# FACTORS RELATED TO INFUSION OF TRAUMA EDUCATION AMONG COUNSELOR EDUCATORS AT CACREP-ACCREDITED PROGRAMS

by

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# ABSTRACT

LANE KIMBERLY GRIFFITH. Factors Related to Infusion of Trauma Education Among Counselor Educators at CACREP-Accredited Programs.
(Under the direction of DR. PHYLLIS POST)

Research has demonstrated the prevalence and cumulative nature of trauma and its lifelong adverse effects on physical, cognitive, emotional, and social wellness (Felitti et al., 1998; Merrick et al., 2019). Thus, counselor educators must prepare their students to work with clients with trauma effectively and ethically. A single study investigated trauma education and found that not all programs offer a trauma course (Montague et al., 2020). Thus, the CACREP (2015) trauma standards may be infused into other courses. The purpose of this study was to explore how trauma history, attitudes related to trauma-informed care, and prior trauma training were related to the infusion of trauma education into non-trauma-specific core courses by counselor educators working full-time for CACREP-accredited programs. It also investigated to what degree the trauma standards were infused. Multiple regression was used to analyze the data collected from 261 participants. Results indicated that moderate and substantial training were positive significant predictors of the degree of infusion ($p$ <.001). The variables accounted for 14.1% of the variance. Although most counselor educators (91%) reported infusing the trauma standards into core courses, the standards were not infused equally. Results highlighted a high incidence of adverse childhood experiences (ACEs) among counselor educators, with 62% reporting two or more and 33% four or more. Implications, limitations, and recommendations for future research are discussed.

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# DEDICATION

"The best and most beautiful things in the world cannot be seen or even touched;

they must be felt with the heart."

– Helen Keller

I dedicate this work to my husband, Dan Stevens Griffith. I am forever grateful for you and your example of strength, service, and love. We are better together. My heart is and always will be yours. I also dedicate this to my parents, Bruce and Margaret Hawes. Dad, you taught me the value of hard work and fostered my love of learning and nature. Mom, you gave me your love of books and taught me to love oh so deeply. Thank you for believing in me.

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# CHAPTER 1: INTRODUCTION

The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014, July, p. 7) states that "Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." Trauma can be categorized into two broad types: natural or human-caused. Natural traumas are events such as wildfires, tornadoes, and earthquakes. Human-caused traumas may include sexual abuse, muggings, terrorism, and interpersonal violence. In 1998, Felitti et al. published their landmark study of 9,508 adults, which examined the relationship between the amount of exposure to adverse childhood experiences (ACEs) with the incidence and risk for disease, the caliber of life, the use of health care resources, and mortality. They reported that more than 50% of participants experienced at least one ACE, and 25% reported two or more. Further, a strong relationship was found between the number of adverse childhood experiences and adverse physical and emotional outcomes in adulthood (Felitti et al., 1998).

The Centers for Disease Control and Prevention (Merrick et al., 2019) reported that 61.5% of adults reported experiencing at least one adverse childhood experience, while 16% reported having four or more. Certain gender, racial, and ethnic populations are at greater risk for four or more ACEs. Kilpatrick et al. (2013) found that 89.7% of participants reported at least one DSM-5 Criterion A (traumatic) event in their study to estimate national exposure to trauma and the incidence of PTSD. Approximately 53% reported sexual or physical assault, and around 30% reported experiencing six or more traumatic events. Minimization is common, and the actual occurrence of childhood trauma may be even higher than stated (MacDonald et al., 2016). The

current statistics are also low because they do not account for racial trauma or the impact of COVID-19, two issues that have dominated the political and social climate for the last few years. Medical trauma, such as chronic illness, is also neglected in the statistics.

Exposure to trauma has been linked to multiple negative outcomes, and exposure appears to be cumulative (Baglivio et al., 2014; Felitti et al., 1998; Kelly-Irving et al., 2013). Persons who reported four or more categories of adversity were significantly more likely to abuse substances, smoke, have more than 50 sexual partners, and, thus, be at greater risk for sexually transmitted diseases. They also were at increased risk for psychological disturbances, sleep issues, and suicide attempts. Chronic trauma was associated with a greater risk of obesity, heart disease, cancer, lung disease, bone fractures, and liver disease (Anda et al., 2006; Felitti et al., 1998). This has been confirmed by more recent research. There is a strong cumulative association between ACEs and premature death (Kelly-Irving et al., 2013). The negative effects of increasing ACE scores have been found across rural and urban populations (Chanlongbutra et al., 2018).

Childhood trauma was significantly associated with altered brain structure, development, functionality, and reactivity and has been associated with chromosomal changes in children (Jedd et al., 2015; Shalev et al., 2013; Sperry, 2016). ACEs were associated with eduring changes in the nervous, endocrine, and immune systems. Changes were seen in childhood and lasted into adulthood, having long-term effects on biological aging and health (Danese & McEwen, 2012). Trauma has been associated with childhood cancer, externalizing problems such as oppositionality and impulsivity, and emotionality (Brown et al., 2013; Price et al., 2013). Childhood adverse experiences were also found to be highly associated with sexual offending in juvenile delinquents (DeLisi et al., 2017).

Given trauma's prevalence and negative consequences, it follows that almost every counselor will work with clients who have experienced traumatic events. It is essential that they have training and education in trauma-informed care to work effectively with these clients to promote safety, empowerment, and healing. The American Counseling Association's (ACA) *Code of Ethics* is clear that counselors are to practice within their boundaries of competence (ACA, 2014). The Council for the Accreditation of Counseling and Related Educational Programs (CACREP, 2015) has included trauma education in its standards. It notes the critical need for counselors to understand the effects of trauma on diverse individuals in all stages of life, be able to assess for trauma, and know strategies for addressing trauma. They must also recognize and mitigate vicarious trauma symptoms in themselves (Day et al., 2017; Diehm et al., 2019; Ivicic & Motta, 2017). There have been few studies about how trauma education is taught in counselor education. The few studies completed have suggested that this area of competency is not addressed sufficiently (Chatters & Liu, 2020; Montague et al., 2020).

More research is needed to examine what factors influence if counselor educators teach about trauma and the trauma standards they cover. Research shows that having a personal trauma history may affect instructors' willingness to teach trauma content due to emotional discomfort and the higher risk for secondary trauma (Hensel et al., 2015; Nation et al., 2022). In addition, exploring the influence of prior training is essential as teachers are less comfortable teaching content in which they have had no training (Asselt et al., 2016). Finally, instructors' confidence in addressing trauma content may also be associated with attitudes related to trauma-informed care, as positive attitudes are positively related to counselors' confidence and willingness to address trauma with clients (Palfrey et al., 2019). Therefore, this study attempted to address the gap in the literature regarding factors related to counselor educators teaching about trauma by

exploring how personal trauma history, prior training, and attitudes toward trauma-informed care relate to whether counselors at CACREP-accredited programs infuse trauma education into their non-trauma courses and to what degree they cover the required trauma standards.

## Theoretical Base

Trauma-informed care (TIC) is the conceptual framework for this research study. This socioecological approach recognizes that the physical, emotional, and social environment is vital in how people perceive and process trauma (SAMHSA, 2014). Increasing knowledge of the prevalence of trauma, its cumulative nature, its negative physical and psychological consequences, and the adverse impact on behavioral health systems, child welfare systems, criminal and juvenile justice systems, employment, and medical systems have highlighted the need to have pervasive and effective ways to address those issues across a wide range of sectors (SAMHSA, 2014, July). Trauma-informed care can reference a set of principles underlying the assessment, understanding, and treatment of trauma in individuals, as well as a set of principles adopted by organizations and systems providing services. The six principles most often referred to are: (a) safety, (b) trustworthiness and openness, (c) the support of peers, (d) collaboration and elimination of power differentials, (e) empowerment, and (f) cultural, historical, and gender responsiveness (SAMHSA, 2014, July). It has been recommended that social policy analysis and advocacy should employ a trauma-informed approach (Bowen & Murshid, 2016). Service providers must realize the prevalence and effects of trauma on individuals, communities, and systems. They must also recognize its symptoms and respond in a trauma-informed manner. It is critical that those who have experienced trauma not be retraumatized while receiving care.

## Variables of Interest

### Trauma Education

Not only will experienced counselors work with clients who have experienced trauma, but brand-new counselors with limited experience will work with clients who have experienced trauma. Therefore, given the prevalence and adverse effects of trauma and its widespread impact on individuals, communities, and systems, counselors-in-training must be educated in trauma-informed care while still in school. Counseling educators are responsible for graduating students who have met competencies and will do no harm (ACA, 2014). The need for education on crisis and trauma was supported by CACREP (2015) with the inclusion of trauma-based standards in their 2016 guidelines. However, they did not specify how or in which classes trauma education should be taught. Some counselor education programs often offer trauma and crisis classes as elective and not required courses. This issue led Chatters and Liu (2020) to recommend integrating trauma content throughout programs. Montague et al. (2020) examined 392 CACREP-accredited counselor education programs in the United States. They found that 31.4% of counseling programs in the United States offered just one class on either crisis, trauma, grief, or some combination of these. They discovered that 29.1% offered no course dedicated to trauma, crisis, or grief. The authors included grief with trauma and crisis due to increased violence in society, including mass shootings and terrorist attacks (Worden, 2018). These studies illustrate the need for infusion of trauma content throughout programs.

There are six standards required of all counseling students, regardless of specialization, that are related to trauma education. First, in the section on professional counseling orientation and ethical practice, students must learn their future "roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams" (CACREP,

2015, 2F1c, p. 9). The standard found in the section on human growth and development states that they must understand the "effects of crisis, disasters, and trauma on diverse individuals across the lifespan (CACREP, 2015, 2F3g, p. 11). Competency in "suicide prevention models and strategies" (CACREP, 2015, 2F5l, p. 12) is found under the section about counseling and helping relationships as is "crisis intervention, trauma-informed, and community-based strategies, such as psychological first aid" (CACREP, 2015, 2F5m, p. 12). The section on assessment and testing lists "procedures for assessing risk of aggression or danger to others, self-inflicted harm, or suicide (CACREP, 2015, 2F7c, p. ) and "procedures for identifying trauma and abuse and for reporting abuse" (CACREP, 2015, 2F7d, p. 12) as additional standards required of all counseling students. Programs have the freedom to decide how the standards will be addressed in their curricula.

As noted above, this study examined factors related to whether counselor educators infused trauma education into non-trauma coursework and the degree to which CACREP (2015) required standards of trauma were infused. The variables of interest were personal trauma history, prior training in trauma, and attitudes toward trauma-informed care.

Personal Trauma History (Adverse Childhood Experiences)

Adverse childhood experiences are those experienced before the age of 18 years (Felitti et al., 1998). There are ten categories that fall under three broad areas: abuse, household dysfunction, and neglect. Falling under the abuse category are emotional abuse, physical abuse, and sexual abuse. Household dysfunction includes intimate partner violence, substance abuse in the household, mental illness in the household, parental separation or divorce, and imprisoned household members. Emotional and physical neglect falls under the third area.

A review of the literature demonstrated scant research about how personal trauma histories affect educators except to illustrate that those with a history of trauma have the potential to be triggered by those they work with (Nation et al., 2022). Studies of secondary traumatic stress suggest that counselors with histories of trauma are more likely to experience discomfort when listening to clients describe traumatic events (Hensel et al., 2015). The same may be true for counselor educators as they teach about trauma and share case studies and details of trauma with their students. This may impact whether they teach trauma or what aspects they teach. There is also the possibility that personal trauma history would make a counselor educator more aware of the need for trauma education and, thus, more likely to teach about trauma in their courses.

### Prior Training in Trauma

Research has shown that with increased training specific to trauma, the participants of these studies demonstrate higher self-efficacy (Desai et al., 2019; Asnaani et al., 2020; Palfrey et al., 2019). Perceived self-efficacy is the belief that one can do something (Bandura, 1977). It is related to willingness to engage in that activity as well. When people believe they are capable, they are motivated to act. Counselor educators may feel uncomfortable teaching content for which they have not been trained (Asselt et al., 2016). Thus, prior training in trauma may impact whether a counselor educator infuses trauma content into their courses. The trauma standards in CACREP are relatively new, and many counselor educators who completed their educations before the inclusion of these standards may not have the training needed to feel comfortable infusing trauma education into their courses. Prior training may increase the willingness to teach content and reduce the risk of secondary trauma in counselor educators, which could impact the desire to include trauma content in coursework (Day et al., 2017).

### Attitudes Related to Trauma-Informed Care (TIC)

Attitudes related to trauma-informed care were also a factor to consider. Trauma education has been positively associated with increased knowledge, self-efficacy, reduced stigma, willingness to address trauma with clients, and improved self-care (Bertram et al., 2022; Niimura et al., 2019). If it is true that counselors' attitudes related to trauma-informed care affect their confidence and willingness to address trauma with clients, the same may hold for counselor educators.

## Significance of the Study

While CACREP has clarified the need for counselors to be educated on trauma, it does not mandate how to accomplish that (CACREP, 2015). There is a dearth of research exploring what factors may influence counselor educators' decisions on whether to teach about trauma and the degree to which trauma standards are covered. This study sought to address this gap. The results of this study may be helpful to counselor educators in assisting them in self-awareness of factors influencing their willingness and ability to teach about trauma. It may also inform them of the need for further training and development. Results may be used by those involved in curriculum development and program evaluation to address the needs of educators through professional development and support to ensure trauma competence in their clinical and school counseling graduates. CACREP may also utilize results to evaluate how educators meet their trauma competency standards.

## Purpose of the Study

The purpose of this study was to examine how personal histories of trauma, prior training in trauma, and attitudes related to TIC were related to the infusion of trauma education in non-

trauma courses and to describe to what degree the CACREP (2015) trauma standards required of all students were covered among counselor educators at CACREP-accredited programs.

## Research Questions

The purpose of this study was to answer the following two questions: Are personal trauma history, prior training in trauma, and attitudes toward trauma-informed care related to counselor educators' infusion of trauma education in their non-trauma courses? To what degree do counselor educators infuse the required CACREP (2015) trauma standards into their non-trauma-specific courses?

## Assumptions

The assumptions made in this proposed study were:

- Participants completed all surveys voluntarily and honestly.
- Participants were able to read English and comprehend survey questions.
- Surveys used were valid and measured the variables accurately.
- The sample was representative of the population.

## Delimitations

The factors the researcher could control in this study were:

- This purposive, convenience, homogenous population sample included counselor educators from CACREP-accredited programs in the United States.
- Counselor educators were defined as full-time faculty members working in CACREP-accredited counseling programs.
- Data was collected electronically and remotely.

## Limitations

The following limitations, or factors outside of the researcher’s control, applied to this study:

- The study's sampling limited the ability of the researcher to generalize results to other counselor educators working in CACREP-accredited and non-CACREP-accredited programs or those working in programs outside of the United States.
- Data was self-reported, and participants may have answered survey questions in a manner they believed was socially desirable.
- Participants with a personal history of trauma may have been less likely to participate.
- This study was correlational. Thus, no causal inferences could be made.

## Threats to Internal Validity

Internal validity examines whether the changes in the dependent variable can be attributed to the independent variables (Mertens, 2015). One factor affecting internal validity is instrumentation. For a study to have internal validity, the surveys and assessments must accurately measure the construct they purport to measure. This study collected demographic information and used instruments that were valid and reliable. Another factor impacting validity is that answers were self-reported. The desire to be seen in a positive light may have affected the honesty of the responses given. Participants were anonymous to reduce the risk of social desirability affecting responses.

## Threats to External Validity

External validity examines the degree to which research results can be generalized to other situations or populations (Mertens, 2015). This study used a convenience sample of counselor educators working within CACREP-accredited programs in the United States. This limited the ability of results to be generalized to counselor educators at accredited and non-accredited programs within and outside the United States.

## Operational Definitions

### Counselor Educators

Counselor educators were defined as full-time faculty members working in CACREP-accredited counseling programs in the United States. Status as a counselor educator at a CACREP-accredited university was self-reported on the demographics portion of the survey.

### Infusion of Trauma Education in Non-Trauma-Specific Core Courses

Infusion was defined as counselor educators' perception that they included trauma content in their non-trauma courses. Infusion was operationalized in two ways. The first was how participants responded to the "yes" or "no" question "Do you infuse trauma education in your non-trauma courses?" on the Trauma Education Checklist. The second way infusion of trauma was operationalized was the degree of infusion of trauma education into non-trauma-specific courses.

CACREP (2015) outlined six competency standards associated with trauma that were required of all students regardless of specialization. These six standards were defined as 12 specific content areas. Participants checked which content areas they infuse into their non-trauma-specific courses. The checks were totaled, resulting in a total score representing the degree of infusion. This checklist was part of the Trauma Education Checklist.

### Personal Trauma History

Adverse childhood experiences (Felitti et al., 1998) are the ten categories that fall under three broad areas: abuse, household challenges, and neglect experienced prior to 18 years of age. For this study, personal trauma history was measured by participants' total scores on the ACE assessment (Felitti et al., 1998).

### Prior Trauma Training

Prior trauma training was defined as courses and activities participants took to develop knowledge, awareness, and skills in trauma counseling and trauma-informed care. In this study, prior trauma training was operationally defined in two ways. The first was the total number of hours from graduate-level trauma course(s) and from activities and workshops that participants self-reported on the Demographic Questionnaire. Graduate-level courses counted as 100 hours each, and the number of reported hours from activities and workshops was added to them for a grand total. The second way trauma education was operationalized was the participants' perceived extent of trauma training. Participants rated the extent of their trauma training on a four-point Likert scale ranging from "no training" to "substantial training. This was self-reported on the Demographic Questionnaire.

### Attitudes Related to TIC

Attitudes related to TIC were measured using the Attitudes Related to Trauma-Informed Care Scale (ARTIC; Baker et al., 2016). The ARTIC was developed to measure the extent to which an organization or individual was trauma-informed. The total scores of the ARTIC-10 for education were used for this study.

## Summary

This chapter included an overview of the theoretical base, the dependent variable, infusion of trauma content in non-trauma courses taught, and the independent variables: trauma history, prior training, and attitudes toward trauma-informed care. The purpose and research questions were outlined, along with assumptions made and threats to internal and external validity. Factors that could (delimitations) and could not be controlled (limitations) when

collecting and analyzing data and interpreting results were presented. Operational definitions were specified.

## Organization

This dissertation includes five chapters. The first chapter is an overview of the issue and the need for and significance of the proposed study. The second chapter is a literature review. It includes literature related to the prevalence and consequences of trauma, the need for trauma education in counselor education programs, and a review of how trauma education is currently being taught. It also includes a review of literature related to personal trauma history, training in trauma-informed care, attitudes related to trauma-informed care, and how those three variables relate to trauma education. Chapter Three covers the methodology used in the research. It provides information on participants, data collection, instrumentation, research design, and data analysis. Chapter Four summarizes the data collected in the study. It presents the results of the analyses conducted. The final chapter includes a discussion of the results and conclusions drawn. It outlines what this research adds to the existing literature on trauma education in CACREP-accredited programs. Chapter Five also discusses the implications and limitations of this research study and suggests directions for future research.

# CHAPTER 2: LITERATURE REVIEW

This study aimed to examine how personal histories of trauma, prior training, and attitudes toward trauma-informed care (TIC) were related to the infusion of trauma education in non-trauma-specific courses among counselor educators. This chapter outlines the literature related to trauma, including its prevalence and effects on trauma workers. This is followed by the literature outlining the theoretical base for this study, trauma-informed care, and its relation to trauma education in various fields of practice. Next, this chapter reviews the literature on personal trauma history, prior training, attitudes toward TIC, and the relationships of those variables with counselor educators infusing trauma education into non-trauma-specific courses. This chapter concludes with a summary supporting the need for this study to address the literature gap.

## Trauma

### Prevalence and Effects

Trauma has become pervasive in our society. The Substance Abuse and Mental Health Services Administration (SAMHSA) depicts trauma as resulting from "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." (SAMHSA, 2014). Briere and Scott (2013) defined trauma more broadly. They classified experiences as traumatic if they are temporarily overwhelming, exceptionally distressing, and create lasting psychological symptoms for the individual. Research has found trauma to be both prevalent and damaging (Felitti et al., 1998; Giordano et al., 2016; Kilpatrick et al., 2013; Sanford et al., 2014).

In a national survey of 2953 adults, Kilpatrick et al. (2013) found the most commonly occurring traumatic events were physical or sexual assault (53.1%), death of a family member or close friend due to violence, accident, or disaster (51.8%), disaster (50.5%), and fire/accident 48.3%). The National Survey of Children's Exposure reported that in a sample of 4000 children aged zero to 17 years old, 37.3% experienced a physical attack in the study year, one in 20 girls 14 to 17 years old underwent sexual assault or abuse, 15.2% suffered mistreatment by a caregiver, and 5.8% witnessed violence between parents (Finkelhor et al., 2015). Data from the National Child Traumatic Stress Network's (NCTSN, n.d.) Core Data Set (CDS) demonstrated a significant relationship between the total number of trauma types experienced and negative behaviors.

Traumatic experiences can lead to cognitive distortion, difficulties in emotional self-regulation, and difficulties in forming attachments to others (Lawson, 2013). Childhood trauma has also been linked to negative consequences for adults. Felitti et al. (1998) surveyed 8,056 adults who had undergone a medical assessment at Kaiser Permanente's San Diego Health Appraisal Clinic. They discovered that 52% of participants had experienced at least one adverse childhood experience (ACE), 25% reported two or more categories of ACEs, and 6.2% reported four or more ACEs. Living with someone who abused substances was the most frequent adverse experience reported by 25.6% of participants, followed by sexual abuse at 22%. Adverse childhood experiences had a robust graded relationship with many adverse adult health outcomes, including substance abuse, depression, suicidal ideation, obesity, heart, lung, and liver disease, and cancer.

The substance abuse consequence of trauma was supported by Giordano et al. (2016), who reported that 85.1% of 121 participants at an outpatient substance abuse clinic experienced

one or more traumatic events in their lives as measured by a shortened version of the Trauma History Questionnaire (Hooper et al., 2011). The average number of categories of trauma was 3.03. While exploring the prevalence and types of trauma experienced by this population, they found that witnessing violence was most common among men, and sexual abuse was more common among women. Sanford et al. (2014) looked at the impact of trauma assessment and intervention on 153 participants in a drug treatment court located in California. They found that participants had an average of 4.25 ACEs. The research demonstrates the negative consequences of childhood and adult exposure to trauma.

## Effects on Trauma Workers

As a result of pervasive trauma, counselors often work with clients who have experienced multiple traumatic events in their lives. The American Psychiatric Association (2013) included "repeated or extreme indirect exposure to aversive details of a traumatic event" to PTSD diagnostic criteria in the DSM-5. This suggests that counselors may be at risk of developing PTSD (Quitangon, 2019). This puts them at risk of vicarious trauma, sometimes called secondary traumatic stress or compassion fatigue. The American Counseling Association (ACA, 2010) has described vicarious trauma as "the emotional residue of exposure that counselors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear, and terror that trauma survivors have endured." The term vicarious traumatization was described by Pearlman and Saakvitne (1995) as the deep change in therapists and their worldviews that may occur due to working with clients who share traumatic experiences. McCann and Pearlman (1990) defined it as negative cumulative changes that can happen to those who have relationships based on empathy with those with whom they work. It is directly related to hearing clients vividly recount what happened to them. Some researchers have found that

vicarious trauma or secondary traumatic stress is related to negative consequences (ACA, 2010; Possick et al., 2015). This was supported by a literature review completed by Branson (2019). Others have found it is related to positive outcomes (Hernández et al., 2007; Engstrom et al., 2008; Kjellenberg et al., 2014). In a conceptual article, Jayawickreme and Blackie (2014) questioned whether those positive outcomes are real and lasting.

