Teaching Trauma Theory and Practice to Master's Level Counselors-In-Training: A Multiple Case Study

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Dedication

I dedicate this dissertation to all educators, in counseling and beyond. You wake up day after day and pour immense amounts of time and energy into changing the lives of your students. This work often goes without recognition of how complicated and challenging it is. Your passion and determination inspire me to want to know more and push me to be the best educator I can be. Thank you for your commitment to the next generation.

Acknowledgments

"I said to the sun, 'Tell me about the big bang.' The sun said, 'it hurts to become."

- Andrea Gibson

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"Find someone who isn't like you, to look at the world beside" - Andrea Gibson

Abstract

The purpose of this qualitative multiple case study was to understand how counselor educators (CEs) facilitate learning in their master's level trauma theory and practice courses. The study addressed two research questions: (a) *How do counselor educators choose which trauma content to address in master's level trauma theory and practices courses?* and (b) *Which teaching methods do counselor educators utilize to facilitate significant learning in master's level trauma theory and practice courses?* Three CEs participated in this study. All three participants worked in CACREP accredited or aligned programs in three different regions (south, north central, north east). The participants had been employed as CEs from 3 years – 15 years. Data sources included two interviews each participant, an open-ended questionnaire completed by each participant, and document review of each instructor's course syllabus and assignment descriptions.

Three methods of teaching were consistent across the three Cases: lecture, discussion, and case study. Themes were examined within and across individual Cases. Case 1, Jade, chose course content and teaching methods based on responsivity to students, instructor awareness of contextual factors and current events, and embracing and capitalizing on instructor expertise and limitations. The hybrid format of the course, mentorship relationships, and program accreditation also impacted course design. Case 2, Jimmy, chose course content and teaching methods based on conceptualizing the role of students as advocates and his role as facilitator, the instructor's experience, and choosing course methods to facilitate application of material. Additionally, the asynchronous online course format and the instructor's conceptualization of Bloom's Taxonomy impacted course design. Case 3, Alex, chose course content and teaching methods based on instructor clinical experience, creating course pedagogy focused on application, wanting to elicit

student self-awareness, and various student influences. Additionally, the face-to-face format of the course and the use of a co-instructor impacted course design. Cross-case analysis indicated themes related to instructor role, instructor identity, methods of teaching that elicit fundamental change in the learner, and methods of teaching to develop student skill acquisition. Based on these findings, I provide implications for CE and recommendations for future research.

Keywords: counselor education, trauma, pedagogy, multiple case study

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CHAPTER ONE: INTRODUCTION

Trauma is a cognitive, physiological, and psychological construct that impacts individuals' ability to regulate emotions, engage with others, and function in daily occupational and personal tasks (Kira, Ashby, Omidy, & Lewandowski, 2015; Layne et al., 2011). Trauma responses are triggered by events that overwhelm individuals' ability to cope and continue to cause distress long after the initial threatening event has ended (Bemak, & Chung, 2017; Goodman, 2015; Hemmings & Evans, 2018; Lawson, 2017; Lawson & Quinn, 2013; Rizkalla, Zeevi-Barkay, & Segal, 2017). Entry-level counselors must understand how trauma responses manifest in their clients and support clients exposed to traumatic events with evidence-informed interventions (Kira et al., 2015; Wachter Morris, & Barrio Minton, 2012).

Although trauma research and attention to clinical practice in the helping professions have been sporadic, results have been consistent enough across domains to create a body of literature to inform practice (Herman, 1997). This literature underscores that exposure to traumatic events can lead to psychological disorders such as post-traumatic stress disorder (PTSD), acute stress disorder, depression, and anxiety and may be linked to much of the psychological distress that brings clients to see mental health professionals (Blankenship, 2017; Courtois & Gold, 2009; Czerny, Lassiter, & Lim, 2018; Herman, 1997; Lutton & Swank, 2018). Additionally, exposure to traumatic experiences, especially chronic traumatic experiences, has been correlated to physical and psychological distress, an increased likelihood of addiction-related disorders, and interpersonal difficulties (Courtois & Ford, 2013; Herman, 1997; van der Kolk, 2005).

Approximately 90% of the respondents in a nationwide study conducted by Kilpatrick et al. (2013) reported experiencing at least one event that would meet the exposure criterion for

PTSD as defined by the DSM-5. Furthermore, mental health agencies serve a disproportionately high number of clients who have a history of trauma (Cunningham, 2004). Due to the high number of people who have experienced traumatic events (Kilpatrick et al., 2013) and the likelihood that professional counselors will provide services to these individuals (Cunningham, 2004), it is imperative that counselors receive appropriate training in their graduate programs to work within their scope of practice (Layne et al., 2014).

In 2009, Courtois and Gold wrote that even though there were mounting scientific evidence and more focus from the general public, there was still no intentional incorporation of trauma in the core curriculum for graduate level psychologists and allied professions (Courtis, 2002; Courtois & Gold, 2009). The Council for Accreditation of Counseling and Related Educational Programs (CACREP), the accrediting body for counseling programs in the United States, embedded training standards specific to trauma in the *2016 Standards* (i.e., F.3.G, F.5.M, F.7.D, C.2.F, and G.2.E). Due to the nature of the CACREP training standards, it is up to counseling programs to determine what trauma content they embed to address these standards and up to instructors to determine methods for teaching and learning.

Despite a growing recognition that counselors need to be prepared to serve clients who have experienced traumatic events (Courtois & Gold, 2009; Layne et al., 2014), there has been little guidance on how to prepare counselors to accomplish this. Many counselors and counselor educators (CEs) have called for professional competencies for helping professions (Avery, 2017; Layne et al., 2014; Mattar, 2010; Paige, 2015; Turkus, 2013; Watkins Van Asselt, Soli, & Berry, 2016). Even with competencies, there is a dearth of knowledge regarding what the teaching process should look like and how CEs can determine the best content and processes to facilitate development of competencies.

When professionals do not have proper training, they may experience negative personal effects (e.g., vicarious trauma, compassion fatigue, secondary trauma) when working with individuals who have experienced traumatic events (Courtois & Gold, 2009), and they may assume they have more competency than they have (Wilson & Lindy, 1994). Furthermore, practitioners who are underprepared to work with clients who have experienced trauma may inadvertently exacerbate original distress by retraumatizing, which is counter to the professional obligation to do no harm (Symonds, 1980). In contrast, practitioners with knowledge of trauma and how it impacts client welfare are better equipped to empathize, customize interventions, and create environments that do not retraumatize clients (Courtois, 1998). With this in mind, scholars have called for the need to better understand trauma and professional competencies necessary to serve those impacted by trauma (Avery, 2017; Layne et al., 2014; Mattar, 2010; Paige, 2015; Turkus, 2013). Due to the need to better understand how CEs teach trauma content, this current inquiry focused on how CEs engage in course design when teaching about trauma.

Conceptual Framework

Fink's *Theory of Significant Learning* (2013) is the conceptual framework utilized in this inquiry to conceptualize course design which includes both content and delivery. According to Fink (2013), there are two main requirements for significant learning:

1. Instructors must expose students to multiple kinds of learning that goes beyond simply understanding and remembering course-related material
2. Significant learning requires that students draw connections to how the information is relevant to life outside of the course

Creating significant learning experiences begins by focusing on learning-centered approaches in contrast to content-centered approaches to teaching (Fink, 2013). Fink (2013) built upon

Bloom's taxonomy (1956) to create a taxonomy of significant learning that moved away from the cognitive domain and attended to the additional domains of affect and process. He broadened and created a new taxonomy which includes six domains of significant learning: (a) foundational knowledge, (b) application, (c) integration, (d) human dimension, (e) caring, and (f) learning how to learn (Fink, 2013).

These six categories of significant learning are relational rather than hierarchical (Fink, 2013) which allows instructors to incorporate and overlap categories to create more complex learning experiences. Instructors can utilize this taxonomy to create learning goals that go beyond the mastery of content and encourages them to combine multiple types of learning in the classroom to "enhance the achievement of significant learning by students" (p. 38).

I chose Fink's framework for this inquiry because CEs are training practitioners who must utilize information presented in the classroom in a variety of settings and situations across the course of their careers. Furthermore, the framework aligns with the wellness and developmental foundations of professional counseling (Kaplan, Tarvydas, & Gladding, 2013). CEs should "want that which students learn to become part of how they think, what they can and want to do, what they believe is true about life, and what they value" in addition to "increase[ing] their capacity for living life fully and meaningfully" (Fink, 2013, p. 6). Fink focused his efforts on course design and how instructors can create environments that elicit change through the process of learning. CEs who can create these types of experiences with their students align with the foundational mission of our profession to promote wellness through a developmental lens. Additionally, they ensure that counselors in training (CITs) can best serve vulnerable populations such as those who have experienced traumatic events.

Statement of the Problem

Most professional counselors will provide clinical services to clients who have experienced a traumatic event (Layne et al., 2014; Zelechoski et al., 2013). Professional counselors who lack adequate training are at a higher risk of personal distress (Courtois & Gold, 2009), providing inadequate services (Wilson & Lindy, 1994), and exacerbating client distress (Symonds, 1980). In addition to the risk of causing harm, practicing outside of the scope of competency is the most common ethical violation reported to state licensing boards for professional counselors (Even & Robinson, 2013).

The allied helping fields of psychology and social work have provided conceptual and empirical literature on teaching process for trauma theory and practice concepts. Literature within these fields included expression of concern with instructors who haphazardly expose students to trauma content in the classroom (Abrams & Shapiro, 2014; Black, 2006/2008; Bussey, 2008; Cunningham, 2004; Gilin & Kauffman, 2015; Gold, 199; Mattar, 2011; Miller, 2008; Newman, 2011). To provide effective clinical services for individuals who have experienced traumatic events, exposure to trauma theory and practice in ways that facilitate significant learning experiences (Fink, 2013) and minimize student distress is essential for mental health professionals including CIT.

CEs have the flexibility to address CACREP standards in ways that best fit their programs, but there is little professional counseling literature regarding how to facilitate learning experiences regarding trauma theory and practice concepts for master's level counseling students (Greene, Williams, Harris, Travis, & Kim, 2016; Kitzrow, 2002; Lokeman, 2011; Sommer, 2008; Veach & Shiling, 2018). The trauma education research in counselor education has focused on trauma competencies which include foundational knowledge and skills necessary for

trauma counseling (Avery, 2017; Layne et al., 2014; Mattar, 2010; Paige, 2015; Turkus, 2013; Watkins Van Asselt, Soli, & Berry, 2016) and has left a void in exploring how instructors can teach trauma content and skills effectively (Green et al., 2016).

Purpose Statement

The purpose of this study was to better understand how CEs design and facilitate significant learning experiences regarding trauma theory and practice. Specifically, this multiple case study focused on how CEs chose which trauma content to address in master's level trauma courses, and which teaching methods CEs utilized to facilitate significant learning experiences in those courses.

Research Questions

Specific research questions for this study were as follows:

1. How do counselor educators choose which trauma content to address in master's level trauma theory and practice courses?
2. Which teaching methods do counselor educators utilize to facilitate significant learning in master's level trauma theory and practice courses?

Significance of the Study

This study had the potential to add to the current research by facilitating a deeper understanding of how CEs design master's-level trauma theory and practice courses. The results of this study may help CEs better understand how to choose trauma content and how to facilitate significant learning experiences with master's-level CITs. The multiple case study format allowed for a deep understanding of individual courses and a multicase analysis to understand design themes across cases.

Definition of Terms

Several key terms appear throughout this study. Here I will define trauma, trauma theory and practice, counselor education, counselor educator, counselor-in-training, Council for the Accreditation of Counseling & Related Educational Programs, professional counselor, multiple case study, and Quintain.

Trauma is caused by an event or series of events perceived as "sudden and/or forceful that overwhelms a person's ability to respond or is perceived as physically or emotionally harmful or life-threatening" (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. 6). Traumatic events "need not involve actual physical harm; an event can be traumatic if it contradicts one's worldview and overpowers one's ability to cope " (p. 7). After exposure to traumatic events, not all individuals experience lasting effects (SAMHSA, 2014). For the purposes of this study, clients who are experiencing "lasting adverse effects that impact[s] functioning including mental, physical, social, or spiritual well-being" (SAMHSA, 2012, p. 2) are experiencing trauma.

