, psychologists in-training can take one intensive course or training where trauma-based information is thoroughly learned and frequently retrieved through testing, practice, or conversation. However, once this course or training ends, if the trainee does not use the trauma information learned, it eventually becomes unretrievable. Although the coursework or training may result in high storage strength, the longer a trainee goes without retrieving the trauma information, the lower the retrieval strength because of disuse (Bjork & Bjork, 1992).

Additionally, if the trauma information has low retrieval strength, it would take more cognitive energy for a trainee to comprehend newly presented information because the foundational building blocks (previously learned information), are not being cued for recall

(Bjork & Bjork, 1992). For example, psychologists in-training may take one trauma course during their first year in their doctoral program but not work with clients from a trauma population until they are in their third or fourth year of the program. If the trainees have not frequently retrieved the information on trauma learned in the course, they are likely unable to recall the information necessary to work with their clients. In this example, the psychologists in-training would need to relearn the information on trauma to increase the retrieval strength of the information.

Further, learning about a phenomenon is dependent upon prior, stored knowledge an individual possesses that can be connected to newly presented information (Mayer, 2010). This way of learning is referred to as a generative learning process (Wittrock, 1989). Through a generative learning process, newly presented information is integrated with information stored in memory to construct new associations and expand relationships upon the previously stored information. This process of generative learning cannot occur if there is no prior knowledge of a phenomenon or if the information is unretrievable due to disuse (Bjork & Bjork, 1992; Mayer & Moreno, 2003).

When there is no prior information stored to assist with conceptualizing newly presented information, cognitive overloading is inevitable (Mayer & Moreno, 2003). Cognitive overloading occurs when an individual's potential for cognitive processing exceeds the learner's available cognitive capacity (Mayer & Moreno, 2003). In the context of trauma education and training, if foundational trauma-based information is unretrievable during a lecture or presentation on trauma-informed care, the trainee would not have the necessary information to make sense of the newly presented material. Cognitive overloading may occur in this situation because the individual would receive information they are unable to integrate with previously

learned concepts, and ultimately are unable to store the newly learned information into memory. A visual representation of this would be like trying to file paperwork away in a filing cabinet that has no file folder for the paperwork you are trying to store. A folder must first be created to house the paperwork and then, over time, additional paperwork can be added to the folder.

Psychologists complete continuing education across their career. Based on Bjork and Bjork's (1992) new theory of disuse and Mayer and Moreno's (2003) concept of cognitive overloading, a psychologist who does not have foundational knowledge in trauma-informed care would be less likely to retain information presented in a continuing education training for trauma because the foundational trauma information was not learned or retrieved frequently enough to be developed (Bjork & Bjork, 1992). This could eventually lead to cognitive overloading as the amount of new incoming information would not connect to stored information because it does not exist in the first place. Additionally, once cognitive overloading has occurred, the ability for an individual to learn and store newly presented information about trauma-informed care into long-term memory is reduced as the individual can only extract, organize, and consolidate relevant details from the presentation (Kirschner, 2002). Ultimately, advanced training in trauma-informed care in later professional stages may not be integrated into long term memory because it cannot attach to preliminary information (Bjork & Bjork, 1992).

Taken together, the new theory of disuse (Bjork & Bjork, 1992) and the concept of cognitive overloading (Kirschner, 2002; Mayer & Moreno, 2003) provide a compelling case for the importance of trauma-informed training to be incorporated throughout counseling psychology doctoral curriculum. Without prior foundational knowledge of trauma-informed care, psychologists lack the necessary fundamentals to ethically and competently work with individuals who have experienced trauma(s) (APA, 2015; APA, 2017). Further, acquiring

foundational knowledge to competently practice trauma-informed care would result in more psychologists being able to practice within the boundaries of their competence as they would receive the relevant education and training required to practice ethically (APA, 2017).