The effects of hearing graphic details from various clients are cumulative (McCann & Pearlman, 1990). Each listened-to story builds upon the ones heard previously. Vicarious trauma can cause emotional, behavioral, and physical symptoms (ACA, 2010; Possick et al., 2015). The American Counseling Association (2010) describes some of the symptoms of vicarious trauma. Counselors working with traumatized clients may experience diminished joy, intrusive thoughts of the trauma or client, anger, depression, apathy, and hopelessness. Behavioral symptoms include hypervigilance, absenteeism, blaming others, making more mistakes, lack of motivation, self-isolation, poor or conflictual relationships, and many others. Physical symptoms may include nightmares, sleeplessness, and exhaustion. The therapist's view of themselves, the world, and others changes and becomes more negative.

In their qualitative study, Possick et al. (2015) explored the experiences of 14 experienced social workers working with sexually abused children. They found two opposing themes. The first was "You Yourself Can Become a Victim of the Therapy." The counselors reported feeling intense anxiety, having intrusive thoughts, and flooding. The second, seemingly opposing theme was "Constructing Empowering Meaning." The participants reported the ability to construct meaning, thus gaining a sense of power in their ability to empower the children and help them heal through therapy. (Possick et al., 2015). Branson (2019) completed a literature review that pointed out issues with current research, such as unclear definitions and overlap of

the terms vicarious trauma, secondary traumatic stress, burnout, and others. Although there are issues, it was clear that research has shown that working with those who have histories of trauma is related to an increased risk of experiencing negative symptoms related to exposure to the details of stories told by victims.

Exposure to clients' traumatic experiences has also been associated with positive outcomes (Hernández et al., 2007; Engstrom et al., 2008; Kjellenberg et al., 2014). The potentially positive impact of vicarious trauma was referred to as vicarious resilience by Hernández et al. (2007) in their qualitative study of 12 psychotherapists from Columbia. It was described as a process in which those working with traumatized clients experience positive growth due to witnessing their clients' resiliency and strength. Participants reported an increased realization of people's ability to heal, renewed hope, feeling empowered, and greater effectiveness in working with trauma. Counselors are witnesses to their clients' healing, making meaning of their experiences, and being resilient. Thus, they can engage in a similar parallel process, resulting in positive change and growth (Hernández et al., 2007).

Kjellenberg et al. (2014) explored the effects of working with refugees who had suffered war, torture, or both on 69 participants made up of therapists (71%) and other personnel. Most of the participants had a personal trauma history, with most having experienced at least one lifetime trauma (91%), at least one childhood trauma (68%), or multiple traumas (68%). Participants heard or read stories of trauma an average of 18 hours per week. Results supported the hypothesis that workers would experience both negative and positive effects from the work. Participants frequently experienced compassion satisfaction but rarely experienced burnout and compassion fatigue. Results were mixed for post-traumatic growth; some participants reported substantial growth, while others experienced little to none.

Engstrom et al. (2008) used a grounded theory approach and interviewed ten counselors working with victims of torture. Three themes emerged from the data: the counselors were able to a) recognize the human ability to thrive despite trauma, b) positively change their views of their own lives, and c) reaffirm the value of therapy. The therapists better understood the therapeutic process and resilience and became more secure in their abilities to provide competent treatment. The concept of post-traumatic growth has been debated in the research. Some researchers question if positive changes are durable over time (Jayawickreme & Blackie, 2014). Also questioned is whether self-perceived growth translates to actual growth.

## Trauma-Informed Care

Due to the prevalence of trauma and its short-term and long-term negative consequences, it is evident that counselors need to provide trauma-informed care (TIC) not only for their clients' well-being but for their own psychological health as well (Possick et al., 2015). The Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) outlined their concept of trauma and wrote a guide for the implementation of TIC. A conceptual article supported the need for all organizations to implement trauma-informed practices (Racine et al., 2019). Berliner & Kolko (2016) examined six articles about TIC and gave their comments and criticisms. Studies of organizations that adopt trauma-informed care have demonstrated that knowledge, awareness, and skills in trauma awareness, assessment, and treatment increase in practitioners, clients, and caregivers, and trauma symptoms decrease in those receiving care (Bartlett et al., 2018; Mendelson et al., 2015).

Trauma-informed care is a comprehensive sociocultural framework that integrates knowledge about trauma into all aspects of healing and support (Racine et al., 2019; SAMHSA, 2014). The underlying assumptions of TIC are: (a) realizing the prevalence and effects of trauma,

(b) understanding and seeing the symptoms of trauma, (c) responding in a trauma-informed way, and (d) avoiding retraumatizing those who are seeking care (SAMHSA, 2014). Trauma-informed policies, procedures, and practices adopted by a wide array of service sectors ensure ethical care and protect those providing services from secondary traumatization (Berliner & Kolko, 2016).

In their conceptual article, Racine et al. (2019) noted the prevalence of trauma in the United States. They strongly supported a trauma-informed approach as an ethical way of protecting patients by assuming any patient could have a history of trauma. This approach would incorporate trauma-informed policies and practices into all aspects of patient care to protect them from retraumatization and ensure ethical and effective treatment. Berliner & Kolko (2016) examined six articles about TIC and gave their comments and criticisms. While they found evidence that adopting a trauma-informed approach had benefits, they noted that more research needs to be done on putting trauma knowledge into practice. Knowledge of TIC may result in increased empathy and understanding for victims. The use of trauma-specific evidence-based practices has resulted in improved outcomes, but knowledge of TIC principles does not equate to knowledge and the use of effective interventions. The authors suggest a need for tools that assess patients' perceptions of safety and empowerment in care settings to provide a more positive experience.

Trauma-informed interventions resulted in more positive outcomes for complex trauma. In their study examining the impact of three different trauma treatment modalities on 842 children with complex trauma, Bartlett et al. (2018) found that symptoms of PTSD decreased significantly at six months for all three treatment modalities: attachment, self-regulation, and competency (ARC), child-parent psychotherapy (CPP), and trauma-focused cognitive behavioral therapy (TF-CBT). The children also had fewer problem behaviors and improved functioning,

strengths, and needs. Results were more inconsistent at 12 months, and the authors endorsed ARC and TF-CBT for government investments.

Mendelson et al. (2015) also reported improvements due to trauma-based interventions. They studied 49 seventh and eighth-grade students from two Baltimore City Public Schools serving low-income areas. Twenty-nine students were in the treatment group and participated twice a week for six weeks in sessions designed to improve social, emotional, and academic functioning by providing psychoeducation about stress and teaching emotion regulation, problem-solving, and communication skills. Twenty students were in the control group. Strategies were adopted from several evidenced-based treatments: dialectical behavior therapy for adolescents (Miller et al., 2007), trauma adaptive recovery group education and therapy (Ford et al., 2004), and school-based trauma/grief group psychotherapy (Saltzman et al., 2001). Results demonstrated that participants in the treatment group significantly improved on emotional regulation, social skills, academic skills, and handling authority and direction as rated by their teachers compared to participants who did not receive treatment. Participants in the treatment group with high baseline depression (n=5) had fewer symptoms after the group sessions. Intervention students with low baseline depression (n=24) also showed improvement in all of the above categories and reduced disciplinary sanctions compared to students in the control group with low baseline depressive symptoms. Participating in more sessions was also related to teacher-rated improvements in academic comparison, discipline, and conduct problems.

Organizations that incorporate this approach institute policies, procedures, and practices to promote healing, recovery, and growth while avoiding retraumatizing those they care for. With trauma-informed care being implemented across various sectors, the benefits of ensuring

new counselors are trauma-informed are clear. It falls to counseling programs to ensure new graduates are ready to face the challenges of working with those who have experienced trauma.

## Trauma Education

### Definition and Conceptualization

Trauma education can be defined as the instruction of students in the awareness, knowledge, and skills that allow helping professionals to competently assess and treat trauma without causing further harm to the victim (SAMSHA, 2014). Professionals who are well-versed in the practice of trauma-informed care respond to clients with empathy and are better able to modify treatment to ensure that clients are better able to tolerate working through trauma content while decreasing trauma symptoms (Bartlett et al., 2018; Courtois & Gold, 2009).

While the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) understood the need for trauma education with its inclusion of trauma standards in its 2016 guidelines, where to teach the standards was left up to the individual programs. There is little research on how programs meet them, whether teaching trauma as a stand-alone course or infusing it into the core courses required of all students (Chatters & Liu, 2020). It is also unknown whether trauma and crisis courses are required or elective courses (Montague et al., 2020). This study seeks to understand the factors related to whether counselor educators choose to infuse trauma education in their non-trauma courses and to what degree they cover the trauma standards required of all counseling students. Due to the lack of relevant research examining factors related to whether counselor educators teach about trauma, trauma education literature was explored in psychology and social work education as well. The literature was found to be made up of conceptual articles outlining the need for trauma education and suggestions for how trauma education could be implemented. There were also research articles

examining how it is currently being implemented, the positive consequences of trauma training, and issues with trauma education.

## Trauma Education Among Psychologists

It is clear that trauma education is essential. The need for trauma education was outlined in two conceptual articles (Cook & Newman, 2014; Courtois & Gold, 2009). Another conceptual article addressed the problems found in the American Psychological Association's (2017) Clinical Practice Guideline for the Treatment of PTSD in Adults (Henning & Brand, 2019). A review of current research studies among psychologists demonstrated the prevalence and continuing problems with trauma education (Cook et al., 2017; Kumar et al., 2019; Simiola et al., 2018).

Courtois and Gold (2009) issued a call to action emphasizing the need to include trauma education throughout psychology programs. The New Haven Competencies consensus conference brought 60 experts in trauma together to identify the knowledge, skills, and attitudes necessary for clinical competence when working with those who have experienced trauma (Cook & Newman, 2014). They identified five broad areas of competencies: a) scientific knowledge about trauma, b) psychosocial trauma-focused assessment, c) trauma-focused psychosocial interventions, d) trauma-informed professionalism, and e) trauma-informed relational and systems. Since then, the American Psychological Association (APA, 2015) has established its *Guidelines on Trauma Competencies for Education and Training*. The guidelines put forth minimal expectations above and beyond the existing professional competencies of the field. They were proposed as a guide for curriculum development for training psychologists desirous of specialization and psychologists' self-monitoring. They were not required for all psychology students.

Henning and Brand (2019) applied the APA's *Guidelines on Trauma Competencies for Education and Training* (APA, 2015) in their conceptual article examining the APA's *Clinical Practice Guideline for the Treatment of PTSD in Adults* (APA, 2017) and found several problems. They reported that the use of the identified evidence-based treatments may cause harm to clients with complex trauma histories. They argued that students may not recognize the limitations of the studies supporting the treatments and their applicability to clients with comorbidities or more complex presenting issues such as dissociation. Students may not be prepared to effectively stabilize such clients. Henning and Brand (2019) also pointed out the lack of proper attention given to the potential impact of multicultural factors. Another problem was not including the principles of trauma-informed care with trauma education. Students and professionals may be unaware of the risk of vicarious trauma and the need for appropriate self-care. The authors recommended that graduate trauma courses make safety a priority for psychology students and clients. They encouraged trauma education in graduate programs to maintain professional standards and to provide trauma survivors with competent and ethical care.

Cook et al. (2017) surveyed 151 directors of training at doctoral programs listed in the Association of Psychology Postdoctoral and Internship Centers' (APPIC, n.d.) *Academic Programs in Psychology* directory to explore education in trauma psychology. Despite the need for trauma education, they found that only 20% offered a psychology course in trauma or a practicum specializing in working with clients who have a history of trauma. Not having the ability to offer elective classes and not having enough time and resources time were the two barriers most often stated by participants. The least cited barrier was lack of student interest (<5%).

Yet even within psychology, teaching about trauma is not being done adequately (Simiola et al., 2018). Research conducted with 259 psychology internship training directors explored services provided to clients with trauma histories and supervisory and didactic training provided to interns. Results illustrated that all programs reported at least one training opportunity given. A minimum of one to three hours of instruction per week was offered by 62.2%, and 54.5% offered supervision specific to trauma training. However, only 30.8% of the sites offered a high level of depth and breadth in trauma education, and only 34.7% taught interns an evidence-based treatment modality. Researchers found that sites that identified as employing a trauma or PTSD lens, such as the Veteran's Administration, offered significantly more trauma training than sites that did not. Identified barriers to trauma education included other program requirements, limited time and resources, and lack of faculty with interest and expertise. Interns reported feeling not well prepared to work with victims of trauma and being worried about damage to the psychological safety of clients and themselves (Simiola et al., 2018).

Kumar et al. (2019) searched the PsycINFO database for "trauma training" and found only eleven relevant studies. This paucity of literature suggests that trauma training is not being adequately addressed. Several of the articles found were published in a special issue of *Psychological Trauma: Theory, Research, Practice, and Policy*, which again highlighted inadequate trauma training in the field of mental health as well as the benefits of training (DePrince & Newman, 2011). Kumar et al. examined the impact of a brief trauma training program on licensed mental health practitioners. They found that participants did not report much systematic training in trauma during their graduate training, residencies, and fellowships. Over two-thirds (68.10%) reported feeling ill-prepared to assess clients for trauma, and 75.3% were unready to work with traumatized clients. Post-training, participants demonstrated

statistically significant increases in feelings of competence and factual knowledge about trauma and its treatment. They also expressed a desire for more training in trauma, noting a need for training in specific techniques and skills (60%) most often.

This body of literature shows that trauma training is not being adequately addressed in graduate education programs despite trauma's prevalence and negative consequences and the development of specific competencies. Education in trauma is not required of all psychology students, and practitioners feel inadequately prepared to work with clients who have trauma histories. No literature was found researching the factors that influence whether educators are willing to teach trauma principles and practices in their courses. A similar gap was discovered in the education of social work students.

### Trauma Education Among Social Workers

In response to the prevalence of trauma, the case has also been made for the inclusion of trauma education and trauma-informed practices in the education of social workers. Carello and Butler (2014, 2015) argued the need for trauma education to protect clients and students and offered concrete suggestions in a series of conceptual articles. The Council on Social Work Education's (CSWE, 2018) Commission on Educational Policy later developed a framework of competencies to resolve this issue. Still, the competencies were not required for all social workers. Research has also supported the need for trauma education, citing an increased risk of vicarious trauma due to the high prevalence of adverse childhood experiences in social work students (Gilin & Kauffman, 2015; Lanier & Carney, 2019). Research has also highlighted that trauma education for social work students effectively increased self-efficacy and intent to implement trauma-informed practices (Strand et al., 2014; Wilson & Nochajski, 2016). Despite this, trauma education remains inconsistent, and no research has addressed the factors related to

whether educators infuse trauma education into courses (Boel-Studt et al., 2022; Carello & Butler, 2014).

While college courses may be offered on trauma, they are often not taught with a trauma-informed approach (Carello & Butler, 2014). Listening to the intimate details of traumatic events can leave students at risk for vicarious trauma. Students are exposed to case studies and may encounter stories of trauma in their field placements. Those students with trauma histories may be at an increased risk for psychological harm as their own trauma symptoms may be reactivated by the trauma of those with whom they work. Thus, emotional safety in learning is critical, and instructors must teach trauma with a trauma-informed lens to mitigate this issue.

Carello and Butler (2015) made a case for trauma-informed educational practice (TIEP) in social work. Their article outlined suggestions for teaching about trauma while ensuring the emotional well-being of students by creating an environment of safety. Their suggestions included the recognition that there will be students at risk for vicarious trauma. Educators are encouraged to warn students of potentially traumatic material and to assess the emotional well-being of students regularly. They recommended processing difficult content with students as well as normalizing the emotions that can come up when learning about trauma. Carello and Butler (2015) also emphasized the frequent modeling and practice of self-care and the provision of resources to students.

The Council on Social Work Education's (CSWE, 2018) Commission on Educational Policy met the need for trauma education by developing a framework of competencies and instruction for master's program students who desire to specialize in trauma. The guide identified nine areas of competence that echo the standards for accreditation: a) to demonstrate ethical and professional behavior, b) to engage diversity and difference in practice, c) to advance human

rights and social, economic, and environmental justice, d) to engage in practice-informed research and research-informed practice, e) to engage in policy practice, f) to engage with individuals, families, groups, organizations, and communities, g) to assess individuals, families, groups, and communities, h) to intervene with individuals, families, groups, organizations, and communities, and i) to evaluate practice with individuals, families, groups, organizations, and communities. The curriculum and activities within the guide are specialized for trauma. The *Specialized Practice Curricular Guide for Trauma-Informed Social Work Practice* can also be used in general education but is not required for accreditation (CSWE, 2018). The problem with these competencies is that they are not required of all social work students. Thus, given the prevalence of trauma, new graduates will not be adequately prepared to serve their clients with trauma histories unless they specialize.

A study examining social work education surveyed 192 social work educators in the United States and Canada. Boel-Studt et al. (2022) found that 61.4% of BSW programs and 65.4% of MSW programs offered trauma education in some manner. Most of the surveyed programs (67.9%) indicated that trauma content was integrated into coursework already in place, although the content offered was not specified. Almost 56% of programs offered a trauma course. The two most frequently cited barriers for programs not offering trauma education were the priority of other content areas (60%) and the lack of educators to teach courses in trauma (36.7%).

A study of 162 MSW students determined that 80% of them reported at least one ACE, 56% reported two or more, and 27.3% indicated they had experienced four or more adverse childhood experiences (Gilin & Kauffman, 2015). Only 22.4% of the students reported no trauma prior to the age of 18 years. The average number of adverse childhood experiences

among the students was 2.29. This suggests that social work students may be at a higher risk of secondary trauma when exposed to case studies and other trauma content during their education. The authors presented 13 teaching strategies designed to reduce vicarious trauma in students. They also point out the need for educators to be trained in recognizing signs and symptoms of secondary or vicarious trauma in their students and positive coping strategies. They also recommend that faculty be trained on physical reactions to trauma and strategies for preventing students from being so overwhelmed by trauma content that their learning and well-being are negatively impacted.

Lanier and Carney (2019) also reported the need for trauma education. They studied 220 school, clinical, rehabilitation, and marriage and family counselors to examine the relationship between the symptoms of vicarious trauma and subthreshold PTSD symptoms in an effort to inform counselor educators on how best to prepare counselors-in-training for their future work. They also looked at what participants felt contributed to their symptoms. The results indicated that 49.5% of participants experienced all of the symptoms of vicarious trauma to some degree. "To some degree" was defined as at least once in the seven days prior. Symptoms experienced were thinking about clients outside of work (85.5%), emotional numbness (80.5%), irritability (79.1%), concentration difficulty (75.5%), discouragement about the future (75.5%), jumpiness (56.4%), and upsetting dreams about clients (49.5%). As for the subthreshold PTSD symptoms, for all 220 participants, the most commonly reported symptoms experienced at least once in the previous month were intrusive memories of the stressful experiences (100%), sleep difficulties (71.4%), concentration difficulties (70.9%), and feeling distant from others (68.2%). Results showed a significant positive association between vicarious trauma and subthreshold PTSD symptoms. Over 40% of the participants expressed a desire for more education on trauma. The

researchers concluded by emphasizing the importance of counselor educators providing adequate supervision and education on vicarious trauma (Lanier & Carney, 2019).

Strand et al. (2014) examined the impact of an elective course to teach masters-level social work students the fundamentals of trauma theory couched in a problem-based learning approach adapted from the National Child Traumatic Stress Network's *Core Curriculum on Childhood Trauma* (CCCT) on students' self-confidence. The adapted course was offered at four schools of social work a total of seven times. Results of the study showed that participants significantly improved their self-confidence in their knowledge and working with traumatized children and adolescents.

A study by Wilson and Nochajski (2016) examined the impact of a trauma-informed care (TIC) approach to social work curriculum on knowledge, attitudes, behavioral intentions, and self-efficacy. They explored the effects on 106 first-year and 137 advanced-year students. Results demonstrated improvements in self-efficacy and intent to implement TIC with future clients among the first-year students. Pre-test scores for knowledge and attitudes toward trauma-informed care were high and were not significantly impacted by the TIC approach. This suggested that knowledge and attitudes may not translate to feelings of competency or intent to act on the knowledge. First-year students were equivalent to advanced-year students on all measures at the post-test.

The literature reviewed on trauma education among social workers revealed issues similar to the ones found among psychologists. Namely, even though trauma education has been identified as necessary, the competencies developed are not required of all students. Because the incidence of trauma in the general population is high, it is safe to say that all new social workers will work with clients who have experienced trauma. The research on the impact of trauma

education shows that while it has been found to be effective for students, it is implemented inconsistently. While suggestions for teaching trauma education have been made, no literature has been found examining what factors may impact educators' inclusion of trauma content, principles, and practices in the courses they teach to social work students.

## Trauma Education Among Counselors

Like the American Psychological Association and the CSWE, the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2015) acknowledged the need for education on crisis and trauma. It stated that counseling students are to learn and understand how crisis and trauma affect those with mental health diagnoses. Standards for trauma competency are found under various headings. Students' awareness of how they will be parts of community outreach and emergency response teams as future counselors is located under the counseling orientation and ethical practice heading. Knowledge of the effects of crisis, disasters, and trauma on diverse individuals across the lifespan and of suicide prevention models and strategies is found under human growth and development in the curriculum, while knowledge of crisis intervention, trauma-informed, and community-based strategies, such as psychological first aid is found under the counseling and helping relationship section. A standard for knowing procedures for identifying trauma and abuse and for reporting abuse is located under assessment, along with one for assessing for suicide or risk of harm to self or others. A single trauma-related standard is also listed under specialty areas such as clinical mental health, clinical rehabilitation counseling, marriage, family, couples counseling, and school counseling (CACREP, 2015).

While CACREP has pointed out the need for trauma education, it does not outline what content should be covered in those areas or where content should be taught. Numerous authors

have advocated for trauma competencies and trauma education in both conceptual (Moh & Sperandio, 2022; VanAusdale & Swank, 2020) and research articles (Paige et al., 2017). Studies suggest that counselor education programs may offer trauma and crisis courses as elective courses or integrate trauma content within existing required coursework (Chatters & Liu, 2020; Montague et al., 2020). The lack of clear guidelines and consistency has resulted in counselors and counselors-in-training feeling unprepared to effectively provide service to those experiencing crisis or trauma (Lu et al., 2017; Morris & Minton, 2012). There have also been numerous studies on the mechanics of implementing trauma education in counseling programs (Greene et al., 2016; Moh & Sperandio, 2022; Morris & Minton, 2012).

The need for trauma education was put forth in a conceptual article by VanAusdale and Swank (2020), who purported that increased trauma competency and self-efficacy in counseling students would result in improved client outcomes and greater wellness in service providers. The authors introduced ways to infuse trauma content throughout the required core curriculum. They made suggestions for integrating trauma content and practices into five core courses: counseling theories, assessment, lifespan, family counseling, and supervision for practicum and internship experiences. The authors believed counselor educators needed to be knowledgeable and skilled at applying trauma-informed care principles in their presentation of trauma content to counselors-in-training. They believed that the infusion of trauma content was necessary to strengthen students' knowledge, skills, and self-efficacy in working with victims of trauma and to reduce the risk of secondary trauma.