Trauma theory and practice include trauma counseling and psychological theory, interventions, policy, models, treatment modalities, and other concepts that are directly applicable to providing counseling to individuals who have experienced traumatic events. This can include both conceptual information and application-based knowledge regarding the phenomena of trauma.

Counselor education is a distinct profession rooted in vocational guidance, developmental principles, supervision, and direct clinical care for clients. Counselor education graduate programs focus on training professional counselors who are "competent to practice,

abide by the ethics of the counseling profession, and hold strong counseling identities*"* (CACREP, 2016, p. 40).

Counselor educators (CEs) are faculty members in higher education settings who focus on the preparation of graduate students to become professional counselors. CEs teach counselors-in-training who will become professional counselors in various specialty areas.

Counselors-in-training (CIT) are graduate level students pursuing master's degrees in professional counseling.

The *Council for Accreditation of Counseling & Related Educational Programs (CACREP)* accredits master's and doctoral degree programs in counseling specialty areas offered by colleges and universities in the United States and internationally (CACREP, 2018). Counseling programs that are accredited through the CACREP may train counselors in one of seven entry-level specialty areas: (a) addiction counseling, (b) career counseling, (c) clinical mental health counseling, (d) clinical rehabilitation counseling, (e) college counseling and student affairs, (f) marriage, couple, and family counseling, and (g) school counseling (CACREP, 2016).

Professional counselors utilize mental health, psychological, or developmental principles, through "intervention strategies, to address wellness, personal growth, career development, and pathology" with the clients they serve (American Counseling Association [ACA] Governing Council, 1997).

Multiple case study is a research methodology that utilizes methodical multicase analysis of single case studies to better understand similarities and differences across cases while maintaining the depth and rigor of single case study research design (Stake, 2006). For the purposes of this study, I will utilize Stake's (2006) method of multiple case study.

Quintain: In multiple case study research, the shared phenomenon between a particulate set of cases is the Quintain (pronounced kwin'ton). The Quintain is a shared characteristic or condition identified by the research at the beginning of the study that binds the cases together (Stake, 2006). Researchers find single cases that manifest the condition, characteristic, or phenomena and examine similarities and differences to better understand the Quintain.

Organization of the Study

This chapter introduced the research topic of focus. In Chapter Two, I describe the history of trauma and describe how this history impacts present-day research and trauma education. I review literature on educational and professional trauma competencies including those in counseling, psychology, and social work in addition to professional competencies such as those endorsed by the Veterans Administration and the National Child Trauma Stress Network. I present results of a thematic analysis of educational and professional trauma competencies to clarify that overlap and differences in the competencies endorsed by various disciplines and professional organizations. Chapter Two concludes with a review of literature on trauma education in the helping professions including counseling, psychology, and social work.

Chapter Three presents an overview of qualitative research and a thorough description of single case study and multiple case study as the methodology for this study of CE course design. A description of my case study design follows, including constructing a theoretical frame, conducting a literature review, identifying the research problem, selecting a sample, collecting data, analyzing data, and creating a report. Next, I introduce the multiple case study design utilized in this study, including identifying the Quintain, selecting multiple cases, conducting multicase analysis, and completing the final report with multicase Assertions. I conclude Chapter Three with discussion of strategies used to ensure rigor in the study.

Chapter Four includes reports of the three individual cases and Findings from the multicase analysis. Chapter Five provides a discussion of findings, examination of limitations, and exploration regarding implications for CEs and recommendations for further research. Finally, I provide references and appendices for the study.

CHAPTER TWO: LITERATURE REVIEW

This chapter introduces the history of trauma in helping professions. Furthermore, it creates a foundation for how history impacts the way that trauma education and research has progressed into the present day. I discuss trauma competencies from counseling, psychology, social work, and professional agencies. This discussion culminates in a thematic analysis of the trauma competencies to highlight consistencies and divergences between the fields. I conclude with a review of trauma education in the fields of counseling, psychology, and social work to gain a better understanding of the conceptual and empirical literature on trauma pedagogy in these specific helping fields.

History of Trauma in Helping Professions

Researchers have intermittently studied trauma theory and practice and these inquiries have been heavily influenced by the zeitgeist at the time (Herman, 1997). To study trauma, researchers must come face-to-face with the reality that humans can and do inflict incredible amounts of pain on each other; there is no controlling when traumatic events strike and whom the events impact. Although trauma is largely an equal opportunity offender, helping professionals employ early intervention or preventative strategies for vulnerable populations in some instances (Herman, 1997).

The study of trauma has been as "one of episodic amnesia," with times of vigorous investigation and others of ignorant bliss (Herman, 1997, p. 7). Over time, understanding of trauma has broadened with focused attention on combat veterans (Benedek & Ursano, 2009), intimate partner violence (Bevacqua, 2000; Russell, 1984), sustained child maltreatment (Felitti et al., 1998), and relational trauma (Siegel, 1999). The same set of symptoms arises from

different situations with every generation; without considering previous generations, scholars of the era repackage and rename work related to psychological trauma.

Contemporary understanding of trauma stems from three historical movements: (a) hysteria in late nineteenth century France, (b) "shell shock or combat neurosis beginning in England and the United States during World War I" and peaking during the Vietnam War, and (c) sexual and domestic violence during the feminist movements in Western Europe and North America (Herman, 1997, p. 9). Amid each of these three time periods during which trauma research flourished, political movements elevated narratives of victims and legitimized scientific research. In the following sections, I review major trends and findings in each period and highlight the impact on traumatology for generations to come.

Hysteria

Trauma research began as a political statement in nineteenth-century France with the work of Charcot. Charcot's research with women exhibiting symptoms he called *hysteria* was an attempt to elevate scientific knowledge above common moral and religious explanations of the time. When his work began, symptoms associated with female distress were attributed to poor moral character, inferiority to men, or religious impurity. He opened a hospital (asylum) which housed "...beggars, prostitutes, and the insane… (Herman, 1997, p. 10)." This hospital was a temple of modern science to which many well-known neurologists and psychiatrists including Pierre Janet, Williams James, and Sigmund Freud made pilgrimage for training.

As the age of hysteria continued to unfold, champions of the movement realized that this was steering them into a world that "required them to listen to women far more than they ever intended" (Herman, 1997, p. 14). It was leading them into territory that required conversations about sex, emotions, and an understanding of the lived experience of women. By all accounts,

these investigators never planned to uncover women's' sexual trauma, and they had little interest in this line of inquiry. Once the secular government of France had firm footing, there was no longer a need for scientists to continue their evidence-based crusade to disprove the mystics of the religious regime (Herman, 1997). After the dust settled, all that was left were male scientists who appeared to be over-involved with their female patients and encouraging the feminist movement, both of which threatened their scientific credibility. The movement of hysteria ended with Charcot regretting that he opened a scientific inquiry into this path (Tourette, 1893).

Of all the early psychiatrists, Freud ventured the furthest into the lives of women with his breakthrough of sexual trauma in childhood as the root of hysteria. His position regarding impact of sexual trauma on women and the frequency with which it was appearing in his office was extremely unfavorable and left him an outcast in the psychiatric community (Herman, 1997). Freud himself began to doubt his line of inquiry after presenting *The Aetiology of Hysteria* (1986); if his hypothesis was correct, the number of women who experienced sexual trauma was much higher than he or society was willing to accept (Deutsch, 1957). There was no social or political movement of the time that was willing to create a framework where Freud's hypothesis of widespread sexual trauma among women was an acceptable epistemology for hysteria. Freud, now cast out from the scientific community, disavowed his female clients and became the most fervent denier of his own theory of hysteria. Out of his failed attempt at discovering and championing the cause of hysteria, Freud created psychoanalysis which flourished in an anti-feminist political climate (Herman, 1997). Shifting from the socio-political zeitgeist of eighteenth-century France, the next major focal point for trauma research was war and its impact on soldiers.

War Neuroses

Literature on war-related trauma dates to the "American Civil War with terms such as 'soldier's heart' and 'nostalgia'" used to describe traumatic stress (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014, p. 267). As tactics of war changed, so did the terminology used to describe trauma. Beginning in World War I (WWI), military officials and doctors described the physiological and psychological effects of high-powered weaponry as "shell shock" (Benedek & Ursano, 2009). Even with a physiological explanation for trauma, the prevailing thought was that soldiers who experienced trauma from exposure to war had a moral deficit (SAMHSA, 2014).

Exposure to unrelenting trench warfare during WWI led field medics to report that soldiers were beginning to act like hysterical women (Herman, 1997). Men exposed to the terror of war were screaming uncontrollably, weeping, frozen, mute, unresponsive, experienced loss of memory, and had a diminished capacity to feel. To maintain the illusion of glory and honor of battle, the media minimized these "psychiatric causalities" (Showalter, 1985, p. 168).

Initially, scholars attributed psychological symptoms of shell shock to physical damage done by explosions (SAMHSA, 2014). British psychologist Charles Myers examined the first case of the nervous disorder which he stated were the "effects of exploding shells in battle" (Myers, 1940, p. 5). The phenomena continued to be named "shell shock" even though it soon became evident that even soldiers who had not experienced physical trauma exhibited similar symptoms. Soon, the evidence forced psychiatrists to come to terms with the realization that shell shock stemmed from psychological distress after prolonged exposure to violent death and suffering (Herman, 1997; Lasiuk & Hegadoren, 2006). This emotional distress had a striking resemblance to hysteria, which researchers thought to be only in women.

Much like with women and hysteria, researchers believed men who exhibited signs of combat neurosis were morally corrupt with an inferior character. Men were supposed to bask in the glory of war, not show signs of emotional distress or terror (Herman, 1977; SAMHSA, 2014). These men were described as “moral invalids” (Leri, 1919), and military personnel debated whether they should be dishonorably discharged instead of receiving medical treatment. During the early years of treatment, psychologists used inhumane tactics such as electric shocks, shaming, treats, and punishment to remind soldiers to be the heroes the world expected them to be (Herman, 1997). Over time, medical authorities argued for humane treatment of soldiers, accepting that even those of high moral character could show signs of combat neurosis. These psychiatrists pushed for the use of treatment based on psychodynamic principles as a primary modality of care (Herman, 1997). One of the leading practitioners in this movement was W.H.R Rivers.

W.H.R Rivers was a professor of neurophysiology, psychology, and anthropology and a champion of humane treatment of soldiers (Herman, 1997). The military referred his most famous patient, Siegfried Sassoon, due to his vehement opposition to the war. Once in his care, this soldier displayed symptoms of what many would now diagnose as post-traumatic stress disorder including irritability, nightmares, restlessness, increased risk-taking, and recklessness. Rivers’ treatment of this soldier, much like Charlot’s treatment of his patients in the hospital, was meant to “demonstrate the superiority of enlightened treatment over more punitive” measures (Herman, 1997, p. 16).

Rather than shamed and silenced, Sassoon was treated with dignity and encouraged to talk and write about his experience in the war. After having an opportunity to process his experience, Sassoon expressed that the single most important factor in his recovery was

understanding and processing the relationship he had with the other soldiers in his unit (Herman, 1997). The relationship he had with the other soldiers was the motivating factor for Sassoon to continue treatment and return to battle to fight alongside them, although he remained a staunch opponent to the war and a vehement advocate for pacifism. Rivers' perceived his initial success with Sassoon as a demonstration of a soldier's ability to recover and return to combat, but readers can see the lasting impact of combat trauma in Sassoon's writings (Herman, 1997; Sassoon, 1918). Although Rivers' more humane methods of treatment allowed Sassoon to rejoin his combat unit, these successes were not enough to keep momentum within the trauma research movement.