### **Connecting Foundational Knowledge to Training Standards and Guidelines**

In addition to theory, there are a host of professional documents to support the need for required, foundational knowledge in trauma-informed care. The *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) provide an initial roadmap for integrating trauma-informed care into education and training. The trauma competencies in the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) were designed to assess the clinical development of psychologists as they grow professionally from trainee to independent practitioner. Similarly, Fouad and colleagues (2009) identify and outline foundational and functional competency benchmarks for professional psychologists in three areas: readiness for practicum, readiness for internship, and readiness for entry into practice. Both the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) and the foundational competencies outlined by Fouad and colleagues (2009) emphasize the utilization of benchmarks for training to assess psychologists' clinical development. These benchmarks include behavioral markers of core competencies signaling a supervising practitioner of the trainee's developmental level, and when the trainee can advance to more complex clinical work (APA, 2015; Fouad et al., 2009; Kaslow, 2004).

Additionally, APA's *Standards of Accreditation for Health Service Psychology and Accreditation Operating Procedures* (SoA's; APA, 2018) distinguish between minimal levels of achievement needed between the doctoral, internship, and post-doctoral levels of training which also coincide with the readiness for practicum, internship, and entry into practice benchmarks

outlined by Fouad and colleagues (2009). These standards reinforce the concept that trainees (should) progress in the complexity of their knowledge and skills from the doctoral level through post-doctoral. This developmental progression further highlights the need for trainees to be exposed to trauma-informed care basics during their doctoral program for them to continue advancing in their knowledge and skill sets for later stages of professional training (Bjork & Bjork, 1992). However, the accreditation standards do not reference trauma education specifically. This lack of specificity in the standards leaves room for faculty members of APA-accredited counseling psychology programs to integrate foundational trauma-based information into the core curriculum. In doing so, all students in the program would receive foundational knowledge in trauma as all students would be required to take the core courses in the program. Furthermore, the integration of trauma-based information throughout the core curriculum would allow for frequent retrieval of this information which would result in the trauma-based information being more accessible in the future to utilize and build upon (Bjork & Bjork, 1992).

Given the previously mentioned prevalence rates of trauma, it is almost guaranteed psychologists will work with clients who have experienced trauma during their professional career. Utilization of the *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) give counseling psychology doctoral programs a blueprint on what information regarding trauma psychology should be integrated into the curriculum to ensure psychologists in-training develop a foundational, holistic understanding of trauma. Additionally, these guidelines provide an illustration of what skills, attitudes, and knowledge are needed for psychologists in-training to advance to the next level of their training and build upon the foundational knowledge initially learned (APA, 2015; Fouad et al., 2009). For this reason, trauma-specific knowledge should be integrated throughout the SoA's various profession-wide competencies (PWC's, e.g.,

intervention, supervision, consultation). By integrating trauma-specific knowledge throughout the PWC's, counseling psychologists in-training will develop the foundational trauma knowledge needed to practice ethically (APA, 2017) and competently (APA, 2015, 2017a, 2017b). As such, the study takes into consideration the developmental perspectives of these standards and guidelines as key components for assessing the experiences of doctoral students enrolled in counseling psychology programs providing trauma-informed education and training.

### **Conclusion**

Based on the literature presented, an exploration of counseling psychology doctoral programs' provision of trauma training should be conducted. Counseling psychologists are likely to encounter clients who have a history of trauma due to the high prevalence of trauma exposure in the United States (U.S. Department of Veteran Affairs, 2023). A foundational understanding of trauma, its manifestation, and impacts are essential to ensure accurate client conceptualization, diagnosis, and treatment. The lack of opportunities to learn foundational trauma psychological knowledge in counseling psychology doctoral programs has resulted in psychologists in-training seeking and engaging in trauma training outside of their program (e.g., practicum site; Simiola et al., 2018). Though psychologists in-training must begin somewhere with their trauma education and practice, this should not be at the expense of clients with advanced mental health concerns who present to practicum sites for services. Moreover, practicing without a foundational understanding of cultural trauma psychology is questionable at minimum as psychologists in-training are treating clients outside the scope of their competence (Standard 2.01, Boundaries of Competence; APA, 2017) as they have limited opportunities to engage in any prerequisite in-depth training to gain a general knowledge of trauma (APA, 2018). The present study aimed to investigate the current training practices and doctoral students' experiences within counseling