Moh and Sperandio (2022) utilized their experience in infusing trauma education into their curriculum and a comprehensive literature review to highlight the need for trauma education in counselor education programs. They argued that the COVID-19 pandemic and the

continuance of racial injustice and discrimination in the United States further exacerbated the incidence and adverse effects of trauma. The authors proposed additions to accreditation requirements and counselor education curricula, standards and guidelines for trauma training, and additions to the code of ethics to ensure competency and ethical practice. The authors stated that their goal was to ensure all graduating counseling students could assess and treat diverse clients who have experienced trauma competently and ethically.

Paige et al. (2017) interviewed 39 fully licensed counselors with three or more years of experience as certified trauma therapists to determine their experiences related to trauma counseling and their perceptions about competency in trauma counseling. Four categories emerged from the qualitative data that the authors linked to Adlerian concepts: social interest, encouragement, lifestyle, and holism. A fifth category, trauma-specific, included attitudes, knowledge, and skills that were related to trauma but not an Adlerian principle. The authors used the data to inform the development of competency-based trauma education, training, and development for students, noting the prevalence and adverse effects of trauma.

Montague et al. (2020) investigated how CACREP-accredited programs teach students about crisis, trauma, grief, and neurocounseling. They examined the practices of 392 CACREP-accredited counselor education programs in the United States. Results indicated that 29.1% did not offer a single trauma, crisis, or grief course, while 31.4% offered a single course on crisis, trauma, grief, or a blend of these. Crisis courses were offered most often (62.2%), while only 41% of the programs offered a trauma class. A little over 21% offered a grief course, while just 5.1% offered a class in neurocounseling. It is unknown whether the courses offered in trauma, crisis, grief, and neurocounseling were required or elective courses. Thus, the question of how

programs meet CACREP's required trauma and crisis competencies, whether through infused content or stand-alone courses, remains unknown (Montague et al., 2020).

Lu et al. (2017) tried to address a gap in the literature by exploring the experiences of counseling students in providing counseling services to those with histories of trauma. In their qualitative study, a need for specific education in trauma counseling was identified. Three major themes emerged from the data. First, participants had immediate reactions to hearing detailed stories of the trauma their clients had experienced. These included deep emotional reactions such as fear and self-doubt, cognitive concerns about their training and ability to provide competent care, and self-identification processes. Second, participants realized they viewed the world differently than their clients and took actions to better understand client experiences, such as by getting supervision, self-reflection, or journaling. Finally, participants reported developing greater self-efficacy and increased motivation for learning and self-care. The authors highlighted the need for trauma education in counseling programs, including wellness practices and coping techniques (Lu et al., 2017).

Greene et al. (2016) examined a case-based strategy for a practicum counseling course to evaluate its impact on the students' general and crisis self-efficacy. A constructivist-developmental pedagogical approach was used within the framework of a crisis counseling model. Course activities and instruction were centered around a single case study. Assessment, treatment, counseling skills, and ethical issues were all directly related to the case. Researchers measured students' self-efficacy in both general and crisis counseling. Results demonstrated that the approach significantly increased students' perceived self-efficacy. The authors concluded that infusing trauma content into a practicum course was effective.

Morris and Minton (2012) explored the experiences of new counselors in preparing for and intervening in crisis during and after their practicum and internship practices. Their study of 193 counselors who had graduated within the past two years found that participants reported little to no education on crisis topics and that the majority encountered crises in their practicum and internship experiences. Participants who took a crisis course reported higher self-efficacy in crisis response than those who did not. The new counselors also indicated that crisis education should be an essential component of counselor education programs.

Counselor educators in CACREP-accredited counselor education programs prepare graduate students to be ethical, competent, and skilled practitioners who promote social justice and strive for lifelong personal and professional growth and development. They help students develop a robust professional identity while preparing them for careers in a multitude of private and public sector organizations (CACREP, 2015). They prepare master's and doctoral-level students to excel in their chosen careers. They take active roles in teaching, supervising, and gatekeeping. Counselor educators must also determine program curricula, advocate for the profession and those in their communities, and maintain membership and leadership roles in professional counseling organizations. They are also asked to lead research and be part of research teams while staying abreast of current research. Given the prevalence and adverse effects of trauma, it is evident that counselor education programs need to better prepare graduates to serve individuals who have survived trauma (Lu et al., 2017). This body of literature shows that trauma training has not been adequately addressed in graduate counseling education programs despite trauma's prevalence and negative consequences.

## Summary

Education in trauma is essential for graduating counselors to competently and ethically assess and treat clients with histories of traumatic events. Conceptual and research articles have made the argument for trauma competencies, pointed out the lack of consistent training, highlighted the benefits of trauma education, and suggested methods of implementation. However, only two articles exploring barriers to trauma education were found. This study attempted to fill that gap by exploring the degree to which the required trauma standards are taught and investigating factors related to whether CACREP-accredited counselor educators infused trauma concepts and practices into their non-trauma courses. Specifically, it explored the relationship between personal trauma history, prior training, and attitudes toward trauma-informed care with the infusion of trauma education into non-trauma-specific courses among counselor educators.

# Personal Trauma History

## Definition and Conceptualization

It is clear from the literature that a history of trauma may result in long-term adverse emotional and physical problems (Felitti et al., 1998). The prevalence and effects of trauma have been well documented among social work students, child welfare professionals, and educators (Hubel et al., 2020; Lee et al., 2017; Thomas, 2016), demonstrating a pattern of ACE scores higher than the general public (Aykanian & Mammah, 2022; Esaki & Larkin, 2013; Steen, Senreich, & Straussner, 2021). However, the incidence and impact on counselor educators are unclear. Studies have suggested that those with trauma histories may be more interested in helping professions (Bryce et al., 2021; Steen, Straussner, & Senreich et al., 2021).

In their study of child service providers, Esaki and Larkin (2013) studied the prevalence of ACEs and found that 70.1% of their 94 participants reported at least one adverse childhood experience (ACE), 53.8% reported two or more, and 15.9% reported four or more ACEs. The prevalence among them was significantly higher than among participants in the original ACEs study (Felitti et al., 1998). Steen, Senreich, and Straussner (2021) found comparable results in their survey of 5,540 licensed social workers. A similar survey of 136 homeless service workers indicated an incidence of adverse childhood experiences greater than in the general population and comparable to that found in other direct service providers (Aykanian & Mammah, 2022). A high percentage of participants reported at least one adverse childhood experience (80.88%), 62.5% reported two or more, and 38.24% said four or more.

Thomas (2016) explored the prevalence of adverse childhood experiences among 79 students seeking a master's degree in social work. Results demonstrated that more than 79% of the participants had at least one adverse childhood experience, 38% experienced one to three, 42% reported four ACEs, and almost 25% indicated six or more. The divorce or separation of parents was the most reported ACE (48.6%), followed by physical abuse (43%), emotional neglect (40.5%), and the substance abuse of someone living in the home (40.5%). More than one-third reported mental illness of a family member and emotional abuse. Results demonstrated that adverse childhood experiences were more common in this sample than in the original ACE study (Felitti et al., 1998; Thomas, 2016). The author highlighted the need for social work educators to employ best practices to ensure resilient and competent social workers.

Bryce et al. (2021) conducted a systematic literature review that examined the relationship between adverse childhood experiences, cumulative trauma, and career choice. They defined helping professions as those dedicated to improving the welfare of individuals, including

psychology, counseling, education, social work, nursing, and human services. They concluded that some helping professionals were motivated to choose a career helping others due to their history of traumatic experiences, the characteristics they developed because of adversity, experiences they had with helping professionals, and a desire to help others with similar experiences. In a qualitative study of 1,828 licensed social workers exploring how adverse childhood experiences affected their decisions to become social workers, Steen, Straussner, and Senreich (2021) found similar associations between ACEs, a desire to help others and career choice. The reasons for deciding on a career in social work included wanting to understand their own history, wanting to help others, negative and positive experiences with therapy, and the past use of protective supports. The prevalence of ACEs in counselor educators has yet to be studied. Still, it seems likely, as helping professionals, to be higher than in the general public and, as such, must be explored as a contributing factor to the infusion of trauma education in non-trauma-specific courses.

### Personal Trauma History Among Psychologists, Social Workers, and Counselors

Literature on personal trauma history in psychology and social work seems to be directed at determining how that history affects practitioners in their clinical practice (Hansen et al., 1997; Page & Morrison, 2018; Steen, Straussner, & Senreich, 2021; Yoshihama & Mills, 2003). In addition, there is research that has examined how a history of trauma is related to the development of secondary trauma symptoms (Diehm et al., 2019; Howard et al., 2015; Ivicic & Motta, 2017; Lee et al., 2017; Peled-Avram, 2017; Steen, Senreich, & Straussner, 2021).

Hansen et al. (1997) explored the relationship between personal history of trauma and identifying and reporting child maltreatment in 85 social workers and 125 psychologists. They found that 27.2% of psychologists surveyed reported a history of parental violence, 56%

experienced physical abuse, 59% witnessed the physical abuse of siblings, and 16.8% were the victims of relationship violence. The authors found that a personal history of violence between parents, physical abuse, marriage or dating violence, and sexual abuse was positively related to psychologists' suspicion and report of abuse in clients. The authors also found that 28.6% of the social workers in their study witnessed parental violence, 54.8% were the victims of physical abuse, almost 60% experienced the physical abuse of siblings, 22.6% survived sexual abuse, and 32.1% experienced marital or relationship violence. All these factors were positively related to the identification and reporting of child maltreatment. This study affirms that personal history of trauma affects the behaviors of psychologists and social workers (Hansen et al., 1997).

The effect of trauma history on clinical behavior was also explored by Page and Morrison (2018) in their study of 292 psychologists regarding believing child sexual abuse disclosures. They discovered that male psychologists with a history of trauma were more likely to believe disclosures than were those without, and believability was associated with an intent to validate a client's experience. Yoshihama and Mills (2003) also suggested that personal trauma histories may affect professional practice. They assessed 303 child protective service workers to explore how trauma history impacted professional responses to assertions of domestic violence. Results were that female child service workers with a history of sexual abuse were more likely to advocate for children to be removed when their mothers were experiencing abuse. Workers with a history of partner violence and who identified with the victims were less likely to recommend removal. Additionally, professionals with a history of physical abuse were more likely to report sexual abuse.

In their qualitative study of 1,828 licensed social workers, Steen, Straussner, and Senreich (2021) explored how trauma histories influenced social workers' work experiences and

whether those experiences impacted their choice of careers. Social workers with adverse childhood experiences reported how these experiences positively affected their work with clients. They could identify with clients' experiences, advocate for change, and establish collaborative relationships with colleagues. They also reported the need for support, such as good supervision and their own therapy.

Helping professionals may have a higher risk of developing secondary traumatic stress (STS) if they have a personal trauma history. Diehm et al. (2019) examined the relationship between the level of exposure to trauma clients, years of experience, and personal trauma history and STS in 77 Australian psychologists. They also examined the impact of perceived social support by supervisors, colleagues, friends, and family on secondary trauma. Results showed that STS was positively related to the level of exposure to clients' trauma stories and personal trauma history. Secondary traumatic stress symptoms also increased when the trauma was perceived as unresolved. Not surprisingly, social support significantly moderated the relationship between the time spent with trauma survivors and secondary trauma. These findings were supported by Ivicic and Motta (2017), who investigated the relationship between trauma history and secondary trauma. They assessed 88 psychologists, social workers, and mental health counselors and found that greater levels of personal exposure to trauma were related to more symptoms of STS. The authors reported that 23 to 27% of participants were positive for secondary traumatization.

Lee et al. (2017) studied 104 child welfare workers and found that 77.4% of participants reported one or more adverse childhood experiences, and 31.0% of participants scored four or more. Child welfare workers who chose their careers due to their personal trauma histories (40%) also experienced higher work-related stress. The authors proposed that those workers may

over-empathize with clients, which increases the risk of secondary trauma or re-traumatization of the professional.

Steen, Senreich, and Straussner (2021) also found a high prevalence of ACEs in their study of 5,540 licensed social workers in 13 states. They explored the occurrence and types of ACEs, the relationships between ACEs and various wellness factors, and the relationship between ACEs and workplace stress and compassion fatigue. Respondents reported an average of 2.1 adverse childhood experiences. Almost 24% reported experiencing four or more. The researchers found that higher ACE scores were significantly related to more physical, mental, and sleep health issues and increased reported workplace stress. A research study by Peled-Avram (2017) explored personal and work-related risk factors for vicarious trauma. They assessed 109 social workers in Israel and reported that social workers with a personal history of trauma (61.5 %) had a higher incidence of vicarious trauma. Peled-Avram also noted that participants receiving more effective and more relational-oriented supervision had fewer symptoms of vicarious trauma.

Contrary to the findings above, Howard et al. (2015) found that providers of direct and indirect services for children living in foster care who experienced more childhood adversity had higher scores for compassion satisfaction and reduced burnout. The authors explored ACEs and resilience in the participants. They also investigated professional social climate and quality of life, including compassion satisfaction, burnout, and STS. Then, they looked at the impact of ACEs, resilience, and professional environment on professional quality of life. They found that a high percentage (25.1%) of the 192 participants reported four or more adverse childhood experiences. Although the ACE scores were higher than the general public, they were not significantly related to secondary traumatic stress. Authoritarian leadership and low levels of

resilience were most predictive of higher compassion fatigue and burnout, while low resilience and being female were predictive of more secondary traumatic stress. It must be noted that a limitation of this study was that 58.9% of the participants did not provide direct services to clients.

It can be inferred from the studies cited that having a trauma history had clinical implications, although it is difficult to see a pattern to the impacts. It may be that having a trauma history may have other behavioral implications which may be extended to teaching trauma principles and practices. A personal trauma history may also impact the risk of developing symptoms of secondary or vicarious trauma or compassion fatigue. Studies are needed to determine the impact of personal trauma history on those charged with educating helping professionals.

### Personal Trauma History Among Educators

A search of the research regarding personal trauma histories among teachers yielded three publications. The two research studies found a high prevalence of adverse childhood experiences and relationships with classroom behaviors or the development of adverse symptoms (Grist & Caudle, 2021; Hubel et al., 2020). A conceptual article addressed the need for trauma-informed early childhood through secondary educators (Lawson et al., 2019).

Lawson et al. (2019) wrote an essay that discussed knowledge of trauma-informed principles and their connection to educators' secondary traumatic stress. Sources of STS were identified and included working with traumatized students and experiences of trauma in the school and community. The authors noted that STS could result in avoidance of people, thoughts, and feelings that remind teachers of trauma experienced by their students. It can also result in a myriad of negative consequences, including negative emotions and behaviors,

declining performance, and job turnover. The writers also suggested that some educators may have trauma histories, which may increase vulnerability to symptoms of secondary traumatic stress. They strongly argue that educators must be trauma-informed to address trauma in students effectively and protect and heal themselves.

Grist and Caudle (2021) explored the relationship between adverse childhood experiences, personality, and burnout in 207 early childhood educators. They found that just under 24% of teachers reported four or more ACEs. ACEs were positively associated with neuroticism and emotional instability. A higher ACE score was also positively correlated to openness to intellectual experience. The personality traits of neuroticism and openness were positively correlated with measures of burnout, such as emotional exhaustion and depersonalization. They were negatively correlated with personal accomplishment, which translated to feeling competent at their job. A study of 349 early childhood caregivers and early childhood education teachers found that 73% of participants experienced at least one ACE, while 22% reported four or more ACEs (Hubel et al., 2020). A higher overall number of ACEs was related to a less positive social and emotional climate in the classroom. Individually, teachers' childhood experiences with the incarceration of a family member were also significantly related ($p$ = .012) to a lower-quality social and emotional climate.

Most trauma history literature focuses on trauma's prevalence and damaging physical, emotional, and social consequences. Researchers investigate the prevalence of trauma in trauma workers, educators, and school children with the general public for comparison. Numerous conceptual articles point out the need for trauma-informed organizations and schools. The literature about personal trauma histories' impact on teachers is sparse. It highlights the need for further study, especially with post-secondary educators.

## Personal Trauma History Among Counselor Educators

Literature on the impact of personal trauma on counselor educators is lacking. As counseling is a helping profession, and research has demonstrated that those with a history of trauma may be drawn to helping professions, counselors and counselor educators may also have personal trauma histories. Literature from other service providers, such as early childhood through 12th-grade teachers, has shown that secondary traumatic stress can result from witnessing detailed stories of trauma from those with whom they work (Lawson et al., 2019). Research on trauma, vicarious trauma, secondary traumatic stress, and compassion fatigue has been well-documented in licensed counselors, therapists, and social workers (Hensel et al., 2015). Studies have shown that those with a history of trauma have the potential to be triggered by exposure to the trauma of others and are at higher risk for secondary trauma (Cieslak et al., 2013; Nation et al., 2022). Personal trauma exposure has also been shown to impact counselor behavior (Day et al., 2017).

Hensel et al. (2015) included 38 studies in their review and meta-analysis of factors contributing to the risk of secondary traumatic stress among professionals exposed to stories and details of trauma through their work with trauma victims. Professionals included volunteers and professionals from various organizational, community, and agency settings, including mental health, school, healthcare, and chaplaincy. In their analysis of 17 risk factors, small but significant results were found relating a higher ratio of trauma cases to non-trauma ones and a greater volume of trauma cases with increased STS. A history of personal trauma was also positively related to secondary trauma, although the strength of the relationship varied between studies. Hensel et al. (2015) did note that the effect sizes of these relationships lessened in studies published after 2008. They suggested this may be due to more awareness of secondary

trauma in the workplace and a greater awareness of workplace balance. The definition and measurement of trauma used may also have played a role.

Cieslak et al. (2013) investigated the influence of secondary exposure to trauma on secondary traumatic stress among 224 social workers (23%), counselors (31%), and clinical psychologists (45%). The traumatic stress symptoms were broken down into intrusion, avoidance, and arousal components. They also explored factors impacting STS, such as personal trauma history, perception of the impact of hearing details of trauma, work factors, and professional support. The researchers discovered that 33.9% of participants had no symptoms of STS, while 19.2% of participants met all criteria for STS, culminating in a diagnosis of post-traumatic stress disorder. The criteria of intrusion were most frequently reported (57.6%), followed by arousal (35.3%) and avoidance (29.9%). Intrusion and avoidance were met by 23.7%, intrusion and arousal by 29.5%, and avoidance and arousal by 22.8%. Five factors positively correlated to secondary traumatic stress were the ratio of trauma clients, personal history of trauma, heavy caseload, excessive paperwork, and perception of negative impact. Upon completing regression analysis with the five factors, researchers found that only having too many patients, personal exposure to trauma, and perception of a negative impact of indirect exposure to trauma predicted STS symptoms. The authors validated their results with a meta-analysis demonstrating similar severity of symptoms across diverse groups of professionals exposed to secondary trauma (Cieslak et al., 2013).

A mixed-methods study was conducted on 55 participants who were part of eight rehabilitation teams in Australia (Nation et al., 2022). The eight teams comprised a transitional housing team, two mobile outreach teams, an early psychosis team, and three residential community care teams. The quantitative research explored baseline attitudes toward trauma-

informed care and training participation rates. The eight team leaders participated in semi-structured interviews examining their experiences and perceptions of the implementation of trauma-informed care. Researchers found that completion of TIC training varied widely between the teams, ranging from 4.8% to 78%. Four themes were identified through qualitative analysis: a) the need to respect the person's experience and the risk of re-traumatization, b) the importance of the context of implementing TIC training, c) TIC as a critical component of mental health care, and d) trauma histories among staff members. The authors noted that a personal trauma history might result in workers being triggered by the training and their work with trauma victims.

Avoidance of reminders of trauma was reported by Day et al. (2017) in their phenomenological study that described the trauma perspectives of eight counselors who provided direct services to those affected by the Virginia Tech shootings in 2007. One theme that emerged was the changed view of those who have experienced shared trauma. Included in this theme was the struggle clinicians had in keeping their own feelings and experiences and feelings away from their clients because they identified with the trauma and pain experienced by those with whom they worked. Some also reported actively avoiding anything that would remind them of the shootings, not only in their work lives but in their personal lives as well. Another emerging theme was how the shared trauma impacted clinicians' work. There were negative and positive effects. Clinicians reported that clients' detailed stories and shared feelings could be overwhelming. Positives reported included more clinical confidence, heightened trauma awareness, enhanced relationships and rapport with clients, and greater interest in self-care (Day et al., 2017). The negative and positive effects of sharing trauma could also hold for counselor educators and their willingness to infuse trauma education in their non-trauma coursework.

This review of the literature demonstrates that a history of trauma may affect the behaviors of early childhood through secondary educators and increase their risk of secondary trauma symptoms. It seems likely that counselor educators with personal trauma histories may also be at greater risk for secondary or vicarious trauma as they teach about trauma with case studies or supervise students who are privy to the details of traumatic events via their clients. A personal trauma history may also affect instructors' willingness to teach trauma content due to emotional discomfort. Due to the gap in the literature, the effects of a personal history of trauma on counselor educators and their desire to teach about trauma are unknown.

For example, trauma education that includes case studies that may be triggering. If counselor educators have a personal trauma history, they are more vulnerable to vicarious trauma and may avoid any reminders, making them resistant to teaching about trauma. On the other hand, those with a personal trauma history may have a heightened awareness of trauma and more confidence in teaching trauma, perhaps making them more likely to infuse trauma content in their classes. The third possibility is that personal trauma history will not affect trauma education. Given the importance of trauma education and helping graduates practice within the bounds of competence, this factor must be researched.

## Summary

Literature about the prevalence and effects of a personal trauma history on psychologists, social workers, educators, counselors, and those in the helping professions has been reviewed. Studies of prevalence and effects show that those in these careers have a higher incidence of trauma than the general public. Having a trauma history may have affected career choice and may have positive or negative effects on professional behaviors.

It is important to note that while all of the studies referenced above cited the high prevalence of adverse childhood experiences in people who chose careers helping others, none recognized that most post-secondary educators for those professions were once helping professionals themselves. Hence, the incidence of ACEs among college and university educators training future psychologists, social workers, counselors, health care providers, and teachers would likely be higher than usual. There is a gap in the literature examining what standards are being infused and exploring factors that may impact the behaviors of counselor educators. This study explored personal trauma history as a potential factor affecting whether counselor educators infused trauma education in their non-trauma classes.

## Prior Trauma Training

### Definition and Conceptualization

Prior training in trauma is defined as courses, workshops, and training activities educators have taken to develop or increase their knowledge, awareness, and skills about trauma-informed care and practices. CACREP (2015) added trauma standards and began holding counseling programs accountable for them. There are six trauma standards in the core areas required of all students, regardless of specialization: (a) counselors' roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams, (b) effects of crisis, disasters, and trauma on diverse individuals across the lifespan, (c) suicide prevention models and strategies, (d) crisis intervention, trauma-informed, and community-based strategies, such as Psychological First Aid, (e) procedures for assessing the risk of aggression or danger to others, self-inflicted harm, or suicide, and (f) procedures for identifying trauma and abuse and for reporting abuse. CACREP did not, however, specify where trauma content is to be taught in the curriculum or how it is to be taught. This study seeks to understand the impact of prior

trauma training on whether counselor educators infuse trauma education throughout their non-trauma-specific courses and to what degree the required trauma standards are addressed.