At the end of WWI, as with the end of the political secularization of France, the literature on trauma began to fade. The interest in the subject for politicians, civilians, and scientists alike all shifted while the long-lasting psychological trauma of war remained with the veterans. Scholars had focused so heavily on getting soldiers back to war, that they did not take into consideration what happened after the war ended.

In 1922, American psychiatrist Abram Kardiner completed psychoanalysis training with Freud in Vienna and returned to New York to open a private practice (Herman, 1997). At the same time, he took a position at the local veterans' administration hospital and was appalled by the lack of support for veterans. In 1941 Kardiner published *The Traumatic Neuroses of War* and went on the create a clinical framework of traumatic symptoms that lay the foundation for what we understand today (Herman, 1997).

Many of Kardiner's theoretical hypothesis aligned with Charcot's and Freud's late nineteenth-century formations concerning hysteria. Despite Kardiner's acknowledgment that neuroses caused by war was type of hysteria, he strongly opposed publicizing the similarities due

to negative connotations the term “hysteria” induced (Kardiner & Spiegel, 1947). Kardiner warned that the episodic research of trauma hindered scientific progress by creating a landscape that required each new generation of scientists to start from scratch. Even with Kardiner’s interest in the mental health treatment of combat veterans, research was not invigorated until another war started and produced demand for soldiers to remain operational and capable of carrying out their duties.

By World War II (WWII), psychiatrists screened military recruits to eliminate those that showed signs of being “afflicted with moral weakness” (SAMHSA, 2014, p. 267). At the same time, these screening measures were put into place, the military implemented rest periods for soldiers before returning to battle as a treatment measure for “battle fatigue” (SAMHSA, 2014). The focus of medical interest in combat neurosis during WWII was pinpointing exactly how much exposure to violence was enough to cause distress in soldiers (Herman, 1997). Two American Psychiatrists, J.W. Appel, and G.W. Beebe concluded that 200-240 days of combat was the maximum amount of combat any soldier could sustain prior to exhibiting signs of distress (Appel & Beebe, 1946).

With this number in mind, psychiatrists focused their energy on identifying protective factors and rapid interventions of recovery. Rivers’ work saw a resurgence as it became evident that attachment and connection were leading protective factors in war trauma (Herman, 1997). In 1947, Kardiner collaborated with Spiegel and revised his book to include that soldiers’ relationships with their commanders and units were the strongest protective factors leading to more positive outcomes (Grinker & Spiegel, 1945). Treatment strategies during these times focused on rapid interventions close to the battlefield to allow soldiers to rejoin their comrades as soon as possible.

Over time, scholars built on findings to develop brief interventions that incorporated the "talking cure" (Breuer & Freud, 1957) by inducing altered states to process traumatic events prior to reintegration. Kardiner and Spiegel (1957) utilized hypnosis, and Grinker and Spiegel (1945) utilized sodium amytal (i.e., narcosynthesis) to support soldiers in processing feelings and experiences concerning the war (Herman, 1997). Both techniques were pioneered as ways to support soldiers in understanding the impact of war on their psychological health and integrating experiences into consciousness. These interventions parallel what we know today about the importance of both recounting the trauma experience and integrating it to make meaning out of the experience (Van der Kolk, 2014). The national report reflected effectiveness of the brief intervention claimed that 80% of American soldiers who showed signs of acute stress during WWII returned to active duty within one week, with 30% of them returning to active combat (Ellis, 1980). With the war wrapping up, the focus of scientists and the public once again dropped until the next major military engagement.

The Vietnam War ushered in a new era of military technology and combat styles that were much different from previous wars. The war also had a significant impact on the general public, due to the controversy surrounding the war. Prior to the Vietnam War, trauma-focused psychiatric research for soldiers was aimed at returning soldiers to combat, but there was little focus given to veterans who had returned from combat and were transitioning back into their civilian lives.

Vietnam Veterans Against the War which was a newly formed organization, structured "rap groups" for soldiers and invited psychiatrists to support those groups. The veterans did not want to seek out services from the Veterans Administration (VA, now called U.S. Department of Veterans Affairs) and preferred smaller groups of their peers with whom they could retell and

process their traumatic experiences of war (Herman, 1997). Hundreds of these groups had formed by the middle of the 1970s, and soldiers utilized them to disband stigma and demand that their experiences not be silenced or forgotten. With the pressure of these groups, the VA began Operation Outreach to create centers staffed by veterans to offer services using a peer support model. With these groups housed within the VA, the government was able to begin systematic psychiatric research regarding the impact of war on the lives of returning veterans (Herman, 1997). The resulting study created the syndrome of post-traumatic stress disorder (PTSD) and established a direct connection between combat exposure and PTSD symptoms (Egendorf, Kadushin, Laufer, Rothbart, & Sloan, 1981).

The political climate created by the atrocities of the Vietnam War led to recognition of traumatic stress from war as a lasting psychological phenomenon and a legitimate precursor to PTSD for many veterans (Benedek & Ursano, 2009; SAMHSA, 2014). It was not until after the Vietnam War that the VA introduced a group therapy treatment protocol for PTSD. This treatment proved to be cost-effective and useful in addressing isolation, fostering communication, and supporting reintegration (Green et al., 2004).

PTSD was the first trauma diagnosis introduced into the *Diagnostic and Statistical Manual of Mental Disorders* (SAMHSA, 2014). The writers introduced it in 1982 to the 3rd edition of the text (APA, 1983; Herman, 1997). The clinical features were congruent with those Kardiner outlined 40 years prior as well as those Janet and Freud discovered 50 years prior to that. Despite sporadic research endeavors, the symptoms appeared stable through time and in two separate clinical contexts. For most of the twentieth century, combat veterans were the primary population on which researchers studied trauma (Herman, 1997). The women's liberation movement of the 1970s was the first time when attention was paid to trauma caused by routine

victimization of women, which began with the work of Freud before the subject became unfashionable, saw a resurgence.

Women's Liberation Movement

Until very recently, societal norms dictated privacy and silence concerning home life and created a space for routine victimization of women without anyone realizing the pervasiveness of the issue. This silence was so pervasive and ingrained in American culture that there was no name for it (Friedan, 1963). The women's movement started with groups that shared many of the same characteristics of the "rap groups" for veterans. These groups were small, confidential, and intended as safe spaces to share truths of participants' experience (Herman, 1997). The groups became known as "consciousness raising" groups, and they provided environments where women could freely speak of sexual and relational trauma many doctors had denied (Amatniek, 1968). Although these groups were like psychotherapy groups, the intention was to enact social change instead of individual change through collective action (Seligman & Reichenberg, 2013). This movement created rape reform around the world, including in the United States (Herman, 1997). Within a decade, the National Organization for Women introduced rape legislation, and all fifty states had enacted reforms which encouraged sexual violence victims to come forward.

Supporters opened the first rape crisis center in 1971; over the years, hundreds more have opened across the United States. In 1972, founders opened the Washington D.C. Rape Crisis Center and released a document titled *How to Start a Rape Crisis Center* which provided a model for other centers to follow (Bevacqua, 2000). This empirical and anecdotal evidence of the pervasiveness of sexual assault created a landscape for other researchers to continue to explore the topic and reduce the shame and silence concerning violence against women and children.

In 1972, Burgess and Holmstrom spent a year interviewing and counseling rape victims at Boston City Hospital. During that time, they saw 92 women and 37 children and observed a pattern of symptoms that they called “rape trauma syndrome” (Burgess & Holmstrom, 1974). The symptoms they observed included insomnia, nausea, increased startle response, dissociation, numbing, and nightmares aligned with what clinicians and medical professionals identified in combat veterans and wrote about hysteria (Burgess & Holmstrom, 1974; Freud, 1896). As those in the women’s movement explored the effects of rape, they also began to uncover the complexity of sexual trauma. Specifically, nuances of victim and perpetrator relationships created a whole new frame to understand trauma that happens between strangers as well as with those who are supposed to love and protect the victim. As scholars and practitioners uncovered these realities, it became clear that women and children were the casualties of this war and “...the psychological syndrome seen in survivors of rape, domestic battery, and incest was essentially the same as the syndrome seen in survivors of war” (Herman, 1997, p. 32).

The American women's movement created pressure for scientific research in sexual assault. In 1975, the National Institute of Mental Health created the center for rape research in response to pressure from the movement. In contrast to methods used by Charlot and Freud in the 18th-century, women were both subjects of inquiry and agents of change in a movement they originated to bring awareness to problems they experienced (Herman, 1997). They pushed for connection and interaction as the key to scientific investigation just like in the lengthy sessions conducted by psychiatrists during the age of hysteria, they encouraged intimate personal interviews as sources of knowledge on the subject (Herman, 1997). The outcome of these interviews confirmed what Freud had promoted prior to his retreat into psychoanalysis: sexual

assault against women and children was an epidemic (Schafer, Caetano, & Clark, 1999; Singh, Parsekar, & Nair, 2014).

Further confirmation of the epidemic continued as scholars published on prevalence and impact of sexual violence. In the early 1980s Russell conducted the most in-depth study at the time of women's experiences with domestic violence and sexual assault, randomly sampling and interviewing over 900 women about their experiences with domestic violence and sexual assault. Shocking results still cited today indicated that "one in four women had been raped, and one in three women had been sexually abused in childhood" (Russell, 1984, p. 13).

Scholars widely understood that traumatic experiences could happen regardless of gender or exposure to combat, in fact, they can occur throughout the lifespan (Courtois & Gold, 2009). Even with the acceptance of trauma as a permanent fixture of PTSD in the DSM, research on the impact of trauma on children lagged that of research for adults. The Adverse Childhood Experiences (ACEs) study funded by the Centers for Disease Control and Prevention (CDC) (Felitti et al., 1998) brought the spotlight on long-term impacts of trauma, and trauma research began to flourish again as researchers explored developmental impacts of trauma on the brain and body over the lifespan.

Adverse Childhood Experiences Study

In 1998, eight researchers funded by the CDC released the results of a large-scale study conducted on the impact of ACEs on long-term physical and mental health**.** This team of researchers asked the question *what the link between these adverse experiences, risky behaviors, and adult diseases is,* and postulated that the answer was that adults were using risky behaviors to cope with the impact of ACEs which was causing adult disease (Felitti et al., 1998). The researchers examined seven categories of experiences (Felitti et al., 1998): psychological abuse,

physical abuse, sexual abuse, substance abuse in the home, mental illness in the home (including if someone had attempted or completed suicide), domestic violence, and incarceration of a member of the household (Felitti et al., 1998). This expanded the understanding of traumatic experiences from sexual trauma and war and began to broaden the conversation on trauma and its prevalence. In addition to ACEs, the researchers gathered self-report and medical record data on risk factors for poor health such as smoking, inactivity, obesity, depressed mood, suicide attempts, alcoholism, drug abuse, parental drug abuse, high lifetime rate of sexual partners, and history of sexually transmitted disease (Felitti et al., 1998). The final information researchers collected was disease conditions including ischemic "heart disease, cancer, stroke, chronic bronchitis, COPD, diabetes, hepatitis, and skeletal fractures" (Felitti et al., 1998, p. 4).

A nationally representative sample of 8,506 adults completed the survey (Felitti et al., 1998). Over one-half (52%) of respondents reported experiencing greater than one category of ACE, and 6.2% reported exposure to greater than four ACEs categories. Respondents who reported a single category had a greater probability of exposure to an additional category, which indicated that exposure to a single ACE increased the likelihood that a person would be exposed to additional ACEs. "As the number of childhood exposures increased, the prevalence and risk of smoking, obesity, physical inactivity, depressed mood, and suicide attempts increased" (Felitti et al., 1998, p. 14). People with four or more categories of childhood exposure had increased risk for diabetes, chronic bronchitis, skeletal fractures, hepatitis, and poorly related self-health compared to those without exposure to ACEs (Felitti et al., 1998).

Prior to this study, exposure to childhood emotional, physical and sexual abuse had not been correlated to health risk behavior and disease in adulthood (Felitti et al., 1998). Previously, trauma researchers had focused on lasting psychological and emotional impacts (Beitchman et

al., 1992; Egelend, Sroufe, & Erikson, 1983; Fnikelhor & Browne, 1985; Straus & Gelles, 1986); this study opened the doors for physicians to conceptualize symptoms that they were seeing from nonclinical populations and use long-term physical health impacts to justify attention to trauma as a public health issue.