psychology programs that are implementing trauma-based training. The present study sought to answer the following question using phenomenological inquiry: What are doctoral students' experiences of trauma education and training who are enrolled in counseling psychology programs? The implications of the present study provide psychologists-in-training with a foundational understanding of trauma and trauma-informed care which would result in more competent services for clients.

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**APPENDIX B: Training Directors Screening Email**

Dear Dr. \_\_\_\_\_,

My name is Alexis Ambeau and I am a doctoral student pursuing my Ph.D. in Counseling Psychology at Ball State University under the supervision of Dr. Sharon Bowman. I am writing to ask for your help with my dissertation (IRB approval #1851755-1) on trauma-informed training in Counseling Psychology doctoral programs. I am studying training programs who implement **required** training in trauma-informed practice. Does your program **require** training in trauma-informed care (e.g., teaching interventions to work with trauma populations, biopsychosocial perspective of trauma, etc.)? “Required” means that you require ALL doctoral students to complete these trainings. **If yes**, can you briefly describe what these requirements include (e.g., specific coursework, clinical experiences, didactics)?

I appreciate your help in this process, as I know how very busy you are!

Sincerely,

Alexis Ambeau, M.S.  
Department of Counseling Psychology, Social Psychology, & Counseling  
Ball State University

**APPENDIX C: Student Recruitment Email – Required Trauma Training**

Dear Doctoral Student,

Are you passionate about trauma-informed education and training? If so, I would love to interview you for my dissertation, **Holistic Trauma-Informed Training in Counseling Psychology Doctoral Programs**, supervised by Dr. Sharon Bowman (sbowman@bsu.edu). Participation in this study will involve a 30–45-minute virtual interview, and you will be compensated with a \$20 gift card upon completion.

To participate in the study, you must be:

- 18 years old or older
- Enrolled in an APA-accredited Counseling Psychology program
- Completed your programs required trauma training

This study has been approved by the Institutional Review Board at Ball State University, #1851755-1. If you would like to participate or have any questions about the study, please email Alexis Ambeau at [avambeau@bsu.edu](mailto:avambeau@bsu.edu).

Thank you for your time and consideration!

Kind regards,

Alexis Ambeau, M.S.  
Doctoral Candidate  
Ball State University  
Department of Counseling Psychology, Social Psychology, and Counseling

**APPENDIX D: Student Recruitment Email – Optional Trauma Training**

Dear Doctoral Student,

Are you passionate about trauma-informed education and training? If so, I would love to interview you for my dissertation, **Holistic Trauma-Informed Training in Counseling Psychology Doctoral Programs**, supervised by Dr. Sharon Bowman (sbowman@bsu.edu). Participation in this study will involve a 30–45-minute virtual interview, and you will be compensated with a \$20 gift card upon completion.

To participate in the study, you must be:

- 18 years old or older
- Enrolled in an APA-accredited Counseling Psychology program
- Completed a trauma course or trauma training offered by your program

This study has been approved by the Institutional Review Board at Ball State University, IRB approval #1851755-1. If you would like to participate or have any questions about the study, please email Alexis Ambeau at [avambeau@bsu.edu](mailto:avambeau@bsu.edu).

Thank you for your time and consideration!

Kind regards,

Alexis Ambeau, M.S.