## Prior Trauma Training Among Psychologists, Social Workers, Counselors, and Healthcare Providers

Although numerous articles highlight the importance of teaching students about trauma-informed practices, there is a notable lack of research on the factors that may influence whether educators choose to infuse trauma content in their non-trauma courses. Several conceptual articles supported the need for trauma education and are reviewed in the Trauma Education section above (Carello & Butler, 2014; Carello & Butler, 2015; Cook & Newman, 2014; Curtois & Gold, 2009). A review of the literature found additional research articles supporting trauma training to prevent secondary and vicarious trauma (Rinfrette et al., 2021) as well as to adequately prepare current and future providers for professional practice (Asnaani et al., 2020; Desai et al., 2019; Palfrey et al., 2019). There was also an article recommending specific approaches to training students and professionals on the principles and practices of trauma-informed care (Layne et al., 2011). Most studies of prior trauma education in psychology and social work focus on the impact of said training on providers. No studies addressed prior training and propensity to teach about trauma.

Rinfrette et al. (2021) studied 89 students pursuing a Master of Social Work degree over a two-year period. Their study aimed to investigate the impact of trauma histories and symptoms on the risk for secondary traumatic stress (STS) and vicarious trauma during internship experiences. Students completed several instruments to assess secondary traumatic stress and trauma symptoms at the beginning of their field placements and the completion of the internship. Students also completed the ACE Questionnaire–Mini Version (Anda et al., 2006). The

incidence of adverse childhood experiences in the sample group was high, with 47% reporting four or more. One-third of the participants self-reported three symptoms of PTSD, and 20% reported seven symptoms. The authors found a significant correlation between ACE scores and pre-test avoidance symptoms, which became insignificant at the post-test. The researchers suggested that the field experience may have been therapeutic for students as they witnessed the healing and growth of clients. Rinfrette et al. (2021) emphasized the importance of trauma training for faculty and field supervisors to guide their students through their field experiences competently and to aid in their professional development as ethical trauma-informed practitioners.

Trauma education has been positively correlated with increased awareness, knowledge, skills, self-efficacy, and willingness to assess and work with clients to promote healing and resilience (Palfrey et al., 2019). Workshops and training on TIC with doctors, nurses, social workers, counselors, and educators have been assessed positively, with trainees reporting increased confidence and comfort in working with those who have experienced trauma (Asnaani et al., 2020; Desai et al., 2019).

Asnaani et al. (2020) explored whether a one-day trauma workshop would affect participants' knowledge about trauma and stigma toward those who had experienced trauma in their mixed methods study. The 41 participants included school counselors, registered nurses, psychiatric providers, advocates, and health educators in Saint Lucia. Results indicated that workshop attendees demonstrated significantly increased knowledge of the prevalence and effects of trauma, effective treatment approaches, reduced negative attitudes towards trauma survivors, and greater confidence in their ability to care for themselves as needed.

Palfrey et al. (2019) conducted a pre-test post-test mixed methods study with 102 participants, composed of nurses (36%), psychologists (28%), social workers (13%), counselors (10%), students (6%), occupational therapists (4%), psychiatrists (2%) and pediatricians (2%) to explore the impact of a trauma workshop on confidence, awareness, and attitude toward TIC. Participants worked in various settings, including Mental Health Services for clients of all ages, Women, Youth and Children, Youth Justice, Youth Mental Health centers, Pediatrics, and Catholic Care services. Participants rated the workshop as germane and helpful. There were significant increases in participants' confidence to assess and skills to respond to trauma. Their knowledge of trauma and TIC also significantly increased. Ninety-seven participants responded to the qualitative questions about changes they would make to their behaviors post-training. Common anticipated changes were routine screening for trauma (58%) and focus on the therapeutic alliance (20%). Participants also expressed a desire for further training in specific trauma interventions (48%). Child and adolescent mental health clinicians were invited to respond to a follow-up questionnaire one year after the training. Eighty-one percent of the 22 respondents reported regularly assessing clients for trauma, and 80% went on to be trained in trauma-focused cognitive behavioral therapy (TF-CBT). Qualitative responses indicated the value of trauma training and improvement in their ability to work with clients (Palfrey et al., 2019).

In a pilot study, Desai et al. (2019) examined the impact of implementing a trauma-informed group parenting curriculum on participants' perceived self-efficacy, satisfaction, and comfort with TIC. Forty-one participants from 24 clinical sites responded to the survey, which resulted in quantitative and qualitative data. Primarily, participants were billing providers and staff facilitators. Results demonstrated that participants felt confident in group care, were

satisfied with the curriculum, and were comfortable working with clients who had experienced trauma. Participants highly rated the need for the curriculum to contain more specific and in-depth trauma content, highlighting the importance of TIC and training in trauma-informed practices and principles.

The National Child Traumatic Stress Network (NCTSN) developed a task force to design a childhood trauma curriculum (Layne et al., 2011). The *Core Curriculum on Childhood Trauma* (CCCT) was designed to educate social work graduate students and professionals about the core principles and practices of trauma-informed care. The training would ready them for later training on evidence-based trauma interventions. The CCCT was intended to educate and enhance the clinical treatment of youth and families exposed to trauma. It included cultural sensitivity and a developmentally appropriate, strength-based family systems perspective of care. The CCCT was piloted as a 30-hour elective course taken over two weeks with 42 social work graduate students who reported that their instructors or supervisors had very little trauma training. Pre- and post-test comparisons indicated significant gains in self-efficacy. Quantitative and qualitative data demonstrated that the students rated the training highly. Students also reported high satisfaction with their ability to apply learned concepts to their work with traumatized individuals and families. Additional findings included the need for supervisors and field instructors to be trained in trauma-informed care and practice (Layne et al., 2011). This suggests that educators of graduate students also need appropriate training to teach trauma content effectively.

Trauma training has been related to increased knowledge, confidence in TIC skills, and comfort in applying the principles and practices of trauma-informed care to clients in various clinical and agency settings. Researchers have emphasized the need for trauma training for

providers and those educating providers. Since trauma training is related to increased knowledge and self-efficacy, it is likely that educators trained in TIC will also be more knowledgeable and confident in teaching those same principles and skills to their students.

## Prior Trauma Training Among Educators

The literature review for trauma training among educators yielded a study highlighting the positive effects of trauma training on primary and secondary educators and the need for organizational supports (McIntyre et al., 2019). Two additional conceptual articles supported the need for trauma education and the importance of trauma-informed trauma education at the post-secondary level (Cook et al., 2019; Paul & Varghese, 2021). A conceptual article was reviewed in the Trauma Education section above but is briefly mentioned again due to its relevance to prior training (Carello & Butler, 2014). One research study examined the connection between knowledge of trauma subject matter and competence in mentoring students at the post-secondary level (Mikkonen et al., 2022).

McIntyre et al. (2019) studied 105 primary and 78 secondary teachers from six public charter schools in New Orleans who participated in a two-day professional development training to prepare teachers to implement a trauma-informed approach to education in their schools. They discovered a significant increase in knowledge and acceptability after the training. The acceptability measure was designed to predict teacher use of behavioral interventions. Results suggested that teachers were more likely to use trauma-informed practices after the trauma training when they perceived a good fit between school norms and trauma-informed approaches. This highlights the importance of administration and peer support for TIC.

A conceptual article from 2019 described the current trauma training efforts and areas for improvement in the education of clinical and counseling psychology students (Cook et al., 2019).

The authors emphasized the high prevalence of trauma and its numerous adverse physical, mental, emotional, and social effects. In their literature review, they cited studies outlining the push for trauma-informed care nationally and internationally across a broad spectrum of professional agencies and organizations. They also discussed the potential harm that may be done to clients by uninformed providers. Training has been inconsistent and inadequate despite the recognition and need for trauma-informed service professionals (Cook et al., 2017). Cook et al. (2019) conclude with unequivocal support for trauma training for students, educators, researchers, and providers to meet minimum competency standards. This article supports the need for counselor educators to be trained in trauma to prepare students to meet the needs of their future clients.

Paul and Varghese (2021) argued in their conceptual article that psychoanalytic theory should be incorporated into the education of future social workers. Teaching about trauma involves modeling and parallel processes. Trauma-informed principles such as safety, collaboration, choice, and empowerment are critical in the classroom. Safety and trust enable students to take necessary risks and protect them from harm. The authors pointed out that while a trauma-informed approach has been accepted in many K-12 schools, it has not in higher education settings. Trauma education may invoke anxiety or unpleasant emotions in students. Using a psychoanalytic approach and viewing instruction and students through a trauma-informed lens may help students develop competency in a safe and empowering manner. Educators must have sufficient prior training to do so successfully.

Carello and Butler (2014) made the case that teaching about trauma is not necessarily teaching with a trauma-informed approach. They stated that due to the high prevalence of trauma in college students, teaching about trauma without using a trauma-informed approach puts

students at risk for re-traumatization or secondary trauma. This indicates that educators who include trauma content in their coursework should have training in trauma-informed care.

Mikkonen et al. (2022) explored the competence of social, health care, and rehabilitation counselors in educating future professionals. They studied 422 educators in Finland, of whom 78% had a master's degree and 21% had a doctorate. Eighty percent taught at a university, while the rest taught at vocational colleges. One aspect explored was the connection of competence in subject matter and curriculum to competence in mentoring students in developing professional competence. These were found to be significantly related, supporting the need for educators to be competent in trauma and crisis to assist students in becoming trauma-competent professionals. Thus, prior training in the subject matter taught is critical.

### Prior Trauma Training Among Counselor Educators

There is a gap in the literature exploring the factors related to whether counselor educators infuse trauma content into the non-trauma-specific courses they teach and the degree to which the standards are infused. As many crisis and trauma courses are often offered as electives, it is vital that trauma content be integrated into non-trauma-specific courses. A literature review of prior trauma training in counselor educators yielded limited results. A single article addressed factors that might impact counselor educators' willingness and perceived self-efficacy to teach about trauma (Asselt et al., 2016). An article discussed in the Trauma Education section is revisited here due to its relevance to the need for educators to be competent in their knowledge and skills related to trauma-informed practice to meet the needs of their students (Morris & Minton, 2012). Swank et al. (2021) wrote an article that supports the concept that counselor educators must have knowledge of the subject to be competent in teaching. Two

studies explored potential barriers to implementing trauma education in counselor education (Asselt et al., 2016; Watkinson et al., 2018).

Morris and Minton (2012) studied new counselors' crisis intervention preparation, self-efficacy, and experiences in crisis. Participants reported no to minimal training in disaster (71.50%), crisis theory (70.99%), physical assault (60.62%), sexual assault (59.58%), intimate partner violence (59.58%), case management (58.55%), interventions for violence (58.04%), trauma (57.51%), collaboration skills (57.51%), and assessing for violence (51.81%). Only suicide assessment was reasonably well covered. They discovered that although participants had limited training, most had encountered and dealt with crises in their field experiences. It was noted that clock hours of prior training in crisis were significantly and positively correlated with perceived self-efficacy in responding to crisis situations with clients. The researchers solicited counselors' advice for counselor educators and found that 32% of recommendations called for increased curricular attention to crisis, including the amount and depth of instruction. Participants also recommended specific models and topics for inclusion, such as strategies, grief and loss, and disaster. This study highlighted the need for more comprehensive coverage of crisis and trauma topics while in school. The authors also suggested that if a separate required crisis course is not feasible, the content may be infused into existing courses (Morris & Minton, 2012).

Swank et al. (2021) explored the psychometric properties of a self-evaluation instrument, the Teaching Competencies Scale (TCS), which purported to measure the teaching competencies of counselor educators and doctoral students studying counselor education. Two hundred eighty-eight counselor educators and counselor education doctoral students participated in the study. Results indicated a four-factor structure in the data: a) instruction and evaluation, b) knowledge, ethics, and preparation, c) dispositions, and d) behaviors and technology use. This study showed

that instructor knowledge is an important component of competency. This supports the need for instructors to have prior training to teach students trauma content effectively and ethically.

To gain a better understanding of the experiences and perceptions of 32 full-time school counselor educators, Watkinson et al. (2018) conducted a phenomenological study. Three themes were identified: breadth versus depth, balancing specialties and professor partiality, and preparation versus practice. School counseling educators struggled to have the time to go deep into content due to the breadth of content they needed to cover. They also highlighted the difficulty of balancing the standards required for specialties within the program with the eight-core CACREP standards required of all. Participants reported the problem associated with courses taught by faculty with differing specialties. It was also discovered that faculty could be biased toward certain academic content. Their results can be applied to instructors' comfort with the infusion of trauma content in non-trauma courses.

Only one study addressed factors that might impact counselor educators' willingness and perceived self-efficacy to teach about trauma (Asselt et al., 2016). In a study of 17 participants in a session at the 2013 Association for Counselor Education and Supervision's national conference, researchers explored personal crisis history, trauma training, and competence. They found that counselor educators were hesitant about teaching curricula they had not learned in graduate school. Many participants had graduated from their programs before CACREP instituted the trauma competencies and thus may not have had any crisis training. Other educators had previous training in crisis but felt it had been too long ago to feel competent in teaching crisis to students. Some participants reported feeling embarrassed by their discomfort teaching the topic; others felt a lack of support to discuss this with colleagues. The length of time since they graduated, changing standards, and lack of interest in content were also reasons they

were hesitant to teach about crisis. Participants discussed their need to feel competent and expressed a desire for more education. All participants agreed that crisis training was critical for counseling students (Asselt et al., 2016).

Research on training in trauma has demonstrated that it positively impacts knowledge, attitudes, skills, and behaviors. Educating those in the helping professions, including future counselors, in trauma-informed care and practices is critical in ensuring competence and ethical practice. Counselor educators must have trauma-informed knowledge and skills to infuse that content into their courses. There is a gap in the literature exploring the impact of prior trauma training and other factors on whether counselor educators infuse trauma education in their non-trauma courses and the degree to which they do so. This study sought to remedy that gap.

## Summary

Literature about training in trauma education has been reviewed. Studies of the impact of trauma training among psychologists, social workers, counselors, healthcare providers, and educators have demonstrated that training impacts knowledge, skills, and attitudes. Trauma training often results in a positive change in on-the-job behavior. As a result, patients, clients, and students are more likely to be treated with empathy and understanding. Thus, they are less likely to be retraumatized. While content knowledge is an important component of educator competency, only one study addressed counselor educators' perceived self-efficacy in teaching about crisis. There is a gap in the literature exploring factors that may impact the behaviors of counselor educators. This study endeavored to explore prior training in trauma as a potential factor affecting whether counselor educators infused trauma education in their non-trauma classes.

## Attitudes Related to Trauma-Informed Care

### Definition and Conceptualization

The extent to which an organization or individual is trauma-informed can be inferred by their attitudes related to trauma-informed care (TIC). This study will explore counselor educators' knowledge, attitude, and skills as measured by the ARTIC-10 for educators (Baker et al., 2016). The ARTIC-35 breaks down TIC into five subscales: Underlying Causes of Problem Behavior and Symptoms, Responses to Problem Behavior and Symptoms, On-the-Job Behavior, Self-Efficacy at Work, And Reactions to Trauma Work. A positive attitude toward underlying causes of problems emphasizes that behavior is external and changeable. A trauma-informed approach is flexible, values safety, and promotes healthy, solid relationships. Empathy is valued more than control and is reflected in on-the-job behaviors. Self-efficacy is feeling competent and able to work with traumatized people. A trauma-informed approach also recognizes secondary trauma and the need for positive coping strategies and the support of others.

Some of the research outlined below employed the ARTIC-35, a more in-depth version of the ARTIC-10, or the ARTIC-45, which includes two additional subscales: Personal Support of TIC and System-Wide Support for TIC. Attitudes related to TIC have typically been used as an outcome variable, often in a pre-test post-test design, when exploring the effectiveness of trauma education or the implementation of TIC (Kim et al., 2021; Liang et al., 2020). Thus, there is an overlap in the literature when searching for research on trauma training and searching for research on attitudes related to TIC. This study will use attitudes related to trauma-informed care as a predictor variable for whether counselor educators infuse trauma education into their non-trauma-specific courses. Thus, for this section, the research reviewed will focus on attitudes related to TIC and behaviors.

Attitudes Related to TIC Among Psychologists, Social Workers, and Nurses

Many studies of attitudes related to TIC in psychology, social work, counseling, and healthcare used the ARTIC Scale (Baker et al., 2016) as an outcome variable when assessing the effectiveness of trauma education. Many utilized a pre-test post-test design (Black et al., 2022; Galvin et al., 2020; Niimura et al., 2019). Earlier research examining the impact of trauma training pre-dated the ARTIC but measured trainees' knowledge, beliefs, and behaviors using an instrument developed by those who later developed the ARTIC (Brown et al., 2012). Other research found was not related to training. The research has focused on how attitudes related to TIC have been related to demographic variables and previous trauma or in-service training (Cilia Vincenti et al., 2022), individual characteristics (Bosk et al., 2020), and readiness for change (Marvin & Volino Robinson, 2018).

A study of 65 mental health practitioners from 29 psychiatric hospitals in Tokyo and the surrounding area found that participation in a one-day TIC training resulted in a significant increase in ARTIC-35 mean scores from pre- to post-training (Niimura et al., 2019). These changes were sustained three months later. Furthermore, 48% of participants reported implementing TIC strategies in their clinical care. Trauma-informed care clinical practices most often implemented were trauma-informed assessment (48%), appropriate tone of voice, volume, and word choice per trauma-informed principles (19%), and managing problem behaviors with positive strategies rather than with the use of force (19%). Those who implemented TIC strategies cited limited skills and experience with TIC, difficulty sharing TIC information with peers, and time constraints as the top barriers encountered. Those who did not implement TIC strategies reported time constraints as their number one barrier, followed by limited skills and

confidence. The researchers emphasized the importance of organizational support for implementation (Niimura et al., 2019).

Galvin et al. (2020) conducted a survey using a pre-post research design to study the impact of a specific organization-wide TIC training and implementation on the attitudes of both direct and indirect care employees working at residential care homes for youth in Australia while accounting for prior trauma-informed training, current position, and experience in the field. Fifty-five participants completed the ARTIC-35 assessment before the training. Participants were culturally diverse, and 60% had been in their current position for four weeks or less. Over 75% of participants reported previous training in TIC through their education, work, or personal development. Forty-five and a half percent had prior training specifically in TIC principles and practices. Thirty-one respondents completed the ARTIC-45 as a post-survey approximately six months after training and implementation. Besides age, where those who dropped out were younger, researchers found no differences in demographic characteristics.

Galvin et al. (2020) found that employees had very positive attitudes related to TIC at baseline, which remained high at the post-test. Notably, 76.4% of participants had multiple prior experiences with trauma training. There were no significant differences between pre-test and post-scores related to the length of experience in the industry either. Significant differences were found in Response to Problem Symptoms and Behaviors, On-the-Job Behavior, and Reactions to the Work Subscales related to the current position held. Case managers consistently had the most positive attitudes, while youth workers had the lowest. Youth workers indicated overall positive attitudes at baseline and at follow-up, but scores were significantly lower at follow-up. Participants with prior training in trauma-informed care scored significantly higher on the Personal Support Subscale comparatively, indicating they were confident in and supported the

adoption of trauma-informed practices. A major limitation of this study was the small sample size (Galvin et al., 2020).

Using a pre-post-post design, Black et al. (2022) studied the change in attitudes related to TIC over time in 429 child welfare employees providing services to juveniles mandated to offender units or protection. The participants received training in trauma-informed principles and practices and took part in ongoing supervision for 12 hours over six to nine months. They completed the ARTIC-35 before training, six months after training, and one year after training. The authors found through multilevel mixed-effect regression models that there were small but significant improvements at both post-tests for the Underlying Cause of Behaviors, Responses to Problem Behavior, and On-the-Job Behavior Subscales. This indicated that workers were more likely to view poor behavior regulation with empathy and to view them as changeable. They increased their ability to respond to problem behaviors with kindness and flexibility, focusing on the relationship rather than with harsh consequences. They endorsed an empathy focus over a control focus. The most improvement was noted during the first six months after training, with continued improvement in the six-month to one-year period after training. The researchers also found that increases in Self-Efficacy at Work and Reactions to the Work Subscale scores reached significant levels one year after the training. For all subscales, child welfare workers serving in a management capacity viewed TIC principles and practices more favorably. Black et al. (2022) concluded that it might be more difficult for direct care workers to apply TIC principles.

Like the researchers above, Brown et al. (2012) were interested in the impact of a trauma training program on knowledge, beliefs, and behaviors. They studied 261 participants at five residential treatment agencies who took part in a curriculum-based, group trauma training program. The participants were direct care workers, clinicians, teachers, administrators, and

nurses. The impact of the training was measured at four different points in time. While the ARTIC Scale was not used in this study, the Traumatic Stress Institute, which later developed the ARTIC, developed the instruments to measure trainees' knowledge, beliefs, and behaviors. Researchers found that the training significantly and positively impacted all three. In other words, trainees gained knowledge, demonstrated positive attitudes about TIC, and self-reported behaviors consistent with a trauma-informed approach to clients. The researchers examined post-training differences between the agencies and highlighted the importance of organizational support.

Cilia Vincenti et al. (2022) examined attitudes related to TIC differently than above for their mixed methods study of 136 mental health nurses at a psychiatric hospital in Europe. The objective relevant to this literature review was to explore relationships between attitudes related to TIC and various demographics and participation in in-service or trauma training. The ARTIC-35 for Human Services was administered to participants. The researchers discovered that nurses held favorable attitudes for four of the five subscales: Responses to Problem Behavior and Symptoms, On-the-Job Behavior, Self-Efficacy at Work, and Reactions to Trauma Work. They received mixed responses for the Underlying Causes of Problem Behavior and Symptoms, indicating disagreement about whether problem behaviors and symptoms were due to trauma.

There was no relationship between in-service or training in trauma and attitudes related to TIC. Mental health nurses who worked for less than five years at the psychiatric facility had significantly more favorable scores for the On-the-Job Behavior Subscale, meaning they were likelier to promote safety, empathy, and relationships with patients over control, rules, and consequences. Cilia Vincenti et al. (2022) also found that nurses working with more severely ill patients had significantly higher scores for On-the-Job Behaviors, Self-Efficacy, and Reactions

to the Work than those who worked with less severely ill ones. In other words, they viewed employing trauma-informed practices and procedures more favorably, were more confident in their skills, and were more likely to engage in self-care. Qualitative themes were the understanding, awareness, and need for trauma-related training, the problem of unhealthy boundaries, and factors inhibiting confidence in skills, such as organizational climate.

Bosk et al. (2020) used the ARTIC-45 in their study of 271 employees of three child and family service organizations in a Northeastern state in the United States. They assessed the relationship between employee characteristics, such as education, type of position (clinical vs. non-clinical), attachment (secure vs. insecure), sensitivity to rejection, knowledge of trauma and violence, and prior training on TIC, with the endorsement of TIC as measured by the ARTIC-45 and intent to find a new job. Participants were surveyed before completing training on a trauma-informed intervention, the Attachment, Regulation, and Competency model. Results demonstrated that staff with higher sensitivity to rejection were less likely to view TIC favorably. The authors supposed that employees with higher rejection sensitivity were more likely to take clients' emotional and behavioral dysregulation personally and not as expected in trauma clients. Staff not endorsing TIC were more likely to want to quit their jobs. There was a relationship between higher levels of education and more knowledge of trauma and violence with support for implementing TIC. Bosk et al. (2020) concluded that education about trauma and training, reflective supervision, and increased support could help offset the impact of rejection sensitivity.