Although the ACEs study had limitations such as retrospective and self-reported data, this was the first study to call on interdisciplinary preventative action for childhood exposure to traumatic events. Until this point, the trauma research narrative had been one of helping individuals who were already impacted, and no one had addressed needs for prevention. Felitti et al (1998) illustrated a need for prevention for ACEs and intervention for those that have experiences leading to risky behaviors to mitigate psychological, social, emotional, and physical impacts of those exposures. The team was the first to call on primary care doctors, mental health works, social service agencies, and emergency medicine to work together to identify, prevent, and treat both diseases and their mechanisms.

The next wave of trauma research built on environmental mechanisms identified through the ACEs study to focus on the impact of relational trauma on brain development. This shift in trauma research is represented in the work of Siegel (1999) and continues to widen the scope of trauma from sexual, combat, household dysfunction, and ACEs to include the impact of relationships on the developing brain. An old notion pioneered by the work of Harry Harlow and his rhesus monkeys (Harlow, 1930) was revitalized by the increase in technology that allowed researchers to better understand the impact of relational trauma on neurobiological development.

Contemporary Advances in Trauma Research

Neuroscience has advanced the realm of trauma research in ways that earlier researchers were unable. The cluster of symptoms identified throughout time is now able to be monitored

through neurological and biological changes in the body (Lanius & Olff, 2017; Prendiville, 2016; van Der Kolk, 2014). Researchers can see that trauma is not purely a psychological phenomenon; rather, trauma causes biological changes in how humans perceive threat (Carlson, 2014). Modern-day trauma therapy harkens back to the early work of Freud and Charlot who understood that the "talking cure" alone was not enough to relieve symptoms of trauma (van Der Kolk, 2014). Mental health clinicians utilize techniques like eye movement desensitization (EMDR), hypnosis, exposure therapy, biofeedback, and neurofeedback to support integration of cognitive, emotional, and physiological symptoms associated with trauma (Benedek & Ursano, 2009; Blackenship, 2017; Bussey, 2008; Gold, 2004; Paige, 2015; van der Kolk & Fisler, 1994; Wyner, 2015).

Understanding the pervasiveness of trauma has expanded the scope of who potential victims are, where services need to be provided, and who should be trained to provide them. Most mental health counselors will work with at least one client, and in most cases many clients, that has experienced a traumatic event (Greene, Williams, Harris, Travis, & Kim, 2016; Goodman, 2015). It is no longer reasonable to assume that individuals who have been exposed to trauma must be seen by trauma experts. Rather, it is reasonable to assume that consumers across settings and systems should be seen by trauma-informed practitioners.

In the most recent years, the movement toward trauma-informed care (TIC) states that any care system and individual, from therapist to administrative assistants, should understand how trauma impacts clients with the aim to prevent re-traumatization and increase chances of recovery at all junctures of treatment (SAMHSA, 2014). In 2014, SAMHSA released a treatment improvement protocol (TIP) for trauma-informed care in behavioral health services. The TIP was accompanied by a literature review that was released on the SAMHSA website, this was the first

government initiative to provide a "comprehensive review of trauma, traumatic stress, trauma-informed care, and trauma-related interventions" (SAMHSA, 2014, p. 1-1) that was not specific to veterans. This large-scale dissemination of information from a government organization solidified the need for all behavioral health providers and systems to understand trauma and how it impacts clients.

The following sections examine trauma competencies that educational fields such as counseling, psychology, and social work have indicated as minimum standards for practitioners. Additionally, I will address training guidelines disseminated by private and public institutions to guide practicing clinicians. These competencies articulate skills, knowledge, and awareness practitioners and practitioners-in-training need to be able to effectively support clients who have experienced a traumatic event(s). These compacities are dictated for the field of professional counseling by the American Counseling Association Code (ACA) *Code of Ethics* (2014) and the CACREP *Standards* (2016).

Trauma Competencies

The ACA *Code of Ethics* (2014) clearly states that counselors should only practice within the boundaries of their competence based on supervision, educational experience, training, credentialing, and professional experience. For professional practitioners, most content related to trauma is provided outside of the classroom at specialized conferences, through continuing education credit, and within independent reading (Courtois & Gold, 2009). Although these venues can be reputable, they lack structure and supervised practice that accompanies counseling training programs, especially when CITs engage in clinical practice through practicum and internship (Courtois & Gold, 2009). Although it is not reasonable to assume that all students would or should be trauma specialists by completion of their master's programs, attention to

trauma education within counselor preparation programs appears to be minimal compared to allied fields.

The CACREP *Standards* (2016) mention trauma on three occasions in the *professional counseling identity* section which details standards for learning experiences that apply to all entry-level programs regardless of specialty area or concentration (e.g. mental health counseling, school counseling). In the *human growth and development* sub-section, CITs should know the "effects of crisis, disaster, and trauma on diverse individuals across the lifespan" (2016, Standard 2.3.g). Additionally, Standard 2.5.m in the *counseling and helping relationships* sub-section states that CIT should understand "crisis intervention, trauma-informed, and community-based strategies, such as Psychological First Aid" (CACREP, 2016). The CACREP standards go on to mention trauma in the *assessment and testing* section explaining that CITs should have an opportunity to learn "procedures for identifying trauma and abuse and for reporting abuse" (2016, 2.7.d.). In sum, minimal competency for CITs appears to include exposure to content that aids in understanding effects of trauma across the lifespan, results in skills to intervene in a trauma-informed manner and assists graduates to assess and report trauma (CACREP, 2016).

In addition to the *professional counseling identity* section, the authors mention trauma in entry-level specialty areas of "clinical mental health counseling; clinical rehabilitation counseling; college counseling and student affairs; marriage, couple, and family counseling; and school counseling" (CACREP, 2016, p. 6). Clinical mental health counseling, rehabilitation counseling, and marriage, couples, and family counseling standards all state that counselors must have exposure to content that provides the opportunity to understand the impact of crisis and trauma on their respective populations (C.2.f., D.2.h., F.2.g). College and student affairs counselors must have the opportunity to learn about "roles of college counselors and student

affairs professionals in relation to the operation of the institution's emergency management plan, and crisis, disasters, and trauma" (2016, E.2.b.). School counselors should have the opportunity to learn "school counselor roles and responsibilities in relation to the school emergency, management plans, and crisis, disasters, and trauma" (2016, G.2.e.). The overarching professional identity standards and the specialty area standards all mention the need for students to be exposed to content that can help them support clients with histories of trauma; instructors and institutions are responsible for determining how content is presented to students.

Professional and government organizations often create standardized trauma and crisis interventions and disseminate them outside of the counseling profession (e.g., the National Child Traumatic Stress Network's Psychological First Aid and the Substance Abuse and Mental Health Services Administration's Trauma-Informed Care). CEs' discretion regarding which government, private, and public "crisis intervention, trauma-informed, and community-based strategies" (p. 12) to expose students to could lead to inconsistent training across counseling programs. The CACREP standards (2016) are purposefully broad to allow counseling programs to customize specific curricula to the needs of their region, university, and students. CACREP "review[s] how programs document meeting CACREP curricular requirements" and decides "on the adequacy and appropriateness of the curricular content and practice elements against empirically supported theories and practices" (CACREP, 2018).

Program faculty may integrate these standards into existing courses or create stand-alone courses to address trauma and crisis. Regardless of how programs decide to integrate the standards, there are currently no educational competencies to stipulate proficiency in trauma theory and practice within the counseling profession. In addition to a lack of competencies in trauma education, there is very little empirical research on teaching practices specific to trauma

education in counseling, despite a growing body of empirical literature on the pervasive impact of trauma on clients' lives (Courtois 2002; Courtois & Gold, 2009; Greene, Williams, Harris, Travis, Kim, 2016; Levers, 2012; Turkus, 2013). Without counseling-specific trauma competencies to guide implementation of the CACREP standards, CEs are left to sift through the quickly growing body of literature from allied fields and clinical articles on trauma practice and evaluate which information is most pertinent for entry-level counselors.

CEs may use various counseling organizations (e.g., American Counseling Association and American Mental Health Counselors Association), private and government organizations (e.g., National Child Trauma Stress Network, SAMHSA, Association of Traumatic Stress Specialists), and allied mental health professions (e.g., American Psychological Association, Council for Social Work Education) to provide a roadmap for trauma competency. Some of these organizations provide competencies for trauma specialists through certifications only available to licensed professionals. Other organizations have developed competencies focused on working with individuals who have specific diagnoses (e.g., post-traumatic stress disorder and acute stress disorder), and yet others cover topics specific to unique populations (e.g., trauma competency with children). Deciding which competencies and organizations to draw from when constructing trauma education courses for masters-level counselors may be particularly complicated because master's level counselors are generalists after graduating and may be unsure what populations they will serve once they enter the counseling profession.

Organizations have developed specialized training, competencies, and workshops to increase mental health proficiency in trauma, and it has become obvious that trauma training is multifaceted (Courtois & Gold, 2009). Practitioners who work with populations that have experienced trauma must understand the emotional, behavioral, cognitive, and somatic responses

that accompany the exposure and develop skills to implement material (Courtois & Gold, 2009). The following section will briefly describe various trauma competencies that have contributed to the training of counselors and allied professionals. For each standard or competency set, I attend to the organization that published the competencies, the year the organization published them, how they were developed, and for whom the competencies are intended.

Educational Standards

The American Mental Health Counselors Association (AMHCA; 2017), Council on Social Work Education (CSWE; 2008), and American Psychological Association (APA; Cook, Newman, & the New Haven Trauma Competency Group, 2014) have outlined trauma competencies for educational curricula. These competencies include the skills, knowledge, and awareness necessary for entry-level practitioners in the respective fields to support clients who have experienced trauma. These competencies were not intended to replace minimum general competency necessary in each field; rather, they were added due to the realization of the pervasiveness of trauma in clients' lives.

American Mental Health Counselors Association (AMHCA). AMHCA, a division of the ACA created "education and training standards for mental health counselors in 1979" which CACREP adopted in 1988 as the first accreditation standards for what is now clinical mental health counseling, a concentration nestled in the larger profession of counseling (AMHCA, 2016, p. 3). In addition to supporting current provisions indicated in the 2016 CACREP Standards for all counselors (2.3.g, 2.5.m, 2.7.d), the AMHCA standards (2016) recommend additional education training in the "biological bases of behavior (i.e., psychopathology and psychopharmacology), trauma, and co-occurring disorders" (p. 5) for counselors specializing in clinical mental health. The current standards of practice state that students can complete this

additional training as a component of graduate work, in post-master's degree coursework, or in continuing education courses (AMHCA, 2016).

AMHCA includes trauma training standards in the recommended standards (AMHCA, 2016). The preamble for the trauma training standards states that treatment of trauma is an essential aspect of clinical mental health because many clients seeking mental health services are attempting to manage symptoms associated with traumatic stress (AMHCA, 2016). The standards go on to say that "...all competent clinical mental health counselors possess the knowledge and skills necessary to offer trauma assessment, diagnosis, and effective treatment while utilizing techniques that emerge from evidence-based practice and best practices" (AMHCA, 2016 p. 18-19).

The Advancement of Clinical Practice committee originally created these standards, whose responsibility is to revise and amend the clinical standards of practice (J. Harrington, personal communication, July 11, 2018). This committee is composed of clinical professionals, CEs, and retired professionals in the field of counseling. The committee did not revise the trauma standards in 2016 but revised them in 2018, the committee has sent the proposed standard amendments to the AMCHA board and are waiting for the board to publish them to the public (J. Harrington, personal communication, July 11, 2018). The standards as they are published currently are divided into two categories (knowledge and skills) with eight knowledge standards and seven skills standards and are located in Appendix A. All Educational and Practice Standards in this chapter are located in the appendix of this document.