Doctoral Candidate

Ball State University

Department of Counseling Psychology, Social Psychology, and Counseling

**APPENDIX E: Informed Consent****Researcher Contact Information****Student Co-Investigator:**

Alexis Ambeau, M.S.  
avambeau@bsu.edu  
Telephone: (765) 285-8040

**Principal Investigator:**

Sharon Bowman, Ph.D. HSPP, ABPP, LMHC  
sbowman@bsu.edu  
Telephone: 765-285-8040

IRB Approval #1851755-1

**Title of the Study:** Holistic Trauma-Informed Training in Counseling Psychology Doctoral Programs

**Purpose of the Study**

The purpose of this study is to examine students' experiences of trauma training within Counseling Psychology doctoral programs.

**Inclusion/Exclusion Criteria**

To participate in the study, you must:

- Be 18 years or older
- Enrolled in an APA-accredited Counseling Psychology Ph.D. program
- Completed a trauma course or trauma training offered by your program

**Description of Procedures**

You will complete a demographic form prior to being asked to participate in a semi-structured virtual interview via Zoom with the co-investigator. You will be contacted via email to schedule the virtual interview. During the interview you will be asked a series of questions regarding your trauma education and training experiences within your doctoral program. Participation in the virtual interview will take approximately 30-45 minutes.

**Audio, Video, or Photography**

For the virtual interview, the interview will be recorded to ensure all your responses are accurately transcribed. The audio recording will be safely stored in a secure OneDrive file. Recordings will be transcribed into electronic transcripts and be kept in a password protected Word document in a secure OneDrive file on a password protected computer and will be retained for 5 years. The audio recordings will not be used for publication or presentation. By signing this consent form, you are agreeing to let the researcher record all answers you provide during the interview.

**Discomforts or Risks**

Much of the virtual interview content relates to trauma training which could include references to sensitive content. As a result, emotional or psychological distress could arise while participating in the virtual interview. You will be provided with information to resources in this informed consent document in the event the interview causes distress.

**Benefits**

There are no direct benefits of participating in this study.

**Data Confidentiality or Anonymity**

All data will be maintained as confidential. No identifying information such as names will appear in any publication or presentation of the data.

**Storage and Retention of Data**

All data will be stored electronically. Zoom audio recordings of participant interviews will be stored in a Microsoft OneDrive folder. Demographic information will be downloaded from Qualtrics into password protected files. Demographic data will be coded with an ID number, to de-identify demographic information. Demographic information will be linked to transcribed interviews, in order to be able to contextualize participant responses. However, no identifying information will be linked via the demographic form and transcribed interview, and any identifying information disclosed during the interview will be redacted during the transcription process. Data will be retained for 5 years. Only the researchers will have access to the data.

**Costs or Compensations**

There is no cost associated with participation. Participants will be compensated with a \$20 Tango gift card upon completion of the virtual interview. Your contact information for receiving a gift card will be shared with Tango. You will receive a generic email from Tango, not the principal investigator, on how to redeem the gift card.

**Voluntary Participation**

Your participation in this study is completely voluntary and you are free to withdraw your participation at any time, for any reason, without penalty or prejudice from the investigator. Please feel free to ask any questions of the investigator before signing this form and at any time during the study. If you decide to withdraw from this study, any data already collected from you will be destroyed. If you withdraw from the study, you will not be compensated.

**Resources:**

Crisis Hotlines

The National Grad Crisis Line

877-472-3457

National Suicide Prevention Lifeline

800-273-8255

Crisis Text Line

Text HOME to 741741

Counseling Resources

Psychology Today

psychologytoday.com

**Contact Information**

For questions about your rights as a research subject, please contact the Office of Research Integrity, Ball State University, Muncie, IN 47306, (765) 285-5052 or at orihelp@bsu.edu.

**Consent**

I, \_\_\_\_\_, agree to participate in this research project entitled (Holistic Trauma-Informed Training in Counseling Psychology Doctoral Programs), I have had the study explained to me and my questions have been answered to my satisfaction. I have read the description of this project and give my consent to participate. I understand that I will receive a copy of this informed consent form to keep for future reference.