Marvin and Volino Robinson (2018) conducted a study that examined employees' readiness for change by assessing attitudes related to TIC as measured by the ARTIC-35 (Baker et al., 2016) and knowledge of TIC as measured by a 12-item instrument developed for their

study. They also included two questions that measured readiness for change by obtaining participants' ratings on a 10-point scale of their perceptions of the importance of TIC and their confidence in their ability to work from a TIC lens. The study was conducted on 43 employees of a non-profit human services organization in Alaska. The organization's programs included a food pantry and services for homeless adolescents, pregnancy, disabilities, veterans, adoption, and refugees. Results found significant positive relationships between ARTC-35 scores and TIC knowledge and ARTIC-35 scores and readiness for change. Participants had very high scores for knowledge of TIC. This may have been due to a suggested limitation of this study. The authors reported that the instrument to measure knowledge was designed to measure basic knowledge of TIC and may not have been adequate (Marvin & Volino Robinson, 2018).

The studies above demonstrate that positive attitudes related to TIC may translate to behaviors or intent to implement behaviors consistent with such care. The research also suggested that personal factors may impact attitudes toward TIC and, thus, the ability or desire to view clients through a trauma lens or to implement trauma-related practices. More research is needed to determine how educators' attitudes related to TIC impact behaviors.

### Attitudes Related to TIC Among Educators

A literature review on attitudes related to TIC among educators yielded several studies assessing the impact of training and implementation of trauma-informed curriculums among different levels of schools. Liang et al. (2020) researched elementary, middle, and high school educators. Two mixed-method studies were conducted with staff from primary schools (Avery et al., 2022; Kim et al., 2021), and one mixed-methods pilot study was conducted with students and instructors at a university (Bertram et al., 2022). A research study explored the relationships between primary and secondary adverse childhood experiences, attachment style, and attitudes

related to TIC while accounting for prior training (Robertson et al., 2021). Another examined the association of elementary teachers' attitudes toward trauma-informed principles and practices, utilization of skills, and readiness to change (Blanton et al., 2022).

Robertson et al. (2021) used the ARTIC-45 to examine the relationships between teachers' adverse childhood experiences, attachment styles, and attitudes related to TIC while taking the influence of prior training in trauma into account. Participants were 128 teaching staff from the United Kingdom who were employed by early childhood or junior schools, senior schools, and alternative schools. Sixty-six percent had no previous trauma training. The researchers found that those with previous training had significantly higher overall scores on the ARTIC-45 and all five subscale scores, demonstrating more positive attitudes related to TIC and motivation to implement its practices. The researchers then conducted five multiple regression analyses with each of the five subscale scores as the independent variable to explore how much of the variance in attitudes toward TIC was explained by prior training, adverse childhood experiences, and insecure attachment styles (avoidant and anxious). Exposure to training and avoidant attachment styles were significant predictors of attitudes related to TIC, with prior training increasing positive attitudes. Controlling for previous trauma training, avoidant attachment style predicted less favorable attitudes for all subscales. Anxious attachment style was a predictor of the Reactions to Problem Behaviors Subscale. Adverse childhood experiences did not predict attitudes related to trauma-informed practices (Robertson et al., 2021).

A research study utilized the ARTIC-10 as a predictor of the use of trauma-sensitive practices in the school environment and explored readiness to change as a mediating factor (Blanton et al., 2022). Forty faculty and staff at a low socio-economic, urban pre-K through 5$^{th}$-grade school were surveyed one year after the completion of training about trauma-informed

schools in which they were taught about the incidence and effects of trauma, principles of TIC, trauma-sensitive classroom management practices, and given emotional regulation materials to use with students. Results demonstrated that participants believed it was imperative to implement trauma-informed practices (8.31 on a 10-point Likert scale). They were less confident in their ability to make needed changes (6.24 out of 10). A significant direct correlation was found between ARTIC scores and the use of trauma-sensitive skills with a medium effect size ($r$ = .33). The relationship between ARTIC scores and trauma-sensitive skill use was influenced by readiness to change, demonstrated by a significant indirect effect of ARTIC on skills use. Almost 59% of the variance in the relationship between ARTIC scores and skill use was accounted for by readiness to change (Blanton et al., 2022). This research highlights the need for programs to focus on building educators' confidence in effectively implementing trauma-informed practices in schools.

Liang et al. (2020) explored the effects of trauma training on ARTIC scores in two related studies. The first study included 552 educators from 14 schools and school districts in the Mid-Atlantic United States. Participants included teachers (61.8%), aides, counselors, psychologists, nurses, administrators, and support staff from elementary, middle, and high school settings. Researchers found that both full-day and half-day training in trauma was associated with a deeper understanding of trauma and more positive outlooks of TIC. Prior training and years of experience in teaching were not found to be significant covariates.

The second study included 159 educators from four middle schools in the Mid-Atlantic United States (Liang et al., 2020). Participants were primarily teachers (77.9%), aides, psychologists, nurses, administrators, and support staff. The research aimed to determine the effects of the degree of prior trauma training and ongoing school support on ARTIC-35 scores in

one school compared with a school that had only received training and had no ongoing support and two schools that received neither training nor support. Subjects in two schools completed a full day of in-service trauma training. Researchers found that the training resulted in significantly higher overall scores and significantly higher scores for the Underlying Causes, Responses to Problem Behavior and Symptoms, and On-the-Job Behavior Subscales. No significant differences were found for Self-Efficacy at Work and Reactions to the Work Subscales. Training combined with ongoing school support was associated with significantly higher scores for the Underlying Causes and Responses to Problem Behavior and Symptoms Subscales compared to trauma training without ongoing support. In other words, training and ongoing support were associated with teachers putting knowledge into action in schools (Liang et al., 2020).

Kim et al. (2021) utilized a mixed methods study to explore the impact of trauma training and implementation of a social-emotional learning curriculum, MindUp, on attitudes related to TIC and burnout. Twenty-six early childhood and kindergarten through third-grade teachers received the training and implemented MindUp for two back to back years, described in the study as involved-twice participants. Forty-five early childhood and kindergarten through third-grade teachers educators were described as involved-once and received the training and implemented MindUp for one year, and 41 teachers and educators received no training and did not implement the MindUp curriculum. The participants represented 17 different schools. Researchers noted that the breakdown of the current job role was statistically different for each group. There was a higher percentage of kindergarten teachers in the control group (43.9%) and the involved-twice group (63.6%) than in the involved-once group, which had more first through third-grade teachers (55.5%).

Kim et al. (2021) found that the participants started with favorable attitudes toward TIC. Those who received training and implemented the MindUp curriculum for two years showed significant increases in their overall scores for the ARTIC-35 and scores for the Self-Efficacy and Reactions to the Work Subscales. The participants in the involved-once group significantly increased overall scores and scores for the Reactions to the Work Subscale. The participants in the comparison group who received no training and did not implement the MindUp showed no significant increases on any ARTIC-35 measures. None of the study groups had significant changes in the Underlying Causes of Problem Behavior and Symptoms, Responses to Problem Behaviors, and On-the-Job Behavior Subscales. The qualitative results supported these findings. Results suggested that trauma training combined with a mindfulness-based social-emotional learning curriculum may help teachers have more positive attitudes toward TIC, feel more confident using trauma-informed practices with students, and be able to employ self-care.

Like Kim et al. (2021), Avery et al. (2022) assessed employee attitudes and perceptions related to the training on and implementation of a trauma-responsive school-wide approach, Reframing Learning and Teaching Environments (ReLATE), in three diverse Catholic urban primary schools in Australia. The researchers explored how ReLATE impacted staff understanding of trauma-informed attitudes and practices and recognition of signs of trauma. They also examined the effect of ReLATE on participants' ability to implement trauma-informed strategies. Finally, Avery et al. (2022) explored the perceived impact of ReLATE on staff and student well-being. The staff consisted of full- and part-time school leaders, teachers, and support staff, and researchers used an equivalent of 53.7 full-time participants. Twenty participants took part in the qualitative portion of the study individually or as part of a focus group.

Results showed positive but insignificant increases in Overall Scores on the ARTIC-35 for Educators from pre- to post-test. Avery et al. (2022) noted that two of the three schools had strongly positive attitudes related to TIC at baseline. The school with more negative attitudes at baseline significantly increased scores on the Responses to Problem Behavior and Symptoms Subscale, indicating a shift from control, rules, and consequences to empathy, flexibility, safety, and relationship. That school also had a significant decrease in the Self-Efficacy Subscale, which the authors suggested was not unusual following new concepts and an expectation of application. It should be noted that despite this decrease in confidence in skills related to TIC, the school committed to another year of the curriculum, suggesting some confidence that it would result in positive outcomes for students and employees. Three main themes emerged from the analysis of the qualitative data (Avery et al., 2022). The first was that understanding the impact of trauma and its varied presentation in students motivated changes in responses to problem behaviors. The second theme was that the perception of school fit and support of collaborative leadership impacted changes to trauma-informed practices and procedures. The final theme was that participants responded positively to collaboration in designing and implementing strategies and routines.

Only one study examined attitudes related to TIC in a post-secondary school environment. Bertram et al. (2022) conducted a pilot study in which they gathered quantitative and qualitative data from 96 participants comprised of nursing doctorate students (n=9), undergraduate nursing students (n=41), and nursing faculty and staff (n=46) at a Midwestern public university. The researchers explored changes from pre- to post-tests assessing attitudes relating to TIC after completing a short-term trauma awareness intervention and looked at relationships between outcomes and changes in self-care strategies. The short-term intervention

was designed to increase the use of self-care strategies and reduce re-traumatization. The researchers found that overall scores for the ARTIC-45 and all seven subscale scores increased significantly after the intervention. The qualitative data supported the increase in favorable attitudes related to TIC. Participants indicated a commitment to change their behaviors. Identified themes included self-awareness, self-care, empathy, applying a trauma lens, changing the narrative, and student-centeredness. The authors concluded that teaching the principles and practices of TIC is critical to improving the well-being of people (Bertram et al., 2022).

The research reviewed demonstrated the positive impact of trauma-informed training on attitudes related to TIC and the implementation of trauma-informed practices in schools. Research suggests that positive attitudes are related to on-the-job behaviors, such as viewing students through a trauma lens, focusing on safety and relationships, and using trauma-informed skills. More research is needed to assess whether positive attitudes related to TIC will translate to the behavior of teaching students about trauma at the post-secondary level.

### Attitudes Related to TIC Among Counselor Educators

There is a shortage of literature on attitudes toward TIC and its relationship with counselor educators. Attitudes related to TIC include knowledge, self-efficacy, and behavior, which may be affected by motivation (Baker et al., 2016). Suppose it is true that trauma education increases knowledge, skills, and attitudes toward TIC in educators, counselors, and other helping professionals. Those aspects may affect helping professionals' confidence and willingness to address and treat trauma. In that case, it seems plausible that the same might be valid for counselor educators. Their attitudes toward TIC and practices may affect their knowledge, confidence, and willingness to teach their students the necessary content to ensure

their competence in working with people with trauma history. Thus, this study was necessary to address that gap in the literature.

## Summary

Literature about attitudes related to trauma-informed care has been reviewed. Most research has focused on changes in attitudes after training and implementing trauma-informed policies, practices, and procedures in various service enterprises, including schools, hospitals, mental health, and child welfare organizations. Studies have demonstrated that, for the most part, service professionals demonstrate improvements in understanding and responding to problem behavior and symptoms with empathy, feelings of competence in their ability to work with traumatized people, and self-care practices. There is a gap in the literature exploring factors that may impact counselor educators. This study explored attitudes related to trauma-informed care as a potential factor affecting whether counselor educators infused trauma education in their non-trauma classes.

# Summary

This chapter began with a literature review establishing the rationale for examining the degree to which the required standards are infused into courses and for investigating counselor educators' knowledge, attitudes, and beliefs about trauma. It presented the theoretical basis for the outcome variable, the infusion of trauma education into non-trauma-specific courses, and included empirical research related to the outcome variable. Next, conceptual commentaries and empirical studies were reviewed for each predictor variable: personal trauma history, prior training, and attitudes related to trauma-informed care. It is critical that factors that may affect whether a counselor educator will integrate trauma content in their courses be explored. Determining how thoroughly the required trauma standards are being infused is important. This

study sought to address a gap in the literature by exploring the relationships between personal trauma history, prior training in trauma, and attitudes related to trauma-informed care with whether a counselor educator infused trauma education into their non-trauma-specific courses, as well as investigating the degree of infusion.

# CHAPTER 3: METHODOLOGY

The purpose of this study was twofold. First, the researcher examined how personal histories of trauma, prior training, and attitudes toward trauma-informed care (TIC) were related to the infusion of trauma education in non-trauma-specific courses among counselor educators in CACREP-accredited programs. Second, the researcher described to what degree trauma standards were being infused into the non-trauma-specific courses counselor educators teach in CACREP-accredited programs in the United States. This chapter outlines the methodology for the study. It is divided into six sections: participants, data collection procedures, instrumentation, research design, data analysis, and a summary.

## Participants

Participants in the proposed study included a convenience sample of counselor educators recruited via multiple methods described below. Inclusion criteria were (a) participants who are full-time faculty members, (b) employed by CACREP-accredited counselor education programs, and (c) located in the United States. A systematic review of 207 counseling journal articles found an average response rate of 43.9% among university faculty and 26.6% among members of the Association for Counselor Education and Supervision (Poynton et al., 2019). The researcher invited more than 2450 counselor educators to participate. The response rate was approximately 11%, resulting in 266 participants.

The researcher decided against a typical power analysis to determine an adequate sample size as similar research was not widely available, and the parameter estimates needed (i.e., probability of an instructor infusing trauma education into non-trauma courses) were unknown. After reviewing the literature, a rule of thumb formula for calculating sample size recommended by Bujang et al. (2018) in their study that proposed sample size guidelines for logistic regression

in observational rather than experimental studies was used. Bujang et al. (2018) recommended two rules of thumb for the needed sample size for logistic regression in observational studies. The first was to use a minimum of 500 participants. Due to low response rates among counselor educators, it was unlikely the researcher could get a sample size that large. The second was to use $n = 100 + 50i$, where 50 is the recommended event per variable (EPV) and i is the number of independent variables. This is more robust than smaller guidelines of ten events per variable, which Bujang et al. (2018) found resulted in too much bias in coefficient estimates. Thus, a minimum of 250 participants was needed, $n = 100 + 50(3)$, to complete the analysis.

## Procedures

The researcher obtained prior approval with Exempt status to conduct research with human subjects from the Institutional Review Board (IRB) at the University of North Carolina at Charlotte. The researcher obtained a list of CACREP-accredited programs in the United States. Participants were recruited through direct emails sent to faculty and department chairs listed in directories at CACREP-accredited institutions and through the CESNET listserv. The emails outlined the purpose of the study and participation criteria. In addition, a snowball strategy was also utilized, and participants were asked to forward the email or post to those they knew who met the participation criteria.

Inclusion criteria were clearly stated at the beginning of the recruitment email. Potential participants were invited to participate and provided a link to Qualtrics. The Qualtrics survey began with an informed consent letter outlining the purpose of the study, potential benefits, potential risks, conditions of anonymity, confidentiality, and the voluntary nature of the study. The ACEs questionnaire may result in emotional distress for some participants, so at the end of the survey, resources were provided to mitigate discomfort. Resources included the Substance

Abuse and Mental Health Services Administration (SAMHSA), Mental Health America, and MentalHealth.gov.

Once participants indicated that they read and understood the informed consent and met inclusion criteria, they completed the ACE Questionnaire, Trauma Education Checklist, Attitudes Related to Trauma-Informed Care Scale (ARTIC), and Demographics Questionnaire in that order. Completing the first instrument led to the second and so forth. The total time to complete the survey was estimated to be 10 to 15 minutes. The researcher downloaded the results into a Microsoft Excel spreadsheet, which was uploaded to IBM Statistical Package for the Social Sciences (SPSS, version 28.0.1.0) software for analysis. A small pilot study (n = 5) was done to check for technical issues in survey administration and data collection. Detected problems were addressed before recruitment for the main study took place. Data from the pilot study was destroyed once issues were detected and repaired.

## Instrumentation

### Personal History of Trauma: ACEs Questionnaire

Personal trauma history was assessed with the ACEs Questionnaire (Felitti et al., 1998). The ACEs Questionnaire was developed by Felitti et al. (1998) and used in their landmark study, illustrating the prevalence of trauma and its relationship to the leading causes of adult mortality. Research has shown a relationship between the total score on ACEs and adverse mental, physical, emotional, and social outcomes in adults and children (Baglivio et al., 2014; Felitti et al., 1998; Lawson, 2013). Although newer versions of this instrument include other factors, such as chronic illness and racial trauma, this study used the original version for ease of comparison. The ACEs Questionnaire was estimated to take participants two to three minutes to complete.

The original ACEs Questionnaire was a ten-item self-report questionnaire that included three broad categories of experiences. The category of abuse included physical, sexual, and emotional abuse. The category of household dysfunction included living with an adult experiencing mental illness, living with an adult experiencing substance abuse, incarceration of a family member, witnessing violence towards the mother or stepmother within the home, and parental divorce or separation. The third category was neglect, which included both physical and emotional neglect. Participants mentally responded "yes" or "no" to whether they had experienced each of the ten items. Participants were then asked to total the number of "yes" responses and enter that score. Researchers did not have a record of which items were experienced by participants, receiving only a total ACEs score.

Examples of questions related to sexual abuse on this survey are "Did an adult or person at least 5 years older ever touch or fondle you in a sexual way?" and "Did an adult or person at least 5 years older have you touch their body in a sexual way?" "Did you ever live with anyone who was a problem drinker or alcoholic?" or "Live with anyone who used street drugs?" are examples of questions related to living with an adult experiencing substance abuse. Examples of questions related to mental illness and violence toward the mother are "Was a household member depressed or mentally ill?" and "Was your mother or stepmother sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?"

While traditional validity studies are lacking for this instrument, validity has been established by its widespread use over the past 25 years and its use to validate other instruments assessing for trauma. An exploratory factor analysis (EFA) was conducted on the 10-item ACE index and yielded two factors: child maltreatment and household dysfunction (Mersky et al., 2017). There were moderate to strong relationships between all the items except parental divorce

or separation and the incarceration of a family member. The two factors were significantly correlated ($r$ = .48, p < .05), and there was adequate internal consistency reliability ($\alpha$ = .77).

The overall reliability of the ACEs instrument is adequate, and the subscales range from fair to excellent based on recommended values for Cohen's kappa coefficient. The values for Cohen's kappa coefficient fall between -1 and 1. Values between 0.41 and 0.75 are deemed fair to good, and values greater than .75 are considered excellent (Fleiss et al., 2003). Dube et al. (2004) examined test-retest reliability of the ACEs instrument using Cohen's kappa coefficient. The kappa coefficients for physical and emotional abuse and neglect were .55 (95% CI, .47–.63) and .66 (95% CI, .55–.76). The kappa coefficient for sexual abuse was .69 (95% CI, .61–.77). For the household dysfunction category, the kappa coefficients were as follows: living with an adult experiencing mental illness .51 (95% CI, .42–.61), living with an adult experiencing substance abuse .75 (95% CI, .68–.81), incarceration of a family member .46, (95% CI, .27–.65), witnessing violence towards the mother .77 (95% CI, .68–.85), and parental divorce or separation .86 (95% CI, .81–.91). The overall ACE-10 scores were also found to be reliable with a Cohen's kappa coefficient of .64 (95% CI, .36–.60).

Trauma Education Checklist

Descriptive information about whether respondents infuse trauma content into their non-trauma-specific courses and the degree to which the CACREP (2015) trauma standards are infused were assessed with the Trauma Education Checklist created by the researcher for this study. Participants were asked to give a "yes" or "no" response to whether they infuse trauma education into their non-trauma courses. The six CACREP (2015) trauma standards required of all students were broken down into twelve separate content areas: (a) counselors' roles and responsibilities as members of interdisciplinary community outreach and emergency

management response teams, (b) effects of crisis on diverse individuals across the lifespan, (c) effects of disasters on diverse individuals across the lifespan, (d) effects of trauma on diverse individuals across the lifespan, (e) suicide prevention models and strategies, (f) crisis intervention strategies, (g) trauma-informed strategies, (h) community-based strategies, such as Psychological First Aid, (i) procedures for assessing risk of aggression or danger to others, (j) procedures for assessing risk of self-inflicted harm, or suicide, (k) procedures for identifying trauma, and (l) procedures for reporting abuse. Participants checked all content areas they infuse into their non-trauma-specific courses. The total number of standards infused was computed as degree of infusion. The infusion of trauma education into non-trauma-specific classes was the dependent variable. The Trauma Education Checklist was estimated to take two to three minutes.

### Attitudes Related to Trauma-Informed Care (ARTIC) Scale

The Attitudes Related to Trauma-Informed Care Scale (ARTIC; Baker et al., 2016) was developed to measure the extent to which an organization or individual was trauma-informed. Scales were designed for both educational and human service settings. Participants in this study were given the ARTIC-10 for education. The ARTIC-10 is a ten-item short form that takes approximately two to three minutes to complete. The proposed use of this instrument was in education settings where time and resource limitations make the longer versions impractical (Traumatic Stress Institute, 2015).

On the ARTIC-10, participants responded on a seven-point bipolar Likert scale (Baker et al., 2016). Statements indicating a positive attitude toward trauma-informed care and statements indicating a negative attitude toward trauma-informed are included to lessen respondents' likelihood of giving answers they believe are socially desirable rather than their true beliefs. Examples of bipolar statements are “I believe that students’ learning and behavior problems are

rooted in their behavioral or mental health condition" versus "I believe that students' learning and behavioral problems are rooted in their history of difficult life events." Trauma-informed care contraindicated items on the ARTIC-10 were reverse-scored, and a total score was obtained for each participant. Higher scores indicated more favorable attitudes toward trauma-informed care.

Internal reliability was high for the ARTIC-10 as determined by Cronbach's alpha ($\alpha$ = .82), indicating individual differences in attitudes pertinent to trauma-informed care were reliably measured (Baker et al., 2016). Temporal consistency was also good. Correlations were .82 at 120 days, .73 at 121–150 days, and .65 at 151-180 days. Pearson's product-moment correlations were used to examine construct and criterion-related validity. ARTIC-10 composite scores were significantly related to personal familiarity with trauma-informed care ($r$ = .30-.38) and to eleven of fifteen indicators of TIC implementation. (r= .30-.58).

Demographic Questionnaire

Demographic information was self-reported. The first question again affirmed that participants met the inclusion criteria for participation. Participants were at least 18 years old and a full-time faculty member working at a CACREP-accredited institution in the United States. Participants were asked to provide their age, race, gender, years of clinical experience, and years of experience as a counselor educator. They were asked questions related to how they rate their trauma training and the extent of their trauma training. The extent of trauma training was measured on a 4-point Likert scale where zero meant no training, and three indicated substantial training. They were asked about the number of graduate-level trauma courses they have taken and how many hours they have participated in activities and workshops on trauma. Next, they were asked about the type, location, and size of their institution and program. Finally, they were

asked to provide descriptive information about trauma education in their program. Participants were asked if their institutions offer a trauma, crisis, or grief course, whether each is required of all students, and whether they teach any of those classes. The demographics portion of the survey was estimated to take participants three to four minutes to complete.