New Haven Competencies. In 2014, sixty psychologists, psychiatrists, and social workers gathered at Yale University for a trauma education conference to create trauma training and practice competencies for mental health professionals (Cook, Newman, & the New Haven

Trauma Competency Group, 2014; Cook, Newman, & Gold, 2014). There were no any of the national counseling associations present (Cook et al., 2014; Webber et al., 2017). The resulting *New Haven Competences* featured a set of guidelines for education and training that articulated essential components and skills psychologists needed to support clients who have experienced traumatic events (Cook & Newman, 2014). These competencies include knowledge, skills, and attitudes for minimum competency of entry-level psychologists regardless of the model of trauma-informed or trauma-specialized care being provided (Cook et al., 2014; Cook & Newman, 2014). Unlike the AMCHA competencies, the New Haven Competencies were not intended for specific concentrations or subsets of psychologists, rather, they applied to all entry-level practitioners.

The working group created competencies that split into six categories with five-to-eleven knowledge, skills, and attitudes embedded in each category. The six categories are: (a) cross-cutting trauma-focused competencies, (b) scientific knowledge, (c) psychological assessment, (d) psychological intervention, (e) professionalism, and (f) relational and systems (Cook et al., 2014; Cook & Newman, 2014). The APA adopted these competencies in 2015 as recommendations to guide curriculum development for entry-level psychologists. The competencies are the most comprehensive of the helping professions with a total of 48 individual competencies embedded in the larger categories (Appendix B).

Council on Social Work Education. The CSWE is the overarching body for educational standards in the field of social work and stipulates a competency-based approach to education (CSWE, 2008). In 2008, CSWE created ten core competency areas referred to as the Educational Policy and Accreditation Standards (EPAS) to create the foundation for minimum practice effectivity in the field of social work for all students regardless of concentration area. Much like

the CACREP standards, these competency areas were not intended as a specialty subset but rather for general competency as professional social workers.

Due to the need for social work programs to have guidance in creating curricula for concentration areas such as a trauma, the National Center for Social Work Trauma Education and Workforce Development directors asked for support of an advanced trauma concentration (CSWE, 2012). In 2011, a working group comprised of deans, faculty members, and four invited trauma experts created curriculum guidelines for the trauma concentration. The group created trauma competencies that corresponded to the 10 competency areas originally established in the EPAS to reinforce the EPAS structure that advanced practice evolves from a foundation of the overarching competencies and is not divergent from the minimum competency all social work practitioners should meet. After many revisions, the document was disseminated in 2012, which marked the creation of the *Advanced Social Work Practice in Trauma* brochure. The working group created these guidelines to frame curriculum development in social work programs that desired to offer a concentration in trauma (CSWE, 2012) (Appendix C).

Licensed marriage and family therapists. The American Association for Marriage and Family Therapy (AAMFT) has not published a set of educational guidelines to inform curriculum development for entry-level or specialized marriage and family counselors (C. Zbikowski, personal communication, July 5, 2018). However, they have published fact sheets on PTSD and sexual assault on the AAMFT website to help keep their practitioners informed. These fact sheets support professionals in practice, much like the next section of competencies is intended to do. Next, I review competencies and professional practice standards endorsed by professional organizations and intended to inform the practice of professionals who work with individuals that have experienced traumatic events.

Professional Practice Standards

Various professional associations, nonprofit organizations, and government organizations have created competencies to guide clinical practice with children, adults, and families that have experienced trauma (Department of Veterans Affairs (VA) and the United States Department of Defense (DOD), 2010/2017; NCTSN Core Curriculum on Childhood Trauma Task Force, 2007; SAMHSA, 2014). These guidelines are not necessarily meant to impact curriculum development as much as they are intended to support professionals across disciplines who deliver care and collaborate across disciplines. Counselors who teach trauma courses may incorporate training modules from various private, government, and public organizations into their course design as supplemental learning material. An understanding of these modules is potentially important to understand how counselors are being instructed about trauma theory and practice. Below I describe the aim and scope of these guidelines including the populations they were created to support, how they were created, and practitioners for whom they are intended.

American Counseling Association. ACA is the association that represents the interests of professional counselors in the United States. Although ACA does not currently have any trauma-specific professional competencies to guide the practice of professional counselors, ACA has charged a task force with creating professional standards for practicing counselors to be completed in the 2018-2019 fiscal year (C. Barrio-Minton, personal communication, July 6, 2018). In time, these standards may be adapted by CACREP and other professional organizations. Like the ACA competencies that may be adapted to impact both practitioners-in-training and practicing clinicians, the next set of competencies also serves that duel role.

National Center for Traumatic Stress Network (NCTSN). One of the notable crossovers between educational and professional competencies are those endorsed by the

National Center for Child Traumatic Stress (NCTS). In 2010 the NCTS published the original core curriculum on childhood trauma. NCTS intended for the *Core Curriculum on Childhood Trauma* to be utilized to train graduate students and practicing professionals alike (Layne et al, 2011). These competencies were created by a task force made up of members and affiliates of the National Child Trauma Stress Network (NCTSN) and were endorsed in 2007. The taskforce continues to meet at every conference, and a second expert panel revised the curriculum in 2011, with a revision released to the public in 2012.

This core curriculum is intended for all mental health professionals or students and outlines foundational knowledge and case conceptualization skills needed to inform interventions when working with children and families who have experienced traumatic events (NCTSN Core Curriculum on Childhood Trauma Task Force, 2012). After creating a login on the NCTSN, individuals can self-pace through interactive online modules that cover the 12 core concepts, complexity of the traumatic experience, and trauma and loss reminders. Each section includes a presentation, evaluation, and certificate of completion. This training is free and intended for mental health professionals to provide a shared vocabulary across the helping professions; it does not include any skills-based training such as supervised clinical practice or participant demonstrations. I include the 12 core components in Appendix D.

National Center for Biotechnology Information (NCBI), National Library of Medicine (nlm), National Institute of Health (NIM), and SAMHSA. These four government health agencies jointly promote and publicize the *Trauma-Informed Care in Behavioral Health Services Treatment Improvement Protocol* (TIP). The TIP series is intended as a framework for treatment providers across disciplines and includes a literature review, protocol manual, protocol brief, and quick reference guide. Chapter Two of the *Trauma-informed Care in Behavioral*

Health Services TIP includes competencies for service providers that include awareness and skills needed to work with individuals from a trauma-informed perspective (SAMHSA, 2014). The preamble to the competencies stated that they were sourced from Hoge et al., (2007) who outlined competencies necessary for clinicians to be effective in a trauma-informed care system (SAMHSA, 2014). The TIP includes trauma awareness and skills necessary to work from a trauma-informed perspective with clients (Appendix E).

Multiplying Connections Initiative - Health Federation of Philadelphia. Much like the competencies created by NCTSN, the Multiplying Connections Cross Systems Training Institute (CSTI) created a set of competencies specific to working with children who have been exposed to traumatic experiences. These competencies address the fact that trauma can have a tremendous impact on young children and that services for this population must be developmentally appropriate (Multiplying Connections Cross System Training Institute, 2008). These competencies include values, attitudes, knowledge, and skills that are necessary for professionals who work with children who have experienced traumatic events (Multiplying Connections Cross System Training Institute, 2008).

A working group from the Health Federation of Philadelphia developed a consensus draft of proposed competencies after a review of mental health, violence and injury prevention in public health, child welfare, and early childhood education literature. The competencies were finalized and approved after review and comment by a group of 35 trauma experts from a variety of fields including research and policy.

The intention of these competencies was to inform primary and secondary curriculum, organizational training, and professional development to ensure that social service systems (e.g., schools, department of child welfare) that support children have common knowledge, attitudes,

and values concerning trauma informed care. As with the other standards, the expectation is that agencies aim to create trauma-informed practices across service delivery by hiring, training, and supporting the strengths of each of the service providers to meet the competencies provided for optimal care (Multiplying Connections Cross System Training Institute, 2008). Currently, these competencies are being utilized to create the foundation for curriculum and training for social service agencies in Philadelphia (Multiplying Connections Cross System Training Institute, 2008). (Appendix F)

U.S. Department of Veterans Affairs. Department of Veterans Affairs and the United States Department of Defense (VA/DoD) disseminated the final set of competencies reviewed in this section (Appendix G). The VA/DOD created these clinical practice guidelines (CPG) to support professionals in accessing research-supported information to aid in decision making (VA/DoD, 2010/2017). In contrast to the other competencies that are specifically for children or those within a distinct profession, this set of competencies is designed to help clinicians assess, manage, and intervene with individuals who meet diagnostic criteria for post-traumatic stress disorder (PTSD) or acute stress disorder (ASD) and receive services from VA and DoD health care systems (VA/DoD, 2010/2017).

Because the writers of these competencies aimed them at supporting any professional working with an individual diagnosed with PTSD or ASD, they are broad enough to cover competencies necessary for psychologists (e.g., testing), psychiatrists (e.g., prescribing medication), counselors (e.g., therapeutic counseling modalities), and social workers (e.g., social services collaborations) (VA/DoD, 2010/2017). I have included in Appendix G the competencies that align with the scope of practice for master's level counseling students who may be working in VA/DoD settings with individuals diagnosed with PTSD or ASD.

Content Analysis of Competencies

There are uniquenesses and themes in each of the professional helping fields and professional practice trauma competencies. To gain a better understanding of overlap and divergence, I thematically categorized all the educational and professional trauma competencies utilizing open coding by word choice, skill, knowledge and/or desired learning outcome, collapsing or expanding categories as themes emerged or became too similar (See Appendix A for content analysis of competencies codebook). Finally, I color coded themes to easily distinguish which competencies belonged to each helping profession or organization. A total of nineteen themes arose which included *research, testing, prevention, trauma theory, vicarious trauma, adapt/communicate information, ethical practice and professional boundaries, biological impact, cross-discipline collaboration, developmental consideration, awareness/prevalence/foundational knowledge, self-awareness and characteristics of provider, approach, advocacy/policy, cultural factors, impact on system, strengths-based/ collaboration/ protective factors, assessment and diagnosis,* and *interventions.* (See Appendix B for a chart of the competencies sorted by theme).

Each of the professional helping fields and organizations approach client care from a distinct paradigm. Over time, clinical practice has continued to overlap, but the training emphasis and types of services provided by each discipline and organization reflect the distinctions in their field. Thus, the following sections briefly introduce the historic paradigms for the helping professions and organizations including a short discussion of the training competencies that align with those paradigms. I mention the theme categories that are overrepresented by each field or organization within the historical paradigm subsections as evidence of the field or organization enacting their mission or goal through stated educational or practice competencies. Furthermore,

I mention the theme categories in all fields and organizations after I introduce each paradigm; I attend to all 19 themes. Although there are differences, I found several themes across trauma competencies which I discuss at the end of this section.

Educational competencies. Counseling, as the newest of the helping fields, originated from the vocational guidance movement, and expanded to support clients with a variety of developmental and wellness concerns. Regardless of treatment setting, counselors share a common goal to practice from a wellness and developmental perspective (Kaplan, Tarvydas, Gladding, 2014). As previously mentioned, ACA does not have trauma education competencies for counselors in general. CACREP (2016) mentioned 3 educational standards for all master's level-counselors, in addition, to mention of trauma in the specialty area standards, and AMHCA (2016) provided a set of educational trauma standards for mental health counselors specifically. Of the three groups with trauma competencies training standards (counselors, social workers, and psychologists), AMHCA has the least amount with a total of fifteen (AMHCA, 2016). Of the fifteen total, three standards addressed the need for counselors to understand the *developmental aspects* of trauma and how that impacts clients, which aligns with a counseling paradigm of working from a developmental perspective (AMHCA, 2016). An additional area where the AMHCA competencies are overrepresented in comparison with the overall number of competencies in the discipline are the three in the *assessment and diagnosis* theme category.

An emphasis on assessment and diagnosis aligns more with the training demands of clinical mental health counselors specifically, in contrast to counselors who work in other settings that may not require as much attention to assessment and diagnosis (e.g., schools). One-third of AMHCA 's competencies represented *developmental concerns* and *assessment and*

diagnosis, which indicates an emphasis on those areas for training mental health counselors to work with clients who have experienced trauma (AMHCA, 2016).