To the best of my knowledge, I meet the inclusion/exclusion criteria for participation (described on the previous page) in this study.

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Participant's Signature

---

Date

**APPENDIX F: Demographic Questionnaire and Screening**

1. Please enter the code you were provided with via email: \_\_\_\_\_
2. What year are you in your program?
  - 1<sup>st</sup> Year
  - 2<sup>nd</sup> Year
  - 3<sup>rd</sup> Year
  - 4<sup>th</sup> Year
  - 5<sup>th</sup> Year
  - Other: \_\_\_\_\_
3. Does your program require a trauma course or training? (If no, go to question 5)
  - Yes
  - No
4. If your program does require a trauma course or training, have you completed the course or training?
  - Yes
  - No
5. What is your age? \_\_\_\_\_
6. What race and/or ethnicity do you identify with? *Select all that apply.*
  - Alaskan Native
  - American Indian/Indigenous
  - Asian/Asian American
  - Biracial/Multicultural
  - Black/African American
  - Hispanic/Latine
  - Middle Eastern/North African
  - Native Hawaiian or Pacific Islander
  - White
  - Self-identify: \_\_\_\_\_
  - Prefer not to answer
7. Which most closely describes your gender identity? *Select all that apply.* (Gender identity refers to one's internal experience and naming of their gender. It can correspond to or differ from the sex assigned at birth).
  - Agender
  - Bigender
  - Cisgender Man
  - Cis-gender Woman
  - Gender fluid
  - Gender nonconforming
  - Genderqueer

- Intersex
  - Non-Binary
  - Transgender man
  - Transgender woman
  - Two-Spirit
  - Self-identify: \_\_\_\_\_
  - Prefer not to answer
8. What is your sexual orientation? *Select all that apply.*
- Asexual
  - Bisexual
  - Gay
  - Heterosexual/Straight
  - Lesbian
  - Pansexual
  - Queer
  - Self-identify: \_\_\_\_\_
  - Prefer not to answer
9. What is your highest level of education?
- Graduated high school
  - GED
  - Bachelor's Degree
  - Master's Degree
  - Post-Master's (e.g., PhD, JD, MD, etc.)
  - Other post-secondary
10. What is your annual income?
- Under \$10,000
  - \$10,000 - \$14,999
  - \$15,000 - \$19,999
  - \$20,000 - \$24,999
  - \$25,000 - \$29,999
  - \$30,000 - \$39,999
  - \$40,000 - \$49,999
  - \$50,000 - \$59,999
  - \$60,000 and up
11. Have you been diagnosed with a disability? (If no, go to question 11)
- Yes
  - No
  - Prefer not to answer
12. If you have been diagnosed with a disability, which of the following have been diagnosed? *Select all that apply.*
- Sensory disability

- Mobility disability
- Cognitive disability
- Mental Health disability
- Chronic Medical illness
- Temporary disability due to illness or injury
- A disability or impairment not listed above: \_\_\_\_\_
- Prefer not to answer

13. What is/are your theoretical orientation(s), if any? \_\_\_\_\_

**APPENDIX G: Semi-Structured Interview Questions**

1. Tell me a little bit about where you are in your program, and your clinical interests?
  
1. Share a story about your trauma-based training.
  - a. When did you experience this training during your time in your program?
  - b. Who facilitated it?
  - c. How was the training organized?
  - d. What did you learn?
  - e. What do you wish you would have learned?
  
2. What kinds of traumatic experiences have your clients been exposed to?
  
3. Tell me a little bit about your experiences working with trauma clients during your program.
  
4. Tell me about a time when your training influenced your provision of trauma-informed practice.
  
5. How competent would you say you feel when working with trauma clients?
  - a. Tell me what makes you feel that way about your level of competence.
  
6. Share a meaningful experience that describes what your work with trauma clients has been like.
  
7. Tell me what information/skills you believe would be helpful in working with trauma clients.