## Research Design

This study used a cross-sectional survey design to answer two research questions: (a) how personal trauma history, prior training, and attitudes related to trauma-informed care relate to the infusion of trauma education in non-trauma courses among counselor educators, and (b) to what degree trauma standards are being infused.

## Data Analysis

### Screening Data

All data was screened for missing data and outliers. Missing data may result in a loss of power or result in potential bias due to a systematic difference between the observed and missing values. Missing data was less than 10%, and pairwise deletion was used. Logistic regression assumes no outliers as they can affect the outcome. The data was screened for outliers. IBM SPSS Statistics software version 28.0.1.0 was used.

### Binary Logistic Regression

Binary logistic regression was used to determine the relationship between the independent and the dependent variable, infusion of trauma education, because the outcome was dichotomous or discrete (“yes” or “no”) rather than continuous (Hahs-Vaughn, 2017). Binary logistic regression allowed the researcher to look at the changes in the log odds that the dependent variable will occur given one or more predictor or independent variables.

In this study, it was used to determine how personal trauma history, prior training in trauma, and attitudes related to trauma-informed care related to the log odds that a counselor educator infuses trauma content into the non-trauma-specific courses they teach. Each independent variable was tested to determine its significance in the model using the Wald statistic. A significant coefficient would increase or decrease the log odds of infusing trauma education into non-trauma-specific courses by a certain amount for each one-point change in the coefficient.

The Hosmer-Lemeshow goodness of fit test was utilized to examine the overall model fit along with measures of model performance (e.g., null deviance and residual deviance). A linear relationship between the predictor and dependent variables should exist in logistic regression. A Box-Tidwell test was used to determine if this assumption was met (Field, 2018). IBM SPSS Statistics software version 28.0.1.0 was used for the analysis.

### Standard Multiple Regression

During the proposal stage of this study, the degree of infusion was noted as an alternative operationalization of infusion. This alternative operationalization would be employed if there were substantial issues using logistic regression. Degree of infusion would be a suitable replacement for infusion of trauma if the logistic model: demonstrated poor ability to predict whether counselor educators would infuse trauma education based on the predictor variables, had a low pseudo $R^2$ value, or there was a lack of participants selecting either response (i.e., very few yes or very few no responses). Standard multiple regression would then be used to determine the relationship between the predictor variables and the continuous outcome variable, infusion of trauma education, as measured by the degree of infusion (Hahs-Vaughn, 2017). As with logistic

regression, multiple linear regression allows a researcher to look at the changes in the outcome variable that are associated with one or more predictor or independent variables.

### Descriptive Statistics

Descriptive statistics were used to describe the degree to which participants infuse the CACREP trauma standards required of all counseling students. An overall mean was determined for the number of trauma content areas counselor educators infuse based on their responses on the Trauma Education Checklist. Frequencies and percentages were also calculated for each content area.

Descriptive statistics were used to summarize the data collected on the Demographic Questionnaire. Specifically, descriptive statistics were provided for participant age, gender, race, years of clinical experience, years of experience as a counselor educator, and institutional demographics. They were included for the rating of trauma training and the perceived extent of trauma training, including the number of semester-long trauma courses participants had taken and the number of workshops on trauma participants had attended. Descriptive statistics were also used to summarize trauma, crisis, and grief courses offered in programs, whether they are required or elective, and whether participants teach any of those courses. Data on the courses in which participants infuse trauma was summarized. Frequencies and percentages were included for categorical variables. Means and standard deviations were determined for continuous variables.

## Summary

This chapter has described the methodology of this research. Participants, data collection methods, and instruments used were outlined. A description of the research design and the data analysis methods to examine how personal histories of trauma, attitudes toward trauma-informed

care (TIC), and prior training were related to the infusion of trauma education among counselor educators was given. The analysis method to describe to what degree trauma standards were being infused was also outlined.

# CHAPTER 4: RESULTS

The purpose of this study was to explore the relationship of personal trauma history, prior training in trauma, and attitudes related to TIC with the infusion of trauma education in non-trauma-specific courses and to describe to what degree the CACREP (2015) trauma standards required of all students are covered among counselor educators at CACREP-accredited programs in the United States. This chapter describes the participants in the first section. The second section presents data collected on trauma education. The results of the major analysis, including information on data screening and the variables, comprise the third section. The fourth section presents the demographic information that answers the second research question. The fifth and final section of this chapter is a summary of the chapter.

## Description of Participants

This study used a convenience sample of counselor educators and a snowball strategy to recruit participants. Participants were full-time faculty members employed by CACREP-accredited counselor education programs in the United States. It is not possible to know how many counselor educators were invited due to sampling strategies, but it is known that more than 2,450 direct emails were sent. A total of 266 participants agreed to participate and completed the survey.

As shown in Table 1, most participants identified as White (74.4%; *n* = 198) and female (76.3%; *n* = 203). More than half of the participants indicated that they had substantial prior training in trauma, and 22.5% taught a trauma course (*n* = 60). Most respondents worked for institutions located in the South region (48.1%; *n* = 128). The least reported region was the West (6.8%; *n* = 18). Continuous variables included age, years of clinical experience, years of experience as a counselor educator, and hours of trauma training. Of the 266 participants, 265

provided their age, with a range of ages from 26 to 74 (*M* = 45.27, *SD* = 10.50). There was a wide range of reported clinical experience from less than one year to 52 years (*M* = 14.10, *SD* = 9.15) and experience as counselor educators with a range of less than one year to 43 years (*M* = 9.07, SD = 7.93). Almost 96% of participants (n = 255) reported participation in trauma education activities. Total prior training hours ranged from zero to 2030 (*M* = 158.56, *SD* = 221.79).

Table 1

*Demographic Information, Frequency, and Percentages*

| Variable | *n* | Percent |
|---|---|---|
| Race | | |
| White | 198 | 74.4 |
| Black or African American | 32 | 12.0 |
| Asian | 13 | 4.9 |
| Native American or Alaska Native | 1 | 0.4 |
| Native Hawaiian or Pacific Islander | - | - |
| Middle Eastern or Arab American | 1 | 0.4 |
| Biracial or Multiracial | 11 | 4.1 |
| Other/Unknown | 10 | 3.8 |
| Ethnicity | | |
| Spanish, Hispanic, Latino | 24 | 9.0 |
| None of These | 242 | 91 |
| Gender | | |
| Male | 53 | 19.9 |
| Female | 203 | 76.3 |
| Transgender | 2 | 0.8 |
| Nonbinary | 2 | 0.8 |
| Other | 6 | 2.3 |

Table 1 (Continued)

*Demographic Information, Frequency, and Percentages*

| Variable | *n* | Percent |
|---|---|---|
| Extent of Trauma Training | | |
| None | 2 | 0.8 |
| Minimal | 28 | 10.5 |
| Moderate | 101 | 38.0 |
| Substantial | 135 | 50.8 |
| Teach | | |
| Trauma | 60 | 22.5 |
| Crisis | 63 | 23.7 |
| Grief | 28 | 10.5 |
| College/University Size by Student Population | | |
| < 5,000 Students | 85 | 32.0 |
| 5,000-15,000 Students | 90 | 33.8 |
| > 15,000 Students | 73 | 27.4 |
| Unknown | 18 | 6.8 |
| Region | | |
| North Atlantic | 47 | 17.7 |
| North Central | 52 | 19.5 |
| South | 128 | 48.1 |
| Rocky Mountain | 21 | 7.9 |
| West | 18 | 6.8 |
| Type of Institution | | |
| Public | 148 | 55.6 |
| Private | 118 | 44.4 |

## Description of Methods of Trauma Education Among Participants

In addition to collecting data to answer the second research question, "To what degree do counselor-educators infuse the required CACREP (2015) trauma standards into their non-trauma

specific courses?", information was collected to explore further how CACREP-accredited programs in the United States are approaching trauma education. Programs may offer courses on trauma, infuse trauma education into core courses, or do both. The data showed that programs offered a course dedicated to trauma more often than they provided a crisis or grief course. 78.6% of participants' programs offer a course dedicated to trauma (*n* = 209), with 47% requiring all counseling students to take that course. Only 14% of participants (*n* = 38) reported that their program offered a trauma specialization. Complete findings are reported in Table 2.

Table 2

*Approaches to Trauma Education, Frequency, and Percentages*

| | *n* | Percent |
|---|---|---|
| Trauma Course | | |
| Offered | 209 | 78.6 |
| Required | 124 | 46.6 |
| Crisis Course | | |
| Offered | 204 | 76.7 |
| Required | 149 | 56 |
| Grief Course | | |
| Offered | 102 | 38.3 |
| Required | 27 | 10.2 |
| Trauma Specialization | 38 | 14.3 |

Data was also gathered to examine if trauma education was infused into the ten core courses required of every counseling student. Results indicated that 67% of participants infused trauma education into internship courses (*n* = 178) and 65% into practicum courses (*n* = 173). A little more than half of respondents infused trauma standards into their counseling techniques courses (*n* = 147) and human development/lifespan courses (*n* = 140). Trauma education was

least frequently infused into research methods courses, with only 13.5% of participants infusing trauma content ($n$ = 36). Results are displayed in Table 3.

Table 3

*Courses Infused, Frequency, and Percentages*

| Core courses | *n* | Percent |
|---|---|---|
| Research Methods | 36 | 13.5 |
| Career Development and Counseling | 54 | 20.3 |
| Assessment and Evaluation | 84 | 31.6 |
| Group Counseling | 102 | 38.3 |
| Counseling Theories | 115 | 43.2 |
| Multicultural Counseling | 124 | 46.6 |
| Human Development/Lifespan | 140 | 52.6 |
| Counseling Techniques | 147 | 55.3 |
| Practicum | 173 | 65.0 |
| Internship | 178 | 66.9 |

## Predictors of Counselor Educators' Infusion of Trauma Education

The dependent variable was a binary, “yes” or “no” response to whether participants infuse trauma education into their non-trauma-specific courses. A vast majority of respondents indicated that they infused trauma education (91%; $n$ = 237). Only 9%, or 24 counselor educators, reported that they do not infuse trauma. The independent variables were scores on the ACE Questionnaire, total scores on the ARTIC-10 Scale, and total hours of prior training. Total hours of prior training were determined by summing the total number of hours in 3-credit graduate-level trauma courses and total workshop hours completed in the last five years. Each 3-credit graduate-level trauma course was considered the equivalent of 100 hours. Total hours of prior training ranged from zero hours to 2030 hours. The means and standard deviations of these variables are shown in Table 4 below.

Table 4

*Predictor Variables for Logistic Regression, Number, Frequency, Mean, Standard Deviation, Range*

| Variable | *n* | *M* | *SD* | Minimum | Maximum |
|---|---|---|---|---|---|
| ACE | 261 | 2.55 | 2.16 | 0 | 10 |
| ARTIC | 261 | 57.34 | 6.44 | 37 | 70 |
| Prior Training | 261 | 161.40 | 223.08 | 0 | 2030 |

## Logistic Regression

Logistic regression was utilized to determine the relationship between ACE scores, ARTIC-10 scores, and prior trauma training relative to the infusion of trauma education in non-trauma-specific courses as indicated by a "yes" or "no" response. See Table 4. The responses were unbalanced, with 91% of participants responding "yes" and only 9% indicating they did not infuse trauma education. Data were screened for missing data and outliers using IBM SPSS Statistics software version 28.0.1.0. Missing data were less than 10%, and pairwise deletion was used.

The model was statistically significant, $X^2$ (3, N= 261) = 16.81, $p < .001$, which lends support to the model. The Hosmer and Lemeshow test was not statistically significant, which may or may not indicate a good model fit. Statistical significance indicates that the model is not a good fit. However, a high p-value cannot be interpreted as a good model fit. It simply shows a lack of evidence against the null hypothesis. The recommended sample size for the Hosmer and Lemeshow is a minimum of 400 (Bewick et al., 2005). Due to the smaller sample size in this study, the p-value of .86 on the Hosmer and Lemeshow test may indicate poor test power or ability to predict the outcome correctly.

Pseudo $R^2$ values for the model ranged from 6.2% (Cox and Snell $R^2$) to 13.6% (Nagelkerke $R^2$). The predictor variables did a poor job predicting the outcome variable. The model accurately predicted the infusion of trauma education into non-trauma-specific courses 100% of the time but completely failed to predict non-infusion.

Due to the logistic model's poor ability to predict whether counselor educators would infuse trauma education based on the predictor variables, low pseudo $R^2$ values, and the lack of participants indicating that they do not infuse trauma education into non-trauma-specific courses (n = 24), the researcher explored the second operationalized definition of trauma infusion, degree of infusion, as the outcome variable. Since 91% of participants infused trauma education, the next logical step was to examine the degree to which the CACREP-required standards were infused.

## Degree of Infusion

Since 91% of participants indicated they infuse trauma education, negatively impacting the ability to use logistic regression, the next logical step was to examine the relationship of ACE scores, ARTIC-10 scores, and prior training relative to the degree of infusion. The second research question was: To what degree do counselor educators infuse the CACREP-required trauma standards into their non-trauma-specific courses? Participants were asked which of the 12 standards they infused into non-trauma-specific courses. The total number of trauma standards determined the degree of trauma infusion participants stated they infused and was collected on the Trauma Education Questionnaire. The degree of infusion directly relates to whether counselor educators are infusing trauma education into their core courses. This allowed the researcher to explore the relationships between the same independent variables and the infusion of trauma education in another relevant way.

The average number of trauma standards infused was 7.5, with a range of zero standards infused to all 12 standards infused (*SD* = 3.60). The standards most often infused were trauma-informed strategies (78.2%; *n* = 208), effects of trauma on diverse individuals (76.3%; *n* = 203), and procedures for reporting abuse (75.6%; *n* = 201). The standards least often infused were community-based strategies such as Psychological First Aid (37.2%; *n* = 99), effects of disasters on diverse individuals across the lifespan (41.7%; *n* = 111), and procedures for assessing risk of aggression or danger to others (47.4%; n = 126). Full results are shown below in Table 5. Multiple regression was employed to examine the degree of infusion.

Table 5

*Standards Infused, Frequency, and Percentages*

| Standard | *n* | Percent |
|---|---|---|
| 1. Counselor's roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams | 158 | 59.4 |
| 2. Effects of crisis on diverse individuals across the lifespan | 185 | 69.5 |
| 3. Effects of disasters on diverse individuals across the lifespan | 111 | 41.7 |
| 4. Effects of trauma on diverse individuals across the lifespan | 203 | 76.3 |
| 5. Suicide prevention models and strategies | 183 | 68.8 |
| 6. Crisis intervention strategies | 154 | 57.9 |
| 7. Trauma-informed strategies | 208 | 78.2 |
| 8. Community-based strategies, such as Psychological First Aid | 99 | 37.2 |
| 9. Procedures for assessing risk of aggression or danger to others | 126 | 47.4 |

Table 5 (Continued)

*Standards Infused, Frequency, and Percentages*

| Standard | *n* | Percent |
|---|---|---|
| 10. Procedures for assessing risk of self-inflicted harm, or suicide | 11. 184 | 12. 69.2 |
| 13. Procedures for identifying trauma | 14. 182 | 15. 68.4 |
| 16. Procedures for reporting abuse | 17. 201 | 18. 75.6 |

## Multiple Regression

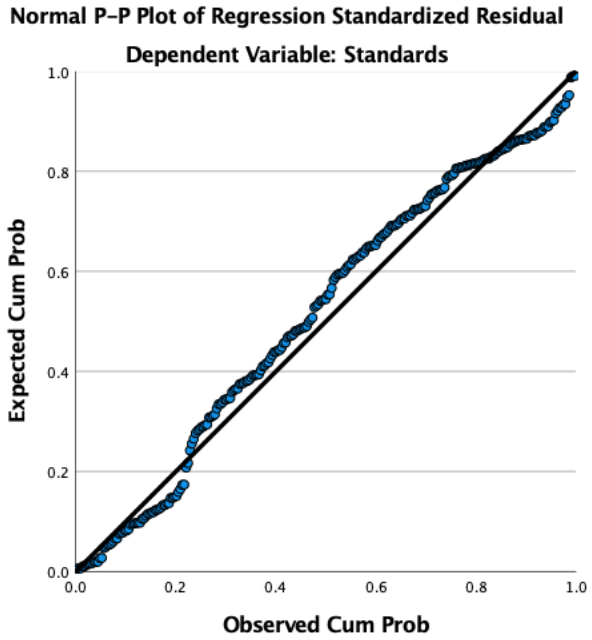
This study used linear regression to determine the relationships of the same predictor variables used above: prior trauma history, prior trauma training, and attitudes related to trauma-informed care (Table 4), with the degree of trauma infusion as measured by the total number of standards infused into non-trauma-specific courses (Table 5). The average number of trauma standards infused was 7.5, with a range of zero standards infused to all 12 standards infused (*SD* = 3.60). Each independent variable was also explored to determine its unique significance in the model. A significant coefficient would increase or decrease the degree of trauma infusion by a specific amount for each one-unit change in the coefficient. An analysis of variance was used to test the model's fit (Baguley, 2012). Data were screened for missing data before running the analysis. Missing data were less than 10%, and pairwise deletion was used. IBM SPSS Statistics software version 28.0.1.0 was used for the analysis.

After the analysis, the normal probability plot of the regression standardized residuals and the scatterplot of the regression standardized residuals were examined for violations of normality, linearity, and homoscedasticity. The normal probability plot of the regression standardized residuals shows the plot of the cumulative frequency of the observed standardized residuals against the plot of the standardized residuals expected from a normal distribution. The

figure shows the expected relationship extending from the bottom left to upper right hand corner. Further inspection shows only minor departures from expected values, suggesting minimal violations of the normality assumption. See Figure 1 below.

Figure 1

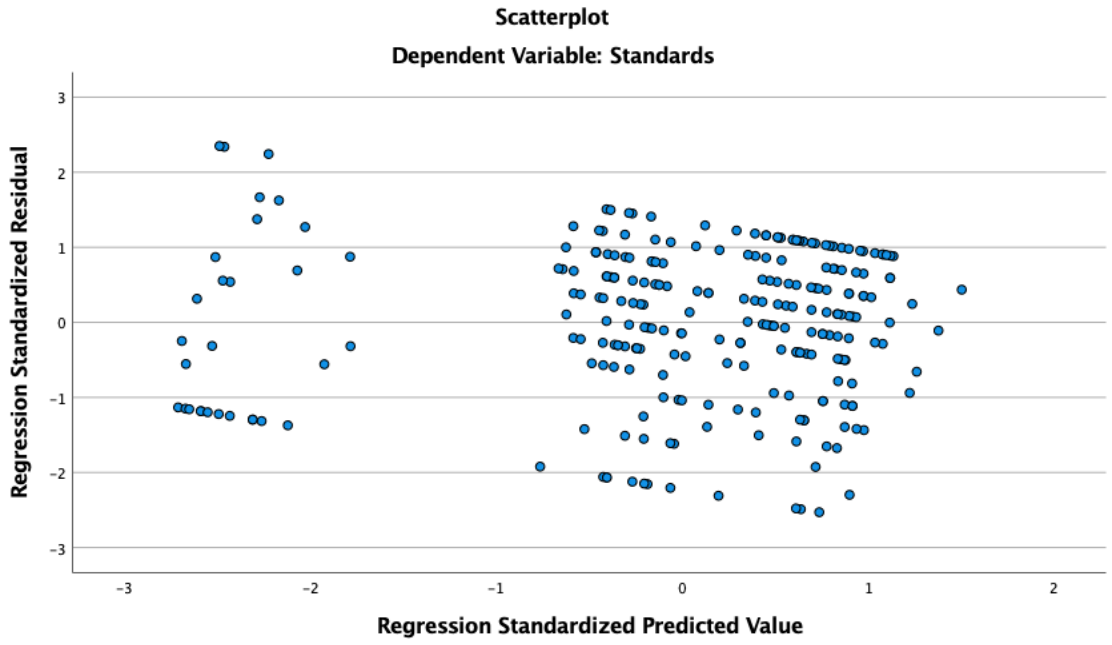
*Normal P-P Plot of Regression Standardized Residuals*




Regression tends to be robust to violations of the normality assumption in large samples where the number of observations is more than 10 per independent variable, so this was not determined to be a major issue (Schmidt & Finan, 2018). No violations of multicollinearity were noted, with variance inflation factors ranging from 1.02 to 2.74, and tolerances ranging from .37 to .98. Further examination of the regression standardized residual scatterplot showed slight deviations from the expected random points around a centralized rectangle. Instead, a pattern of higher points on the left side and lower points on the right side suggested a possible violation of the linearity and homoscedasticity assumptions. See Figure 2 below.

Figure 2

*Scatterplot of Regression Standardized Residuals*




However, nearly all residuals fell within -2 to +2 range and none exceeded -3 or +3. Furthermore, the pattern of points at the top and bottom and the rows of dots reflect that the outcome variable, degree of infusion, is a count variable. A Poisson regression was conducted and produced similar results, suggesting any violations do not cause problems with the analysis. Multiple regression is presented here for ease of interpretation.

The variance ($R^2$) accounted for by the model was 4.9% (adjusted $R^2 = .038$), which was significantly different than zero ( $F$ = 4.39, $p$ = .005). In other words, the predictor variables, taken together, had a significant predictive relationship with the degree of infusion of trauma education in non-trauma-specific courses but predicted very little of its variance. The linear regression was computed again, removing the four multivariate outliers identified by Mahalanobis distances exceeding the critical value of 16.27 for three independent variables. This did not improve the variance explained by the predictor variables.

Problems with trauma training defined as actual hours of trauma training over the past five years were noted. There was a wide range reported and the standard deviation was large. Some comments written by participants indicating difficulty remembering and confusion as to whether to include hours of teaching trauma caused the researcher to doubt the accuracy of the reported hours. Due to poor predictive ability, low variance explained, and the issues with prior training defined as actual hours, the researcher decided to switch to prior training operationalized as the perceived extent of prior trauma training(Table 6). On the Demographic Questionnaire, participants rated their perceived extent of prior trauma training on a 4-point Likert scale ranging from "no training" to "substantial training." The zero and minimal training categories were consolidated because only two participants stated they had received no trauma training. This resulted in three total categories. The zero or minimal training category indicated that the participant reported taking one workshop, seminar, or in-service training. The moderate category was defined as completing a couple of workshops, and the substantial training category meant multiple workshops, earning a certificate, or other extensive formal training.

Table 6

*Perceived Extent of Trauma Training, Frequency and Percentages*

| Variable | n | Percent |
|---|---|---|
| Extent of Trauma Training | | |
| 0. None/Minimal | 30 | 11.5 |
| 1. Moderate | 99 | 37.9 |
| 2. Substantial | 132 | 50.6 |
| Total | 261 | 100 |

A standard linear regression model was employed to examine the relationship between personal trauma history, attitudes related to trauma-informed care, and the perceived extent of

prior trauma training with the degree of infusion. The regression was computed, entering two dummy variables for the perceived extent of trauma training. The variance accounted for ($R^2$) by the model was 14.1% (adjusted $R^2 = .128$), which was significantly different than zero ( $F$ = 10.51, $p$ <.001). In other words, the predictor variables, taken together, had a significant predictive relationship with the degree of infusion of trauma education in non-trauma-specific courses. The overall variance explained was still fairly low but much improved from the previous model.