Professional psychology has historically focused on psychological testing, assessment, evidence-based practice established through empirical research, and collaboration with medical professionals (Benjamin, 2005). These themes were evident in the overrepresentation of training competencies in thematic domains of *testing*, *cross discipline collaboration*, and *intervention* (APA, 2015). In addition to those historically connected to the discipline, there were also high representations of training competencies in *advocacy* and *policy*, *the ability to communicate and educate* about trauma and its impact, and *preventive measures* (APA, 2015). The APA has the most comprehensive list of training competencies out of the three professions examined, so a representation of themes that are historically aligned with the field and some that are not is to be expected with the broad scope of the standards.

Social work is deeply rooted in principles of systemic change, supporting underrepresented populations, social justice, preventative practice, and advocacy (Axinn & Stern, 2007). These themes are seen through an overrepresentation of competencies in the thematic categories of *advocacy and policy*, *systemic impact*, and *cultural factors*. There were no training competencies that specifically mentioned preventative strategies (CSWE, 2008). Social work was the only discipline that mentioned practitioners should have the ability to conduct practice-informed research and utilize data to make clinical decisions. Additionally, they were the only educational discipline to mention the impact of *vicarious trauma* for clinicians and *systems* working with individuals who have experienced traumatic events (CSWE, 2008).

Keeping these paradigms in mind, it would be expected to see a slightly different emphasis in preparation from each of the distinct helping fields. Overall AMHCA had 15

competencies, CSWE had 10 that were broken into 28 categories due to multiple themes being represented in each competency, and APA had 45 distinct competencies. The number of competencies in each field impacts the specificity of training standards with AMHCA standards tending to be broader and APA standards being very specific.

Professional practice competencies. Much like the paradigms of the professional helping fields, the organizations that support clinical practice are driven by the mission and vision of their institution. Each organization that provides recommendation for clinical practice in trauma counseling has a unique philosophical framework that drives how they believe their institution can support clinical practice in this area. The next section will briefly introduce the mission and vision of each institution and the competency alignment. Much like the educational competencies, there are several differences in depth and focus of the trauma competencies endorsed by each organization, but there are also many themes that arose across both educational and practice competencies.

The VA and DoD are United States government agencies with a primary purpose to "...provide lethal joint force to defend the security of our country and sustain American influence abroad" (https://www.defense.gov/) and to care for American veterans and their families (U.S. Department of Veterans Affairs, 2018) respectively. The Veterans Benefits Administration (VBA), National Cemetery Administration (NCA), and the Veterans Health Administration (VHA) are the three administrations that form VA. The VHA is the world's largest health care system and provides training for nurses, doctors, and allied health professionals that work in outpatient, inpatient, and telehealth care for United States Veterans (U.S. Department of Veterans Affairs, 2018). The VHA's emphasis on hospital-based clinical services aligns with their historical and paradigmatic approach that the majority of the trauma competencies in the

clinical practice guidelines were categorized into the themes of *evidence-based approach, assessment and diagnosis, and interventions*.

The competencies provided by the DoD and VA (2010/2017) also take a unique perspective as the only competencies specifically for practitioners that provide services to individuals that meet clinical threshold to be diagnosed with post-traumatic stress disorder (PTSD) or acute stress disorder (ASD). This is important for the *prevention* theme as two of the DoD and VA (2010/2017) competencies were in that category and unlike the other agencies, the competencies are not focused on prevention of exposure to traumatic experience, but on clinical interventions that could be utilized after a traumatic event is experienced to prevent the development of ASD or PTSD. Much like the DoD and VA competencies (2010/2017), SAMHSA is a government organization that specializes in serving a specific population and allocates much of its resources toward assessment and intervention (SAMHSA, 2014).

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency within the United States Department of Health and Human Services. The agency's primary mission is the advancement of behavioral health through the reduction of substance abuse and mental illness in US communities (SAMHSA, 2014). The United States congress established SAMHSA in 1992 to increase accessibility of information, research, and services concerning mental health and substance abuse issues. Through strategic initiatives, interagency activities, advisory councils, and social media campaigns the organization aims at increasing awareness and services for communities impacted by substance abuse and mental health issues (SAMHSA, 2014). Aligning with this mission, the trauma competencies endorsed by SAMHSA are primarily concerning *increasing awareness and knowledge* of trauma, *collaboration* strategies, *interventions*, and *assessment and diagnosis*.

The unique feature of SAMHSA competencies is that they mention substance abuse in five of the trauma competencies, which is more frequent than any of the other educational or practice standards examined. Much like the specialty services for veterans and individuals managing substance abuse issues, the following two organizations provide services for a specific population. The National Child Traumatic Stress Network (NCTSN) and Multiplying Connections Initiative provide services to children and families who have experienced trauma. Naturally, the shift in population changes the shift in the emphasis of the trauma competencies.

The United States Congress created NCTSN in 2000 as part of the Children's Health Act. The primary mission was to increase the standard of care and access to services for children and families that had experienced traumatic events. The network focused on moving scientific research into practice as quickly as possible to improve care for impacted children and families (https://www.nctsn.org/about-us/who-we-are, n.d.). The Center for Mental Health Services, SAMHSA, and the US Department of Health and Human Services funded NCTSN. The NCTSN enacts its mission by providing services, developing resources and interventions, offering training and educational programming, collaborating with already established health systems, collecting data, informing public policy, and increasing public awareness (https://www.nctsn.org/about-us/who-we-are, n.d.). The network's emphasis on interventions for children and families aligns with their trauma competencies that focused on *impact to the system*, *assessment and diagnosis*, and *interventions*. The other organization that created competencies specific for children and families impacted by trauma is Multiplying Connections. Of the professional practice competencies, these two organizations were the only two that mentioned the impact that trauma has on the entire system including family and community members

(Multiplying connections cross-system training institute, 2008; NCTSN Core Curriculum on Childhood Trauma Task Force, 2012).

A group of health and child welfare leaders in the Philadelphia area founded the Multiplying Connections Cross System Training Institute. This group wanted to find ways to utilize the vast amount of scientific literature on the importance of meaningful adult relationships for children (Multiplying Connections, 2015). The mission of the organization is to create strategies and interventions to help support children in creating positive relationships with the adults in their lives. The organization enacts its mission by collaborating with community partners that provide services to children and families (Multiplying Connections, 2015).

Through the Cross Systems Training Institute, Multiplying Connections can provide training on trauma-informed techniques to professionals. The organization also offers opportunities for administrators to collaborate on ways to improve policy and practices to enhance systems that provide services to children and families. The final way that Multiplying Connections enacts their mission is through developing standards of practice that emphasize assessment guided services, such as the core competencies for trauma informed and developmentally appropriate practice that were examined for this current study. Multiplying Connections' broad mission to impact policy, clinical practice, and increase awareness are reflected in their trauma competencies (Multiplying Connections, 2015). With a total of 31 competencies, most of them were categorized in the themes of *interventions*, *strengths-based/collaborative*, *impact on systems, advocacy and policy*, and *characteristics/self-awareness* of the service provider. The organization had more competencies focused on *self-awareness or characteristics of the service provider* than any of the other competences examined. Additionally, Multiplying Connections (2015) had just as many competencies as SAMHSA

(2016) regarding *assessment and diagnosis* which reflects an emphasis on utilizing evaluation to guide service delivery for children.

The professional organizations had varying specificity to their trauma training standards. Overall VA and DoD had 23 competencies, SAMSA had 19, NCTSN had 10, and Multiplying connections had 31. Now that I have explained the uniqueness of each of the educational fields and organizations, the following sections will examine overlapping themes between the education and professional standards.

Themes across disciplines. There were six themes represented in most of the educational and organization standards: *biological impact of trauma, awareness of self and practitioner characteristics, evidence-based practice, cultural factors, impact on systems, strengths-based collaborative protective factors,* and *assessment and diagnosis.* This overlap indicates that these training areas hold importance regardless of practitioner paradigmatic emphasis and the mission of the organization.

Biological impact. The physiological impact of trauma has become a focal point in trauma informed care (Mulvihill, 2005). With developments in technology and a push for primary care doctors to begin recognizing the physiological signs of trauma and refer clients to mental health services, it has become imperative for practitioners to have a foundational understanding of how trauma impacts the body. Each of the educational competencies mention an understanding of the neurobiological, somatic, and psychological impact that trauma can have on a client (AMHCA, 2016; APA, 2015; CSWE, 2008). This includes affect regulation, development, relational, health behaviors such as substance abuse, and psychotropic medication (AMHCA, 2016; APA, 2015; CSWE, 2008).

The need for understanding the biological impact of trauma was emphasized much more in the educational competencies than the practice competencies. The only organization to mention the biological impact that trauma has was the NCTSN, which stated that it is important to understand that the reaction to trauma seen in children is linked to developmental neurobiology (NCTSN Core Curriculum on Childhood Trauma Task Force, 2012). This brings light to a misalignment between the educational emphasis of mental health practitioner training and what organizations focused on practicing professionals endorse as necessary competencies. In contrast to the mismatch between educational and professional practice competencies in this current category, the next section examines a theme that is shared across five of seven competencies.

Awareness of self and practitioner characteristics. Each of the three educational fields had at least one competency stating that practitioners must know how their own trauma-related history may impact their ability to work with clients (AMHCA, 2016; APA, 2015; CSWE, 2008). Furthermore, the APA competencies (2015) addressed clinician dispositions such as attending with a non-judgmental presence and implementing non-avoidant strategies. Just as important as it is for practitioners-in-training, two of the professional standards also emphasized the need for practitioner self-awareness and disposition.

SAMHSA (2014) and Multiplying Connections Cross Training Institute (2008) outlined characteristics, beliefs, and awareness that are necessarily for practitioners to effectively support clients who have experienced traumatic events. These include the ability to recognize when a client's needs exceed scope of practice (SAMHSA, 2014), the belief that providing trauma-informed and developmentally appropriate services is important, the ability to examine personal beliefs about trauma and childhood adversity and having the perspective that childhood trauma is

a preventable health care problem (Multiplying Connections, 2008). Furthermore, Multiplying Connections (2008) postulated that practitioners must develop a specific interpersonal style while delivering interventions. Just as self-awareness and practitioner dispositions can go by many names so can the umbrella of evidence-based practice which is the next category examined.

Evidence based practice. Evidence-informed, research-informed, evidence-based, and research-supported are all terms used to describe clinicians utilizing the most up-to-date research to support their clinical practice. Each of the respective helping fields had at least one competency describing the need for practitioners to ensure that their approaches, treatments, assessment, conceptualization, and foundational knowledge were informed by current research (AMHCA, 2016; APA, 2015; CSWE, 2008). This overlap speaks to the cross discipline need for practitioners-in-training to be able to read, interpret, and put research into practice in their respective fields.

Three of the four organizations endorsed *evidence-based practice* in their respective competencies. SAMHSA, Multiplying Connections, and the DoD/VA all mentioned the use of evidence-based practice as an aspect of practitioner competence. They each outlined that practitioners should be able to identify and exhibit models, interventions, and treatment practices that demonstrated efficacy via empirical evidence (Multiplying Connections Cross System Training Institute, 2008; SAMHSA, 2014; VA/DoD 2010/2017). Examples of these practices include grounding techniques and relaxation tools (SAMHSA, 2014), Sanctuary Model and Community Connections Model (Multiplying connections cross-system training institute, 2008), and collaborative care models provided within primary care settings (VA/DoD, 2010/2017). These are all models and interventions that have been found to be effective through empirical

research for the specific populations that these institutions serve. Cultural factors are a theme that shares less definitive boundaries but seems to be equally as important based on the number of educational competencies.