Moderate and substantial training were significant unique predictors of the degree of infusion ($p$ <.001), as reported in Table 7 below. Extent of training rated as substantial had the strongest relationship with the outcome (standardized $\beta = .57$). An increase from zero or minimal prior training to substantial prior training was associated with an increase of about 4 degrees of infusion while controlling for all other independent variables. An increase from zero or minimal prior training to moderate prior trauma training was related to an increase of 3 degrees of infusion while controlling for the other variables. ACE and ARTIC-10 scores were not significantly related to the degree of infusion of trauma education into non-trauma-specific courses after controlling for perceived extent of training.

Table 7

*Multiple Regression Analysis Measuring Relationship Between Predictor Variables and Outcome Variable*

| | *Unstd* | | *Std* | | | *95% CI* | |
|---|---|---|---|---|---|---|---|
| | *B* | *SE* | *B* | *t* | *p* | *Lower* | *Upper* |
| ACE | .14 | . 10 | .08 | 1.40 | .164 | -.06 | .33 |
| ARTIC | .03 | .03 | .05 | .83 | .414 | -.04 | .09 |
| TText2[a] | 2.87 | .71 | .39 | 4.05 | <.001 | 1.46 | 4.27 |

Table 7 (Continued)

*Multiple Regression Analysis Measuring Relationship Between Predictor Variables and Outcome Variable*

| | *Unstd* | | *Std* | | | *95% CI* | |
|---|---|---|---|---|---|---|---|
| | *B* | *SE* | *B* | *t* | *p* | *Lower* | *Upper* |
| TText3[b] | 4.06 | .69 | .57 | 5.85 | <.001 | 2.69 | 5.42 |
| Constant | 2.45 | 1.9 | | 1.30 | .195 | -1.28 | 6.22 |

*Note.* [a]TText2 = Extent of Training - Moderate, [b]TText3 = Extent of Training - Substantial

## Summary

The first goal of this study was to explore the relationship between adverse childhood relationships, attitudes related to trauma-informed care, and prior trauma training in relation to the infusion of trauma education in non-trauma-specific courses. The second goal was to examine the degree to which the trauma standards required by CACREP for every counseling student are being infused. Data was collected from 266 participants. Most respondents were White (74.4%) and females (76.3%). Over 90% of participants reported infusing trauma education. This imbalance in the data negatively impacted the logistic regression. The logistic regression model could accurately predict trauma infusion 100% of the time but could not correctly predict non-infusion. The model explained little variance in the outcome.

This chapter also described the degree to which the 12 trauma standards that CACREP requires every counseling student to meet are infused. Data collected found that the average number of trauma standards infused by counselor educators was seven and a half. A revised model using the degree of infusion as the measure of trauma infusion only explained 4.9% of variance in the degree of infusion. The model was revised a third time to use the second operationalized definition of prior training, the perceived extent of prior training. This model

explained 14.1% of the variance in the degree of infusion when a standard regression analysis was computed. Moderate and substantial training were both significant predictors of the degree of infusion.

# CHAPTER 5: DISCUSSION

The purpose of this study was to explore how trauma history, attitudes related to trauma-informed care, and prior trauma training were related to the infusion of trauma education into non-trauma-specific courses by counselor educators working full-time for CACREP-accredited programs in the United States. Furthermore, the degree to which the trauma standards required by CACREP (2015) for every counseling student were infused was also investigated. This chapter provides an overview of the study and discusses the findings and conclusions drawn. That is followed by the study's contributions, implications, limitations, recommendations for future research, and concluding remarks.

## Overview

The Centers for Disease Control and Prevention found that about 61% of adults were exposed to at least one adverse childhood event (ACE), and 16% reported four or more ACEs (Merrick et al., 2019). Approximately 90% of participants in a study to estimate national exposures to traumatic events and PTSD prevalence reported at least one DSM-V Criterion A (traumatic) event, and 30% reported six or more (Kilpatrick et al., 2013). The actual incidence is thought to be higher than reported as exposure tends to be underreported (MacDonald et al., 2016) and may not include racial trauma, the impact of the recent COVID-19 pandemic, or chronic illness. Trauma has become pervasive and is believed to be cumulative (Baglivio et al., 2014; Felitti et al., 1998; Kelly-Irving et al., 2013). Chronic trauma has been associated with negative physical, emotional, cognitive, and social consequences. Physical effects may include obesity, heart and liver disease, cancer, changes in brain circuitry, and premature death (Felitti et al., 1998; Jedd et al., 2015). Trauma has also been associated with substance abuse, poor

emotional regulation, suicidal ideation, and difficulty with relationships (Anda et al., 2006; Giordano et al., 2016; Lawson, 2013).

Due to the pervasiveness of trauma and its negative impact on physical, cognitive, social, and emotional well-being, one can assume all counselors will work with those affected by it (Racine et al., 2019). Counselors must be taught CACREP's (2015) trauma standards to provide ethical care. They must be aware and knowledgeable to competently assess for trauma and effectively implement trauma-informed interventions (Paige et al., 2017; SAMSHA, 2014). Little is known about how the trauma standards required of every counseling student are taught, whether they are infused into core courses or covered in a specific trauma course. There is little existing research on factors that may impact faculty members' desire or ability to teach about trauma, such as their personal trauma history, their attitudes toward trauma-informed care, or their training in trauma. This research seeks to fill a gap in the existing literature by exploring the relationship of those factors to infusing trauma education into core courses and investigating the degree to which the standards are infused.

The results of this study of 266 full-time faculty members in CACREP-accredited programs in the United States will help counselor-educators gain insight into factors that may impact their willingness and ability to infuse trauma standards into their courses. They may better understand their need for training in trauma-informed care. Results may inform programs of the need for curriculum development and program evaluation, as well as professional development and support of educators to aid them in developing trauma competence in their graduates.

# Discussion and Conclusions

This section will first highlight demographic findings and trauma education statistics. Next, it will present the study's results and conclusions related to the existing literature.

## Demographic Data

There was a lack of diversity in the respondents to this survey compared to the 2022 statistics on full-time faculty members reported by CACREP (2023). In this study, about 74% of the 266 participants were White, 12% were Black, and 5% were Asian. Roughly 76% identified as female, 20% as male. This is less diverse than what was reported in the 2022 statistics published by CACREP, which showed that 62% of full-time faculty members were White, 17% were Black, and 6% were Asian. Additionally, gender identity was reported as 56% female and 32% male. The current study had a higher percentage of respondents who were more than one race (4%), or Spanish, Hispanic, or Latino (9%), or who identified as transgender, nonbinary, or other (4%) as compared to the s 3% multiracial, 6% Hispanic or Latino, and 2% as something other than cisgender reported by CACREP (2023) for full-time faculty members. Perhaps there was a higher representation of females in this study because the historical oppression and marginalization of females may have given them more interest in the topic of trauma education. The higher percentage of those identifying as transgender, nonbinary, or other in the current research is reflective of current population trends. It may also indicate that this group may have a heightened interest in being represented in the current study due to poor representation in the past (Swank et al., 2021; Watkinson et al., 2018).

Despite the relative lack of racial diversity in the sample population, the counselor educators represented geographically diverse programs as well as ones of diverse types and sizes. Fifty-six percent of respondents work for public institutions and 44% for private ones. Roughly

32% of the participants worked at small institutions with less than 5,000 students, 34% at institutions with 5,000 to 15,000 students, and 27% at places with more than 15,000 students. The regions of the United States represented were also diverse, with about 48% in the South region, 20% in the North Central region, 18% in the North Atlantic area, 7% in the Rocky Mountain region, and 8% in the West. This roughly corresponds with the breakdown of programs according to regions designated by the Association for Counselor Education and Supervision (ACES). The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2023) reported that 41% of programs are located in the South, 25% in the North Central region, 20% in the North Atlantic, 8% in the West region, and 5% in the Rocky Mountain region. This means that the current sample of counselor educators is representative of the general disbursement of CACREP programs throughout the United States. However, there is no way of knowing how many individual programs are represented by the data. This research adds to the existing literature, as previous research was either conducted outside of the United States or did not collect data on the types, sizes, and locations of the institutions represented by the sample populations (Mikkonen et al., 2022; Montague et al., 2020).

Regarding personal trauma history, participants had a mean ACE score of 2.55, and scores ranged from zero to ten (*SD* = 2.16). The data showed that 79% of participants in the current study experienced at least one adverse childhood experience (ACE). This is much higher than the 52% reported in the original ACEs study and the estimated 61% found in more current research (Felitti et al., 1998; Merrick et al., 2019). Approximately 62% of the current participants reported having experienced two or more ACEs compared to the 25% prevalence found by Felitti et al. (1998). The high incidence of ACEs in the current research sample is clear, as evidenced by 33% reporting four or more ACEs. This is more than double the 16% prevalence

reported by the Centers for Disease Control and Prevention (Merrick et al., 2019). This result supports existing research that has shown a higher incidence of ACEs among those in helping careers than in the general population (Esaki & Larkin, 2013; Lee et al., 2017; Thomas, 2016). It also supports research linking ACEs with choices of careers within helping professions (Bryce et al., 2021; Steen, Straussner, & Senreich, 2021). Results of the current study suggest that some counselor educators may be drawn to their careers because of their histories of trauma. Although a history of personal trauma was not found to be a significant factor in the current study's analysis exploring its impact on the infusion of trauma education, the high incidence of trauma among counselor educators highlights the need for them to be aware of and mitigate the risk of secondary trauma in themselves and their students (Berliner & Kolko, 2016; Possick et al., 2015).

The current research examined participants' attitudes related to trauma-informed care as measured by the ARTIC-10 for education. Scores were high, with a mean score of 57.34, and ranged from 37 to 70 ($SD$ = 6.44). There is no existing research on counselor educators' attitudes related to TIC nor their impact on teaching their students trauma-informed awareness, knowledge, and skills. One interpretation of the data is simply that counselor educators have positive attitudes toward TIC due to their training in trauma. This conclusion is supported by the existing literature, which demonstrates that training is related to an increase in ARTIC scores (Avery et al., 2022; Bertram et al., 2022; Kim et al., 2021). Another interpretation is that counselor educators are educated enough in trauma to know what responses on the survey are socially desirable. Although ARTIC-10 scores were not significant in this study's analysis of factors impacting the infusion of trauma education, it is essential to note that participants in this study appeared to be trauma-informed. This is most likely due to increased emphasis on trauma

education in CACREP-accredited counselor education programs (CACREP, 2015; Moh & Sperandio, 2022; VanAusdale & Swank, 2020).

Regarding prior training, a promising finding was that about 96% of participants reported participation in trauma education activities. The final analyses included 261 participants with reported trauma training hours ranging from zero to 2030, with an average of about 161 hours. Due to the extensive range and large standard deviation (223.01), it was difficult to determine how well-trained the participants were. Respondents were also asked to report their perceived extent of trauma training. Only 11% of participants reported having no to minimal training (one workshop). Approximately 38% stated they had completed two workshops, and 51% reported substantial training, meaning they had completed multiple workshops, had extensive formal training, or had earned a certificate in trauma. Numerous authors on the topic of trauma education have pointed out the need for educators to be knowledgeable and competent with the curriculum and subject matter, but no studies have explored the amount of trauma training counselor educators have received (Cook et al., 2019; Mikkonen et al., 2022; Paul & Varghese, 2021; Swank et al., 2021). Results of the current study suggest that most counselor educators are equipped to provide a learning environment conducive to the development of trauma-competent professionals.

### Trauma Education

This study brought to light advances made in trauma education in CACREP-accredited programs in the United States. Due to the pervasiveness of trauma in the world today and its negative short-term and long-term consequences, counseling students must be prepared to provide TIC. Previous studies in psychology, social work, and counseling indicated that service providers felt unready to work with clients who have histories of trauma (Morris & Minton,

2012; Lu et al., 2017). The existing literature has highlighted that specific content, where and how the trauma standards required by CACREP (2015) are taught, has been left up to the individual programs (Chatters & Liu, 2020; Moh & Sperandio, 2022).

Regarding the infusion of trauma education into core, non-trauma-specific courses, 91% of the current study's participants profess to do so. Infusion has been advocated for by many authors (Chatters & Liu, 2020; Greene et al., 2016; VanAusdale & Swank, 2020). Approximately 79% of participants from the current study indicated that their programs offered a trauma course; of them, about 47% stated that the class was required. Similarly, 77% of the counselor educators offered a crisis course, with about 56% of them indicating it was a required course. Just under 38% of respondents reported that their program offered a course on grief, with roughly 10% stating that it was required. Montague et al. (2020) found that approximately 31% of the 392 programs investigated offered a single course on trauma, crisis, grief, or some combination of these and did not ascertain whether these were required or elective. The number of CACREP-accredited programs represented in the current study is unknown. While these two studies collected data on different sample populations, counselor educators vs. programs, the current research suggests that gains have been made in trauma education.

For the counselor educators (91%) who reported infusing trauma education into non-trauma-specific courses, data was gathered on which classes they chose to infuse trauma education. The courses reported by the highest percentage of faculty members to infuse trauma education were internship (67%), practicum (65%), and counseling techniques (55%). The least popular courses to infuse trauma education were assessment and evaluation (32%), career development and counseling (20%), and research methods (14%). As trauma directly impacts human development and is more prevalent among specific marginalized populations, it is

surprising that the percentage of participants infusing trauma education into human development/lifespan (53%) and multicultural counseling (47%) courses was not closer to 100%. These results partially support the recommendations of Van Ausdale and Swank (2020), who proposed Lifespan, assessment, practicum and internship supervision, theories, and family counseling as the five core courses most appropriate for infusing trauma content. Results also supported Greene et al. (2016), who suggested practicum as an effective place to infuse trauma education.

Previous researchers have made the case for training in trauma-informed practices and principles (Mikkonen et al., 2022; Rinfrette et al., 2021). Research has found that trauma training increases knowledge, self-efficacy, and the use of trauma-informed skills (Asnaani et al., 2020; McIntyre et al., 2019; Palfrey et al., 2019). This research is supported by the current study, which demonstrates that training is associated with action. This study adds to the knowledge about trauma education in CACREP-accredited programs by examining trauma training in a new population, counselor educators. The participants of this study reported being well-trained in TIC, and training in trauma-informed care was associated with how thoroughly counselor educators cover the CACREP-required trauma standards in the core courses. The vast majority of participants in this study indicated that they had completed moderate to substantial training in trauma and were infusing trauma content into their non-trauma-specific core courses. This finding supports a previous study that found knowledge of the subject matter necessary for self-efficacy and willingness to teach crisis content (Asselt et al., 2016). It is also critical to mentoring counseling students competently as they develop into ethical, competent practitioners while mitigating the potential for secondary trauma (Lu et al., 2017; Mikkonen et al., 2022). The current research demonstrates an increased focus on and gains in trauma education at CACREP-

accredited counseling programs. It serves to begin filling the gap in the literature examining counselor educators and how trauma content is taught to counseling students.

## Contributions and Implications

Research on counselor educators at CACREP-accredited programs and trauma education is extremely limited. This study makes several contributions to the existing literature on counselor educators and trauma education in CACREP-accredited programs in the United States. It adds to the scant data on what trauma-specific courses are offered by programs and whether they are required of all students. It may be the first data on how and to what degree counselor educators deliver the trauma standards CACREP requires of all counseling students and into which core non-trauma-specific courses counselor educators most often infuse trauma content. It adds to the existing database about counselor educators: the incidence of ACEs, their attitudes toward trauma-informed care, and the extent of trauma training they have had. Finally, this study may be the first to investigate the impact of personal trauma history, attitudes related to trauma-informed care, and prior training in trauma on the infusion of trauma education into core, non-trauma-specific courses.

An interesting finding was that although almost every counselor educator (91%) indicated they infuse the trauma standards into their core courses, the standards were not infused equally. Certain parts of the same specific standard were not infused equally. It may be that counselor educators are more comfortable with some standards than others, find some standards or components of standards more important than others, or have difficulty infusing some trauma content. Results also suggest that the standards are being infused in unexpected ways. For example, it makes sense that identifying trauma would happen through an assessment. However, while procedures for identifying trauma were infused by a high percentage of participants (68%),

the assessment and evaluation course was not a course into which trauma was infused by most educators (32%). If they cover only some parts of a standard, where are the rest being covered? The implication for counselor educators is to be aware of gaps in instruction and make sure they are eliminated. These results can inform those who manage counseling programs to develop systematic approaches to trauma education to ensure that every standard is covered thoroughly. They must clearly outline the role of educators in helping students build trauma competency and foster clear communication and collaboration among faculty members.

This study's results showed a high prevalence of adverse childhood experiences among its participants, with 79% of participants indicating they had experienced at least one adverse childhood experience (ACE), 62% reporting two or more, and 33% four or more ACEs. The results have critical implications for counselor educators and counselor education programs. . First and foremost, results demonstrated that ACE scores were not a significant predictor of degree of infusion of the trauma standards into core non-trauma-specific courses. This implies that even though the prevalence of ACEs in the sample population was high, it did not affect counselor educators' willingness or ability to infuse trauma education. Counselor educators are doing what they should be doing despite personal factors. This is a positive finding.

Counselor educators must be aware that having a personal history of trauma may make them more susceptible to secondary trauma. Self-awareness can lead to a recognition of their potential triggers and the need to not only teach wellness to their students but also to practice self-care themselves. Counselor educators were once former counseling students. So, the results of this study may indicate a higher prevalence of trauma among their students as well. This highlights the importance of a trauma-informed approach to counselor education to empower students and train them to be trauma-competent professionals without inadvertently triggering

them and retraumatizing them. This study demonstrates how important it is for counselor educators to have processed their own trauma to protect themselves and better serve their students.

The high incidence of ACEs in faculty members has implications for those who develop and manage counselor education programs. Appropriate steps must be taken to prevent and mitigate secondary trauma. The needs of educators may be addressed in training and development activities. Programs must take steps to ensure counselor educators can maintain a healthy work/life balance. Self-care activities can be encouraged and made readily and easily accessible and available. Wellness should be broached at every faculty meeting, and an environment of safety and support should be established. Mental health resources should be made available and accessible to all.

Given the high incidence of trauma in counselor educators and, presumably, counseling students, there are also implications for CACREP. Secondary trauma needs to be addressed in the standards. The Substance Abuse and Mental Health Services Administration (2014, July) has made it clear that organizations and providers need to have effective and pervasive ways of addressing trauma. Trauma-informed awareness, knowledge, and skills are not only beneficial in decreasing trauma symptoms and preventing re-traumatization in clients but may also be beneficial in establishing a safe and empowering environment for counseling students and counselor educators. Awareness, knowledge, and skills to prevent and mitigate secondary trauma are essential components of trauma education and can no longer be ignored.

The current research found that most of the surveyed counselor educators had positive attitudes related to trauma-informed care, with a mean score of 57.3 on the ARTIC-10 for educators. This suggests that counselor educators are well-versed in TIC principles and practices

and at least know what responses correspond to a trauma-informed conceptualization of students. This is in keeping with the perceived extent of training received by the participants. Results demonstrated that the participants are well-trained in trauma. Almost 89% of the counselor educators reported that they had had moderate to substantial training in trauma. It is important to note that a little more than a tenth of the participants stated that they had minimal to no training in trauma. This is unacceptable, as the current research found a significant association ($p < .001$) between perceived moderate and substantial extent of prior training in trauma and the degree of infusion of the trauma standards into students' core courses, with training rated as substantial having the strongest relationship with the outcome (standardized $\beta = .57$). In other words, educators who were better versed in trauma were more likely to infuse more trauma content into the core non-trauma-specific courses they teach. This has implications for those in CACREP-accredited programs charged with overseeing professional development. It falls on them to ensure their faculty members have the training they need to be well-prepared to aid in the development of trauma-competent professionals. They must provide and fund professional development opportunities in this area to guarantee that every faculty member has had the training they need to do their jobs competently and thoroughly.

Overall, this research has multiple implications for counselor educators, those involved with professional development, curriculum development, program evaluation, and CACREP. Results suggest that advancements have been made in trauma education in CACREP-accredited counselor education programs. Additional research is needed to develop a more comprehensive and complete picture of gains made, improvements needed, and the effect on counseling students.

## Limitations of the Study

This study's results indicate the need for future research, but the limitations must be examined first. This study has several limitations, including the generalizability of the results, social desirability, low response rate, and differences between colleges or programs. These limitations must be understood before forming any conclusions about the results and the implications.

Participants in the study included a convenience sample of counselor educators at CACREP-accredited programs in the United States. This limits the ability to generalize the results to other counselor educators working in CACREP-accredited and non-CACREP-accredited programs. It also impacts the ability to generalize the results to counselor educators working for counseling programs outside the United States. A very high percentage of participants reported that they infuse trauma education into non-trauma-specific courses. A similarly high percentage of respondents perceived that they had received moderate to substantial training in trauma. The possibility that those with a higher interest in trauma or more training had more interest in participating must be considered. If true, the research may only reflect counselor educators with this interest. These are other factors potentially impacting generalizability.

Social desirability is a limitation of this study because all data was obtained through self-report methods. Counselor educators are considered experts in the field of counseling, and given the recent emphasis on trauma, they may have answered in ways that reflect favorably upon them (Callegaro, 2008). The survey was anonymous to try to reduce this possibility. It must also be acknowledged that the answers given may only partially translate into actual teaching practices.

The low response rate is an additional limitation. The researcher searched the CACREP website and pulled up all currently accredited counselor education programs. Each program

website was then visited, and the email addresses of full-time faculty were gathered. It must be noted that only some programs had faculty email addresses available, and some programs blocked recruitment attempts as perceived as junk mail. While more than 2450 individual emails were sent out and an additional three waves of recruitment emails through the CESNET listserv, the response rate was about 11%. It cannot be assumed that the 11% are representative of all counselor educators.

Finally, the counselor educators in this study both worked for and studied under programs housed in various colleges or departments. Some of the programs were under the direction of colleges of education. Others were found in colleges of psychology or even health services. Although the CACREP (2015) standards are the same for all, different colleges or departments may have differed in the degree of attention given to trauma education. Thus, the participants in this study may have been trained in various ways depending on their educational backgrounds. This may have affected how important they think trauma education is or how comfortable they are with the content. Their approach to trauma education may also vary depending on the college or department in which they teach. Despite the limitations of this study, the results add to the existing knowledge base and provide a starting point for future research.

## Recommendations for Future Research

This study was the first to explore the impact of personal factors on counselor educators' infusion of trauma education into core non-trauma-specific courses. The results have highlighted the critical need for more research into trauma education in CACREP-accredited counseling programs. It has also demonstrated the need to examine personal factors impacting counselor educators, such as how they teach and how they are affected by what they teach.

The current research demonstrated that of personal trauma history, trauma training, and attitudes related to trauma-informed care, only the perceived extent of prior training in trauma was associated with the degree of infusion of the trauma standards into core non-trauma-specific courses. It would provide valuable insight if the study were repeated using a reliable instrument to determine the actual hours of training received instead of the perceived extent of trauma training. Additional research is needed to find out what factors do impact infusion. Research can be conducted to look at the potential impact of other personal factors, such as age, years of clinical experience, or experience teaching, on the degree of infusion of trauma content into core non-trauma-specific courses. Regarding training in trauma, the importance of perceived competence in subject matter and curriculum related to self-efficacy, willingness to teach, and competence in mentoring students has been established (Asselt et al., 2016; Mikkonen et al., 2022; Swank et al., 2021). However, participants in the current research reported actual trauma training hours ranging from zero to 2030 ($M$ = 158.56, $SD$ = 221.79). The extensive range and issues with the instrument used make it difficult to determine how much training participants had. More research is necessary to identify if programs have a required number of training hours in trauma for faculty members, and if so, how many hours are required, how they monitor this, and how they provide training and professional development as the CACREP standards evolve.