***Cultural factors*.** The largest category of shared educational competencies were *culture factors* when working with clients that have experienced traumatic events or understanding the unique factors of each client. Social work and psychology both had 4 and counseling had 3 competencies referring to culture or client uniqueness (AMHCA, 2016; APA, 2015; CSWE, 2008). These competencies included an understanding of intersectionality of client identities, oppression, intergenerational and historical trauma, marginalization, and the ability to tailor interventions that align with clients' cultural values (AMHCA, 2016; APA, 2015; CSWE, 2008). Cultural awareness and an understanding of client uniqueness are an emphasis in the teaching content of each of the helping fields as evident by the number of competencies aimed at attending to this theme. Although this is an emphasis in the educational competencies, it was not as prevalent in the professional practice competencies.

In general, there was much less of an emphasis on *cultural factors* in the professional practice standards than in the educational standards. Only two of the four organizations mentioned cultural competence in their trauma training standards. SAMHSA and National Child Traumatic Stress Network each mentioned cultural awareness as a component of trauma competency once. SAMHSA (2014) stated that practitioners should be able to demonstrate knowledge regarding how clients interpret trauma differently depending on culture and how this can impact individuals' attitudes toward mental health treatment. Additionally, NCTSN drew attention to how clients integrate culture into their individual experience, response, and recovery from traumatic events (NCTSN Core Curriculum on Childhood Trauma Task Force, 2012). This

mismatch in competency theme draws attention to the different emphasis in educational and professional practice competencies expectations, with the professional practice competencies tending to be much more action oriented (e.g., *assessment, diagnosis, intervention*) than conceptual (e.g., *developmental, cultural, and biological*). One theme that straddles the line between conceptual and action-oriented is impact on the system. This theme can be interpreted as a way to conceptualize the impact of trauma and a place of convergence for intervention, assessment, and environmental factors.

***Impact on system*.** An overarching focus of trauma-informed care is the ability to conceptualize client symptoms and distress within context (SAMHSA, 2014). In broad terms, trauma impacts not only individuals but also their communities, families, and social service systems with which they engage (CSWE, 2008; SAMHSA, 2014). Practitioners-in-training must understand that they are always working within a system that has the ability to re-traumatize, and trauma happens within a larger social context (AMHCA, 2016; APA, 2015; CSWE, 2008). Understanding that context shapes the way individuals respond to traumatic events, perceive feelings of safety and trust in the therapeutic relationship, and engage in treatment is a shared educational competency in the helping fields (AMHCA, 2016; APA, 2015; CSWE, 2008). Mention of trauma's impact on the system was limited to just two professional practice sets of competencies which addressed the needs of families and children primarily.

The two organizations that emphasized *impact on systems* in their trauma competencies were the National Child Traumatic Stress Network (2012) and Multiple Connections (2008). Both of these organizations focus on practitioners that provide services to children and their families which aligns with a need for practitioners to be competent in a systemic perspective of trauma. These competencies include an understanding of how traumatic experience impacts

children in multiple circumstances, traumatic events generate adversity that expands beyond the initial event, trauma impacts the family and the entire caregiving system (NCTSN Core Curriculum on Childhood Trauma Task Force, 2012), and trauma impacts multiple generations and caregivers should be involved to maximize recovery for children (Multiplying connections cross system training institute, 2008). These first five categories had more educational competencies than professional practice competencies. The following two categories shift and represent the two thematic categories that had all seven competency sets examined represented.

***Strengths-based/collaborative/protective factors*.** Client empowerment and collaboration is another cornerstone to trauma-informed care (SAMHSA, 2014). Each of the three educational disciplines featured competencies that expressed the need for clinicians to work from a *strengths-based* perspective in an attempt to reduce client shame and increase resilience throughout the therapeutic relationship (AMHCA, 2016; APA, 2015; CSWE, 2008). They go on to state that by assessing *protective factors* and ways of coping, clinicians can support clients in utilizing their resources and promoting skills that will lead to long-term growth (AMHCA, 2016; APA, 2015; CSWE, 2008). This category differentiates itself from the intervention categories by describing more of an overarching strengths-based perspective than a specific therapeutic intervention or method. Just as it was emphasized in all three of the educational standards, strengths were mentioned in all of the professional competencies.

Included in the professional practice trauma competencies are the need for practitioners to utilize *protective factors* to reduce the impact of trauma (NCTSN Core Curriculum on Childhood Trauma Task Force, 2012; SAMHSA, 2014), empower clients through the use of choice during treatment (VA/DoD, 2010/2017; SAMHSA, 2014), support clients as they identify *strengths* and resources (SAMHSA, 2014), and work with clients to involve *collaborative*

partners in treatment planning including family members (VA/DoD, 2010/2017; SAMHSA, 2014; Multiplying connections cross system training institute, 2008). Although this theme did not have highest number of competencies represented in it, it was one of only two that captured all seven of the trauma standards examined.

***Assessment and diagnosis*.** The other thematic category capturing all seven competency sets was *assessment and diagnosis*. This category is different from psychological testing which is primarily the domain of clinical psychologists. *Assessment and diagnosis* encompass the collection and organization of client information concerning symptoms, distress, and history of exposure to traumatic events in a way that does not re-traumatize the client (AMHCA, 2016; APA, 2015; CSWE, 2008). All clinicians working with individuals who have experienced a traumatic event need to be able to organize information expressed in session and place that information into the framework of clinical diagnosis (if appropriate) and treatment planning (AMHCA, 2016; APA, 2015; CSWE, 2008).

Furthermore, the practice standards emphasize the need to understand the variety of symptoms that can be caused by exposure to a traumatic event (NCTSN Core Curriculum on Childhood Trauma Task Force, 2012) and demonstrate competency in screening for a history of trauma (VA/DoD, 2010/2017; Multiplying connections cross system training institute, 2008; SAMHSA, 2014). In the practice standards there is an emphasis on recognizing and assessing symptoms of trauma experience, but also providing a safe environment in recognition that trauma elicits feelings of danger, and clients should feel safe throughout the assessment process to ensure an accurate diagnosis (Multiplying connections cross system training institute, 2008; SAMHSA, 2014).

Summary. There were three areas emphasized more often in the practice competencies than the training competencies: *assessment and diagnosis, intervention*, and a *strengths-based perspective focusing on protective factors and collaboration*. Each of the four organizations endorsed practice competencies concerning the need for *interventions* that ensures a sense of safety for the client, are non-confrontational, organized, increase coping skills, reduce stress, and teach new skills for soothing and grounding (VA/DoD, 2010/2017; Multiplying connections cross-system training institute, 2008; NCTSN Core Curriculum on Childhood Trauma Task Force, 2012; SAMHSA, 2014). The commonalities in *assessment and diagnosis* and a *strengths-based perspective focusing on protective factors and collaboration* are mentioned above.

There is much overlap and divergence in the trauma competencies examined. In some cases, the organizations aimed their competencies for specialized populations like children and families or veterans. In other cases, they focused on a specific helping profession like counseling, social work, or psychology. By looking at each of the competencies and categorizing them by theme, it was easier to see areas of commonality and difference. Regardless of the emphasis, it appears important from the competencies that practitioners understand *interventions*, *assessment and diagnosis*, and working from a *strengths-based perspective*. In addition to those, the educational competencies placed emphasis on attending to the *system* and working from a *culturally competent perspective*. With a base in the competencies that educators use to frame the content in their classrooms, the next section will examine the literature on current practices in teaching trauma theory and practice to graduate students in the three helping fields (e.g., counseling, social work, psychology).

Trauma Education

The following sections examine trauma education in the fields of counseling, psychology, and social work. I want to note that there are differences in the length of training of psychologists in contrast to professional counselors or professional social workers. For professional counselors and professional social worker's, the clinical degree is a master's degree (https://www.counseling.org/PublicPolicy/WhoAreLPCs.pdf, n.d.; https://www.bls.gov/ooh/community-and-social-service/social-workers.htm#tab-4, n.d.). The 2-3 years of graduate level training includes all clinical and foundational knowledge necessary to be provisionally licensed or practice under supervision in most states. After that, states specify clinicians acquire a certain amount of supervised clinical hours prior to practicing independently. During this time there are no formal training obligations other than yearly professional development requirements satisfied through conference attendance, workshops, webinars, and other activities approved by state licensing boards.

In the field of psychology, the clinical degree in most states is a doctorate. There are options to obtain a terminal master's degree in psychology, but most state licensing boards require a doctorate to practice in a clinical capacity (http://www.apa.org/education/grad/faqs.aspx, n.d.). Most clinically focused psychology programs end with a yearlong internship or postdoctoral experience where the focal point is intensive clinical practice under supervision. The average length of formal training for a professional psychologist is five to seven years post bachelor's degree (http://www.apa.org/education/grad/faqs.aspx, n.d.). The additional three to five years of formal training for psychologists allows for more time to integrate trauma education into the curriculum and is an important point to be aware of moving forward. Additionally, the intensive internship

component at the end of the psychology doctorate offers time for supervision, monitored caseloads, group consultation, and additional structured learning opportunities that may not be available once an individual graduates and enters the world of work.

The educational training models examined in the following sections were created due to the increase in literature on assessment and diagnosis, treatment, societal impact, and adverse symptoms associated with trauma exposure (Asmundson et al., 2000; Bowman, 1999; Brett, 1996; Buckley, Blanchard, & Hickling, 1998; Davidson, 2000; Davidson & van der Kolk, 1996; Herman, 1997; Sherman, 1998; Taylor, Thordarson, Maxfield, Fedoroff, & Ogrodniczuk, 2003; Van Etten & Taylor, 1998; van der Kolk, MacFarlane, & Weisaeth, 1996). Additionally, there has been a focus on the impact working with individuals that have experienced traumatic events has on helpers like case workers, counselors, psychiatrists, and psychologists; this impact called vicarious trauma or compassion fatigue is a real risk for those providing services to individuals that have experienced trauma (Figley 1995, 2002; McCann & Pearlman, 1990; Saakvitne & Pearlman, 1996). The following sections will review empirical and conceptual literature on trauma education in counselor education, psychology, social work, and end with non-discipline specific educational recommendations.

Counselor Education

There is limited literature on teaching trauma theory and practice in counselor education. The available trauma-specific training literature focused on school counselors (Lokeman, 2011), specific populations such as survivors of sexual abuse (Kitzrow, 2002), specialty settings such as integrated care in a hospital setting (Veach & Shiling, 2018), and concepts for supervision to recognize vicarious trauma (Sommer, 2008). Authors addressed trauma theory and practice in general counseling in one article, but the content was not specific to trauma and attended to the

need for counselor preparation to support clients who have experienced crisis, disaster, and trauma-causing events (Greene, Williams, Harris, Travis, & Kim, 2016). There has been a dearth of research on what counselor education programs are doing to prepare counselors to work with clients who have experienced traumatic events, and it appears that the literature has not caught up with the emerging focus on competencies which I highlighted in the previous section.

Kitzrow (2002) surveyed CACREP accredited counseling programs regarding types of sexual abuse content and training provided in each program. Of the 68 programs that responded 9% (n = 6) required a course on sexual abuse, and 22% (n = 15) offered a course as an elective. The majority of respondents indicated that they offered neither an elective nor a required course that covered sexual abuse. Rather, instructors infused content into other coursework. This study corroborated previous studies (Pope & Feldman-Sommers, 1992; Priest & Nishimura, 1995) that found that many counseling programs do not provide training in counseling survivors of sexual abuse.

Kitzrow (2002) stated that research is needed to understand how best to teach sexual abuse content whether that is infused across the curriculum (Pope & Feldman-Summers, 1992) or in a standalone course. Regardless of the format, it is imperative that training is both didactic and clinical to provide an in-depth understanding of the foundational knowledge and skills necessary to support this population (Kitzrow, 2002). Kitzrow (2002) also noted that the material introduced in these courses can cause distress in both the faculty and the students. With that in mind, she recommended that instructors ensure they create a safe space and are sensitive to the issues that this course may bring up for students. This includes having referral resources for students and faculty that may need them. The infusion of trauma content across curriculum is

not unique to survivor of sexual abuse content. Lokeman (2011) found similar results when she examined trauma content in school counseling curriculum.