This research demonstrated that a majority of the counselor educators who responded to the survey had a high prevalence of ACEs as compared to the general population, with 33% reporting four or more ACEs compared to the 16% prevalence reported by the Centers for Disease Control and Prevention (Merrick et al., 2019). The researcher used the original ACEs Questionnaire for ease of comparison (Felitti et al., 1998). However, there are newer versions of the instrument that include other important and prevalent categories of trauma like racial trauma,

chronic illness, community violence, bullying, and others. This indicates that the actual incidence of personal trauma among counselor educators is most likely higher than this study indicates. Studies should be done to explore the incidence among counselor educators utilizing the newer versions of the ACEs Questionnaire. Studies researching those who have chosen careers in the helping professions, such as psychologists, social workers, counselors, and nurses, have suggested that having a history of ACEs may impact career choice (Bryce et al., 2021; Steen, Straussner, & Senreich, 2021). Future research is recommended to see if ACEs are associated with career choice among counselor educators.

The high incidence of personal trauma among counselor educators also demonstrates the critical need to investigate the relationship between personal trauma histories and the incidence of burnout, compassion fatigue, workplace stress, secondary trauma, and perhaps turnover in this population. A history of trauma has been strongly associated with all of those among social workers, psychologists, and counselors, along with symptoms of secondary traumatic stress and workplace stress (Diehm et al., 2019; Ivicic & Motta, 2017). It is unknown if this association is found among counselor educators. Along with this, studies are needed to gather information on how programs are protecting their educators and students from the effects of either teaching trauma content or, in the latter case, of learning about trauma and hearing the intimate details of trauma from their clients during their practicum and internship experiences. Surveys on how programs promote wellness among their faculty and students would be helpful to gain insight into strategies used. Research investigating the effectiveness of strategies employed with students or counselor educators to reduce symptoms of secondary trauma is needed.

Since previous studies have shown that a history of trauma may impact behaviors, future studies must be done to examine the relationship between counselor educators' trauma histories and

their teaching, supervisory, and mentorship styles (Page & Morrison, 2018; Yoshihama & Mills, 2003). It may be helpful to explore the relationship of faculty members' trauma histories with positive or negative teaching evaluations given by their students. Additionally, qualitative research may be used to gather rich data and provide insight into faculty members' lived experiences as they teach trauma-informed care within these roles.

Study results indicate that the trauma standards CACREP (2015) required for every counseling student are not equally infused. Results also suggested that some components of individual standards are more emphasized than others. Counselor educators reported infusing an average of 7.5 of the trauma standards, with a range of zero standards infused to all 12 standards (*SD* = 3.60). Trauma-informed strategies (78%) and effects of trauma on diverse individuals across the lifespan (76%) were the standards counselor educators most often infused. The standards infused by the lowest percentage of respondents were community-based strategies, such as Psychological First Aid (37%) and the effects of disasters on diverse individuals across the lifespan (42%). This warrants further investigation. Future research could explore the impact of ACEs, prior training, and other personal factors on the infusion of individual trauma standards. It is also important to note that this study did not investigate how the standards are taught nor how thoroughly and deeply the content associated with each one is covered. It is unknown if the content is taught solely via assigned readings or if faculty members are discussing them and fostering classroom discussions. It is unclear how much time is spent on each standard. Future research could investigate this and provide a clearer picture of trauma education in CACREP-accredited programs.

This study also looked into which core courses the standards were being infused. The results were somewhat surprising. Assessment and evaluation was one of the least popular

courses to infuse trauma education (32%). This is concerning because assessing for trauma is a required standard, and teaching it in the assessment and evaluation course seems logical. It may be that the survey participants did not include many faculty members who teach an assessment and evaluation course. The percentages of participants reporting trauma infusion in lifespan and development courses (53%) and multicultural counseling (47%) were also lower than the researcher expected. Research is needed to find out where the standards are being infused. Given that just under 79% of participants indicated their programs offered a trauma course, but less than 47% stated it was a required course, where are the standards taught? Further research is critical.

Finally, and maybe most importantly, how effective is trauma education in CACREP-accredited counseling programs? There is no research on how well-prepared counseling students are to meet the needs of traumatized clients. It is critical that research be conducted to assess the competence and effectiveness of new counselors in assessing and effectively treating those with histories of trauma. Perceived self-efficacy, knowledge, and attitudes affect the willingness and ability of counselors to employ trauma-informed principles and practices (Black et al., 2022; Galvin et al., 2020; Niimura et al., 2019). Studies are needed to investigate how well the training new counselors receive in graduate school translates to self-efficacy, attitudes, skills, and practices in the field.

The pervasiveness and far-reaching adverse short- and long-term consequences of trauma have been well-established (Felitti et al., 1998; Finkelhor et al., 2015; Merrick et al., 2019). CACREP (2015) recognized the need for trauma education and added trauma to its standards. However, this study has clarified the need for an in-depth investigation into trauma education in CACREP-accredited programs. From the factors potentially impacting how

educators teach about trauma to the effectiveness of strategies employed to prevent and mitigate secondary trauma to how well-prepared recent graduates are to provide ethical and competent service to their clients, the opportunity to investigate and add to the knowledge base is broad and deep.

## Concluding Remarks

There is virtually no research exploring counselor educators and trauma education in CACREP-accredited programs in the United States. This study sought to fill the gap in the research by exploring how trauma history, attitudes related to trauma-informed care, and prior trauma training were related to the infusion of trauma education into non-trauma-specific courses by counselor educators working full-time for CACREP-accredited programs in the United States. Furthermore, the degree to which the trauma standards required by CACREP (2015) for counseling students were infused was also investigated. The findings indicate that the perceived extent of trauma training was a significant predictor of the degree of trauma infusion.

The results of this study provide some needed insight into counselor educators and trauma education in CACREP-accredited programs in the United States. Trauma training was positively associated with how many trauma standards counselor educators infused into their core non-trauma-specific courses. Counselor educators must be responsible for seeing that their training needs are met. This also underscores the need for systematic training within programs to ensure all faculty members are equipped to assist their students in their development into ethical, trauma-competent professionals.

Although not a significant predictor of the degree of trauma infusion, a high percentage of counselor educators in this study reported they had experienced childhood trauma. This is an essential consideration as counselor educators evaluate their efforts within their programs and

gain a fuller understanding of how their history may impact their teaching, relationships with students, and their need for proactive self-care. The high incidence of ACEs could also indicate a similarly high prevalence among counseling students. Counselor educators must be able to recognize the symptoms of secondary trauma in themselves and their students and be able to teach and use effective strategies to prevent and mitigate symptoms. This finding also has implications for counseling programs. It highlights the critical need to ensure faculty members have adequate training, supervision, and a working environment that is supportive and responsive to their needs.

This research found that almost every counselor educator in this study reported that they infuse trauma education into the core courses they teach. This is great news! It suggests that counselor educators value the importance of trauma education. It also indicates that counselor educators are doing what they should be doing and are not impacted adversely by personal factors when it comes to infusing trauma content into core courses. Most participants stated that their programs offered a trauma course, and almost half of them were required of all counseling students. A high percentage of participants indicated that their programs offered a crisis course, and more than half stated that it was a requirement. This implies that since the CACREP (2015) trauma standards were added, counselor education programs have made a concerted effort to ensure the standards are being taught. This is heartening news for the counseling world and reflects awareness of the pervasiveness of trauma in today's society and the need to address it effectively and ethically.

Author Judith Lewis Herman (1997) said, "The pain of trauma can be the catalyst for personal growth, leading us to discover inner strength and resilience we never knew we possessed." Counselor educators play a pivotal role in the mentorship and instruction of future

counselors tasked with guiding clients in their journeys toward healing and growth. It is a great responsibility, honor, and privilege.

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# APPENDIX A: MENTAL HEALTH RESOURCES FOR PARTICIPANTS

**MentalHealth.gov**

https://www.mentalhealth.gov/

**Mental Health America**

https://mhanational.org/

**988 Suicide & Crisis Lifeline**

https://988lifeline.org/ Dial 988 for immediate assistance

**The Jed Foundation**

**https://jedfoundation.org/resource/how-to-cope-with-psychological-trauma/**

**Veterans Crisis Line**

https://www.veteranscrisisline.net/

**National Alliance on Mental Illness (NAMI)**

https://nami.org 1-800-950-6264

**Substance Abuse and Mental Health Services Administration (SAMHSA)**

https://www.samhsa.gov 1-800-662-4357

# APPENDIX B: INTRODUCTORY LETTER

Dear Counselor Educator,

I am a doctoral candidate in the Counselor Education and Supervision program, in the Department of Counseling, at the University of North Carolina at Charlotte. My dissertation chair is Dr. Phyllis Post.

My dissertation study is on factors related to the infusion of trauma education into non-trauma-specific courses. Specifically, this study aims to understand how adverse childhood experiences, prior training, and attitudes related to trauma-informed care relate to whether counselor educators infuse trauma content into non-trauma-specific courses, and to describe the degree to which the six required trauma standards are infused.

I am inviting you to participate in this study if you meet the following criteria:

- You are at least 18 years old.
- You are full-time faculty member working in a CACREP-accredited counseling program in the United States.

I also ask you to pass this email to someone you think is eligible to participate in this study. Your participation is entirely voluntary, and your responses will be confidential. You may choose to leave the survey at any time with no explanation. Completing the survey will take approximately 15 minutes.

This study has been approved by the University of North Carolina at Charlotte's Institutional Review Board. If you decide to participate in this study, please read and sign the inform consent electronically to proceed to the survey by clicking the link below.

Thank you in advance for your participation. This research will inform the counseling field and could lead to better professional development related to competency in teaching trauma-informed practices and principles. Research has demonstrated the high prevalence and adverse effects of trauma and the need to graduate trauma-informed professionals. Greater competency in teaching about trauma leads to more effective graduate programs and ethical practice. If you have any questions, please contact me or my chair.

Sincerely,

Lane K. Griffith, MA, LCMHC, NCC
Doctoral Candidate
Department of Counseling
University of North Carolina at Charlotte
Lgriff40@uncc.edu
704-682-4058

Dr. Phyllis Post, LPC, RPT
Dissertation Chair
Department of Counseling
University of North Carolina Charlotte
ppost@uncc.edu
704-687-8961

APPENDIX C: INFORMED CONSENT


Department of Counseling
9201 University City Boulevard, Charlotte, NC 28223-0001

**Consent to Participate in a Research Study**

**Factors Related to Infusion of Trauma Education Among Counselor Educators at CACREP-Accredited Programs**

Principal Investigator: Lane K. Griffith, Doctoral Candidate
Dissertation Chair: Phyllis Post, PhD

You are invited to participate in a research study. Participation in this research study is voluntary. The information provided is to help you decide whether to participate. If you have any questions, please ask.

**Important Information You Need to Know**

- The purpose of this study is to explore factors that may impact whether counselor educators infuse trauma education in the non-trauma courses they teach and to describe the degree to which the six trauma standards CACREP requires of all counseling students are infused.
- You may withdraw from the study at any time.
- No identifying information will be collected. Your answers are completely confidential and cannot be identified to you specifically.
- We will be collecting demographic information
- We ask participants to complete three brief assessments assessing their history of adverse childhood experiences, infusion of trauma education into non-trauma-specific courses, and their attitudes related to trauma-informed care. The assessments can be completed in approximately 10-15 minutes. The assessments can be done on any device with access to the internet.

**Why are we doing this study?**

The purpose of this study is to explore how personal trauma history, prior training, and attitudes related to trauma-informed care relate to the infusion of trauma education in non-trauma-specific courses and to describe the degree to which the six required trauma-related standards are infused. Results may inform participants of their training needs. They may inform professional development and support of faculty to ensure trauma competence in their clinical and school counseling graduates.

**Why are you being asked to be in this research study.**

You are being asked to be in this study because you are a full-time faculty member working in a CACREP-accredited counseling program in the United States.

**What will happen if I take part in this study?**

If you choose to participate, you will complete online assessments. There are no other requirements. We will collect your demographic information. You will take the two assessments. Your total time commitment if you participate in this study will be approximately 10 to 15 minutes.

**What benefits might I experience?**

You may develop an awareness of factors influencing your willingness and ability to teach about trauma and the potential need for training and development. However, research will inform the counseling field and could lead to better professional development related to competency in teaching trauma-informed practices and principles. Research has demonstrated the high prevalence and adverse effects of trauma and the need to graduate trauma-informed professionals. Greater competency in teaching about trauma leads to more effective graduate programs and ethical practice.

**What risks might I experience?**

This study has minimal foreseeable risks. Reflecting on adverse childhood experiences could trigger mild negative physical and mental symptoms. The ACE Questionnaire asks about the types of stressful experiences you had as a child, including abuse, neglect, or household dysfunction. Resources have been attached on a separate page for your use should you experience discomfort. Participation in the study is voluntary. You may withdraw at any time.

**How will my information be protected?**

There is no identifying information. When you access the assessments, we will not collect any information that can identify you as the survey taker. Emails of participants who wish to be included in the drawing for Amazon gift cards will be separate from data.

**How will my information be used after the study is over?**

After this study is complete, study data may be shared with other researchers for use in other studies without asking for your consent again or as may be needed as part of publishing our results. The data we share will NOT include information that could identify you.

**Will I receive an incentive for taking part in this study?**

Participants who complete the surveys may be entered into a drawing for a $25.00 Amazon gift card. Eight gift cards will be given away.

**What are my rights if I take part in this study?**

It is up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time.

**Who can answer my questions about this study and my rights as a participant?**

For questions about this research, you may contact Lane Griffith, lgriff40@uncc.edu or Phyllis Post at ppost@uncc.edu. If you have questions about your rights as a research participant or wish

to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the Office of Research Protections and Integrity at 704-687-1871 or uncc-irb@uncc.edu.

**Electronic Consent to Participate**

By Clicking "Begin Assessments," you acknowledge that you are at least 18 years old, are an associate professor, assistant professor, professor, or clinical professor working in a CACREP-accredited counseling program in the United States, have read this consent form, have understood the above information, and agree to voluntarily participate in this research.

Begin Assessments

# APPENDIX D: ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE

Total ACEs score (possible 1-10) from the following page.

Only the **total number** of "**Yes**" **responses** from the is requested here.

---

Non-proprietary Adverse Childhood Experiences Questionnaire (ACE)

(CDC, 1997; Felitti et al., 1998)

## Adverse Childhood Experiences (ACE) Questionnaire

Finding your ACE Score

**While you were growing up, during the first 18 years of life:**

1. Did a parent or other adult in the household **often**… **Yes** **No**

- Swear at you, insult you, put you down, or humiliate you? **OR**

  Act in a way that made you afraid that you might be physically hurt?

2. Did a parent or other adult in the household **often**… **Yes** **No**

- Push, grab, slap, or throw something at you? **OR**
- **Ever** hit you so hard that you had marks or were hurt?

3. Did an adult or person at least 5 years older than you **ever**… **Yes** **No**

- Touch or fondle you or have you touch their body in a sexual way? **OR**
- Try to actually have oral, anal, or vaginal sex with you?

4. Did you **often** feel that… **Yes** **No**

- No one in your family loved you or thought you were important

  or special? **OR**

- Your family didn't look out for each other, feel close to each other,

or support each other?

5. Did you **often** feel that… **Yes** **No**

- You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? **OR**
- Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

6. Were your parents **ever** separated or divorced? **Yes** **No**

7. Was you mother or stepmother: **Yes** **No**

- **Often** pushed, grabbed, slapped, or had something thrown at her? **OR**
- Sometimes or often kicked, bitten, hit with a fist, or hit with something hard? **OR**
- **Ever** repeatedly hit over at least a few minutes or threatened with a gun or a knife?

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs? **Yes** **No**

9. Was a household member depressed or mentally ill or did a household member attempt suicide? **Yes** **No**

10. Did a household member go to prison? **Yes** **No**

**Add up your "Yes" answers** and record **only the TOTAL here: _____**.

**Source.** Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading cause of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine, 14*(4), 245-258.

**Permissions.** This scale can be used for non-commercial research and educational purposes without seeking written permission.

**Scoring Protocol**. The scores on the overall **scale** and on the subscale are reliable. This study will use the total score, which is the sum of all items.

# APPENDIX E: TRAUMA EDUCATION CHECKLIST

1. **Do you infuse trauma education into the *non-trauma-specific* courses you teach?**
   - Yes
   - No
2. **Please check ALL trauma content you infuse into your *non-trauma-specific* courses:**
   - Counselor's roles and responsibilities as members of interdisciplinary community outreach and emergency management response teams
   - Effects of crisis on diverse individuals across the lifespan
   - Effects of disasters on diverse individuals across the lifespan
   - Effects of trauma on diverse individuals across the lifespan
   - Suicide prevention models and strategies
   - Crisis intervention strategies
   - Trauma-informed strategies
   - Community-based strategies, such as Psychological First Aid
   - Procedures for assessing risk of aggression or danger to others
   - Procedures for assessing risk of self-inflicted harm, or suicide
   - Procedures for identifying trauma
   - Procedures for identifying and reporting abuse

# APPENDIX F: ARTIC-10 FOR EDUCATORS

**ARTIC** | *Attitudes Related to Trauma-Informed Care Scale*
VERSION: ARTIC-10 EDUCATION

TRAUMATIC STRESS INSTITUTE

People who work in education, health care, human services, and related fields have a wide variety of beliefs about their students, their jobs, and themselves. The term "student" is interchangeable with "client," "person," "resident," "patient," or other terms to describe the person being served in a particular setting.

**Trauma-informed care** is an approach to engaging people with trauma histories in education, human services, and related fields that recognizes and acknowledges the impact of trauma on their lives.

**INSTRUCTIONS**

For each item, select the circle along the dimension between the two options that best represents your personal belief during the past two months at your job.

***Sample***

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|
| Ice cream is delicious | ○ | ● | ○ | ○ | ○ | ○ | ○ | Ice cream is disgusting. |

***Note:*** *In this SAMPLE ITEM, the respondent is reporting that he/she believes that ice cream is much more delicious than disgusting.*

***I believe that...***

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Students could act better if they really wanted to. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Students are doing the best they can with the skills they have. |
| 2 | Focusing on developing healthy, healing relationships is the best approach when working with people with trauma histories. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Rules and consequences are the best approach when working with people with trauma histories. |
| 3 | If students say or do disrespectful things to me, it makes me look like a fool in front of others. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | If students say or do disrespectful things to me, it doesn't reflect badly on me. |
| 4 | The ups and downs are part of the work so I don't take it personally. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | The unpredictability and intensity of work makes me think I'm not fit for this job. |
| 5 | It's best not to tell others if I have strong feelings about the work because they will think I am not cut out for this job. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | It's best if I talk with others about my strong feelings about the work so I don't have to hold it alone. |
| 6 | Students do the right thing one day but not the next. This shows that they are doing the best they can at any particular time. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Students do the right thing one day but not the next. This shows that they could control their behavior if they really wanted to. |
| 7 | Students need to experience real life consequences in order to function in the real world. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | Students need to experience healing relationships in order to function in the real world. |
| 8 | I realize that students may not be able to apologize to me after they act out. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | If students don't apologize to me after they act out, I look like a fool in front of others. |
| 9 | I feel able to do my best each day to help my students. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | I'm just not up to helping my students anymore. |
| 10 | The most effective helpers find ways to toughen up – to screen out the pain – and not care so much about the work. | ○ | ○ | ○ | ○ | ○ | ○ | ○ | The most effective helpers allow themselves to be affected by the work – to feel and manage the pain – and to keep caring about the work. |

*Thank you for your participation.*


370 Linwood Street, New Britain, Connecticut 06052 | (860) 832-5562 | artic@klingberg.org | www.traumaticstressinstitute.org

# APPENDIX G: DEMOGRAPHIC QUESTIONNAIRE

1. **Are you at least 18 years old and a full-time faculty member working in a CACREP-accredited counseling program in the United States?**
   - o Yes
   - o No
2. **What is your age? _____ (Fill in the blank)**
3. **How would you describe your race?**
   - o White
   - o Black or African American
   - o Asian
   - o Native American or Alaska Native
   - o Native Hawaiian or Pacific Islander
   - o Middle Eastern/Arab American
   - o Biracial or Multiracial
   - o Other/Unknown
4. **Are you Spanish, Hispanic, Latino, or none of these?**
   - o Yes
   - o None of these
5. **With what gender do you identify?**
   - o Male
   - o Female
   - o Transgender

- Non-binary
- Other

6. **How many years of clinical experience as a mental health professional do you have since completing your master's degree? _____ (Fill in the blank)**
7. **How many years of experience do you have as a counselor educator since completing your doctoral degree? _____ (Fill in the blank)**
8. **Please rate your trauma counseling training by checking the appropriate answer below.**
   - I feel I need to learn a great deal more before I would call myself competent.
   - I still have much to learn in order to call myself competent.
   - I feel comfortable with my knowledge and skill level.
   - I am highly competent; I could teach others.
9. **Please indicate the extent of training you have received specific to the treatment of trauma and trauma survivors.**
   - No training
   - Minimal training (e.g., one workshop, seminar, and/or in-service training)
   - Moderate training (e.g., a couple of workshops)
   - Substantial training (e.g., multiple workshops, semester-long course, certificate, other extensive formal training)
10. **How many graduate-level (3 credit) trauma courses have taken (include ones currently attending)? _____ (Fill in the blank)**
11. **Have you participated in any educational activities on trauma in addition to trauma courses, such as workshops or trainings?**

- Yes
- No

**12. If yes, approximately how many *total hours* of workshops, training, or professional development related to trauma have you taken in the last five years? _____ (Fill in the blank)**

**13. At what type of institution do you teach?**

- Public
- Private

14. **In what region of the United States is your program located?**

- North Atlantic

  (Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont)

- North Central

  (Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, Oklahoma, South Dakota, and Wisconsin)

- South

  (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, South Carolina, Texas, Tennessee, Virginia, and West Virginia)

- Rocky Mountain

  (Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming)

- West

  (Alaska, Arizona, California, Hawaii, Nevada, Oregon, and Washington, and Pacific Rim Countries)

**15. How many students attend your university or college? _____(Fill in the blank)**

**16. How many students are in your program? _____(Fill in the blank)**

**17. In what type of setting is your program located?**

- Urban
- Suburban
- Rural

**18. Does your program offer a course on trauma?**

- Yes
- No

    **a. Is it a required course for ALL counseling students?**

    - Yes
    - No

    **b. Do you teach this course?**

    - Yes
    - No

**19. Does your program offer a course on crisis?**

- Yes
- No

    **a. Is it a required course for ALL counseling students?**

    - Yes
    - No

    **b. Do you teach this course?**

    - Yes
    - No

**20. Does your program offer a course on grief?**

- Yes
- No

**a. Is it a required course for ALL counseling students?**

- Yes
- No

**b. Do you teach this course?**

- Yes
- No

**21. Does your program offer a specialization in trauma counseling?**

- Yes
- No

22. In which courses do you infuse trauma education? Check any that apply.

- Human Development /Lifespan
- Research Methods
- Assessment and Evaluation
- Counseling Theories
- Counseling Techniques
- Group Counseling
- Multicultural counseling
- Career Development and Counseling
- Practicum
- Internship