Lokeman (2011) examined access to and the importance of trauma training for school counselors-in-training (SCIT). The purpose of the dissertation study was to better understand which CACREP-accredited counseling programs offered content on trauma response for school counselors, how instructors provided content to students (e.g., infusion into the entire curriculum or standalone course), and the perceived level of importance of trauma content in the program. Lokeman (2011) surveyed 101 CEs on preparing school counselors to respond to students exposed to trauma. The majority (69.3%) of CEs reported their school counseling program infused trauma training in the curriculum. Furthermore, over one-half of programs that offered a stand-alone course indicated that it was offered as an elective. The topics most frequently covered in the courses include types of trauma, assessment, symptom recognition, compassion fatigue, trauma response skills, and legal and ethical considerations (Lokeman, 2011). Trauma-focused cognitive behavioral therapy (TF-CBT), cognitive-behavioral intervention for trauma in schools (CBITS), and multi-modal trauma treat program (MMTT) were the trauma sensitive interventions most commonly taught (p. 74). Both Lokeman (2011) and Kitzrow (2002) focused on whether trauma content was being taught, but they did not examine how the content was being taught. Greene, Williams, Harris, Travis, and Kim (2016) were the first in the counseling profession to narrow in on teaching pedagogy of trauma content in an already existing practicum course.

Greene et al. (2016) sought to investigate the efficacy of infusing trauma content into the curriculum, specifically examining the impact it had on self-efficacy when infused in the practicum course. The researchers implemented an unfolding care-based approach into the

practicum course through weekly video segments which exposed students to the case of Charlee; instructors connected these segments to out of class assignments. Participants in this study were 24 masters level CIT enrolled in a practicum course, with a total of 21 completing the pre and post semester assessment and 19 completing the mid semester assessment. The authors utilized the 41-item Counselor Activity Self-Efficacy Scales (CASES; Lent et al., 2003) to measure general feelings of self-efficacy and crisis specific feelings of self-efficacy. To target CIT crisis specific self-efficacy, the authors examined 6 -items in the CASES Client Distress subscale.

Students attended class once a week for 14 weeks with class time divided evenly between lecture and small group supervision for the first 7 weeks; instructors utilized all class time for small group supervision for the last 7 weeks. The case that was presented to the class was in the format of a 2-5-minute video of Charlee. The authors had an actress not affiliated with the university film the case segments to increase believability of the role. Instructors asked students to imagine Charlee was their client. The format of the video was set up so that Charlee spoke directly into the camera and no counselor was present in the video to better facilitate students' ability to imagine themselves as the counselor (Greene et al., 2016). The specific course content included:

> (a) intake and informed consent; (b) ethical and legal issues; (c) relationship building and diversity; (d) risk assessment and crisis intervention; (e) counseling during and after crisis, disaster, and other trauma-causing events; (f) clinical writing and documentation; and (g) conceptualizing and treatment planning. (Greene et al., 2016 p. 222-223)

Green et al., (2016) included trauma specific content in the *counseling during and after crisis, disaster, and other trauma-causing events* week. Instructors required students to read three trauma specific readings including the Psychological First Aid: Field Operations Guide (Brymer

et al., 2006). Additionally, students learned about Briere and Scott's (1996) three-part model in managing trauma exposure in session.

To measure impact of the course, Green et al. (2016) utilized qualitative data from the mid-semester assessment and quantitative data from the post and post assessment. The mid semester assessment instructed students to complete four free-response questions describing what they learned about intervention; differences between adaptive and maladaptive reactions; and the impact of crisis, disaster, and trauma-causing events on clients. Additionally, the authors reported that both general counselor self-efficacy and crisis specific self-efficacy measured by the CASES Client Distress subscale increased from pre-semester to mid-semester and mid-semester to post-semester. Furthermore, the authors compared their data with the normed score data and found that their post semester "CASES total scores were one standard deviation above the normed sample" (Greene et al., 2016, p.227). The authors did not include the analysis or results information for the qualitative data collected mid-semester.

This study is the only of its kind measuring the efficacy of teaching practice for trauma content in the field of counselor education. Unfortunately, this study included trauma, crisis, and disaster content which makes it difficult to know if this teaching format is effective for all of these content areas or more applicable for one or two other another. The authors also did not include a comparison group to display the efficacy of this teaching method over another style. Furthermore, completion of the practicum course often creates an increased sense of self-efficacy in master's students, so it is difficult to know how that impacted the results of this study (Greene et al., 2016). These first three articles examine the content and practices of coursework associated with trauma theory and practice. The following articles from Veach and Shiling

(2018), and Sommer (2008) look at implications of focusing on trauma in field placement and throughout the supervision process.

Veach and Shiling (2018) described a program that incorporated full time clinicians and field placement counseling students in an integrated care hospital setting providing trauma-informed mental health services. These services took place in a Level 1 trauma center with mentally stabilized clients that need "...mental health support, crisis intervention, grief support, depression and anxiety screening" (p. 88) and substance use screening. Through supervision, counselors increased their awareness of trauma and the impact it can have on clients and their families. Additionally, the authors provided knowledge about intervention tools and assessments that they integrated in the field placement training which aligned with collaborative and brief strengths-based trauma-informed approaches to increase resilience in clients.

In this field placement training model, supervisors slowly exposed new CITs to trauma patients and injury types to decrease the chances of secondary trauma (Veach & Shiling, 2018). Students began by shadowing other trauma counselors to have exposure to the assessment and counseling skills without feeling pressured to perform them. Additionally, CITs had weekly individual or triadic supervision sessions and daily debriefing sessions which could increase in frequency if they had a challenging case. Supervision consisted of review of audio recorded sessions, role plays, processing of emotions and experiences, live observations, on-going professional development training, and supervisor/peer feedback. The authors reported that self-care was an integral part of supervision with the concepts of vicarious trauma and secondary trauma introduced early in the supervision relationship. Supervisors were encouraged to actively monitor the caseloads of all CIT to ensure that they are assigned both trauma and non-trauma clients to reduce the risk of vicarious trauma (Veach & Shiling, 2018). Related, Sommer (2008)

described the importance of supervision acting as a safe guide and a training space for counselors to learn to recognize and monitor signs of vicarious trauma.

Sommer (2008) stated that CEs have an ethical responsibility to train counselors that can identify and manage symptoms of vicarious trauma. This is achieved by integrating information about crisis and vicarious trauma into master's field placement courses such as internship and practicum; doctoral supervision courses where students can be encouraged to recognize signs in their master's level supervisees; and in-class discussions about crisis and trauma. More specifically, Sommer's recommended having students provide topic specific presentations in field placement class that include vicarious trauma, self-care, and crisis response (2008). She encouraged instructors to use round-robin check-ins to gauge stress levels of students and to incorporate group mindfulness activities to model self-care practices. Sommer ended by recommending incorporating a reflective reading component that allowed students to connect their experiences with other counselors and simulated conversation about some of the challenges of working as a professional counselor.

The counseling profession has approached trauma education through development of specialty courses for survivors of sexual assault (Kitzrow, 2002), for counseling specialties like school counselors (Lokeman, 2011), in field placement settings such as hospitals (Veach & Schiling, 2018), and focused on counselor self-care in the supervisory relationship (Sommer, 2008). This varied approach is mirrored in psychology, which utilizes both field placement and in-class training to teach trauma content.

Psychology

Most psychologists, regardless of specialty, serve individuals who have experienced traumatic events (Cook, Dinnen, Rehman, Bufka, & Courtois, 2011; Courtois & Gold, 2009;

Newman, 2011). In a nationwide survey of psychologists, Cook et al., (2011) reported that 76% of their sample had worked with a client that had experienced a traumatic event, and 64% of respondents were interested in additional training in trauma. Although the sample size for this survey was relatively small (n = 276), these results align with the findings of other helping professions (CSWE, 2012; Greene, Williams, Harris, Travis, & Kim, 2016; Goodman, 2015). Trauma is far more common than was originally thought, and psychologists must know how to recognize, assess, and intervene to meet the needs of this population, which begins with adequate training in graduate programs (Courtois & Gold, 2009).

Courtois and Gold (2009) proposed a meta approach to integrating trauma-specific content across the psychology curriculum, beginning in undergraduate education and extending into graduate curriculum. In this model, undergraduates have exposure to trauma theory as a framework to understand how trauma can impact human development and to create a foundation of traumatic experience as common, instead of outside of the norm (Courtois & Gold, 2009). They recommend an inclusion approach over reliance on standalone courses or temporary courses due to the importance of creating continuity across content areas.

At the graduate level Courtois and Gold (2009) recognized the need to provide specialty courses for more advanced practitioners and provided suggestions for specializations in "foundations and trauma theory; trauma and its effects across the lifespan; biobehavioral responses and psychoimmunology; risk and resilience factors assess of trauma; emergency and disaster trauma… (p. 14)". The authors went on to acknowledge that training must be multifaceted and comprehensive featuring both didactic and experiential components. In addition to trauma specific training, an emphasis on self-care and coping strategies is important to

introduce throughout the curriculum to reinforce the need for taking care of one's own self while working with individuals who have experienced trauma (Courtois & Gold, 2009).

Mattar (2010/2011) also took a big-picture approach by focusing on the need to infuse cultural competence into trauma training for graduate level psychologists. Like Courtois and Gold (2009), Mattar provided broad guidance on important aspects of training that should be integrated across the curriculum regardless of the specific teaching or training method. Adding to the compelling rationale for integrating trauma training into psychology curricula (Courtois & Gold, 2009; Gold, 2009; Marotta, 2009), clients' abilities to adapt to trauma are impacted by personality, resilience, and resources that are dependent on contextual and cultural factors (Kirmayer, Lemelson, & Barad, 2007). Just as cultural competence is a necessary component of trauma intervention, it is one of the necessary components of trauma training (Courtois & Gold, 2009; Mattar, 2010). As competencies are incorporated into trauma training, Mattar (2010) asserted that it is imperative that pedagogy and training focus on cultural dimensions of trauma response and intervention as a critical piece of client care.

Mattar (2010) provided eleven suggestions for integrating culture into trauma research and training.

1. Benchmarks should be established to assess cultural competence for undergraduate, graduate, and fieldwork programs specifically in trauma psychology.
2. Educators should expand the definition of culture to include socioeconomic status, gender, level of acculturation and many other factors beyond ethnicity and race.
3. The field should ensure a diverse representation of individuals and expertise areas on accreditation boards, in national and state associations, at conferences, and in institutions

that specialize in the study of trauma such as the VA and International Society of Trauma Stress Studies.

4. Students should have an opportunity to learn about their own cultural backgrounds as well as exposure to research methods that allow them to understand the cultural background of others. In doing so, students should have an opportunity to critically analyze the culture of mental health to understand how that impacts communities through community partnerships.
5. Curricula should include courses that offer an in depth understanding of trauma and culture such as “the mental health impact of racism, colonialism, and social exclusion” and “the cultural brain: plasticity and development” (Mattar, 2010 p. 51).
6. Graduate trauma curricula and course work should integrate scholarly writing from international journals and include cross discipline training in anthropology or cultural psychology. It should also incorporate an international training experience in a non-Western country.
7. Students should become familiar with international research and promote research grants and training that enhance the understanding of indigenous cultures. This includes concepts of health and international models of mental health to develop awareness.
8. The field should include diversity in editorial boards for journals that specialize in trauma to decrease the chances of perpetuating marginalization of underrepresented groups.
9. Educators should address theories and systems of trauma psychology in texts and critically analyze current theory for transcultural applicability.

10. Awareness of cultural differences should be integrated into assessment curriculum so that students can avoid assessment bias and understand the impact that culture has on analyzing and interpreting data.
11. Educators should ensure that courses and research describe the process of recovery and the intergenerational transmission of trauma. They should also include mitigating factors such a religion and morality that impact coping. By ensuring that cultural considerations are infused, psychologists can offer better care for diverse individuals and communities (Mattar, 2010, p. 50-51).

In a follow-up article, Mattar (2011) focused on three areas to increase cultural competence in trauma care. For the first point, Mattar (2011) suggested there is a need to shift from the Western conceptualization of trauma and PTSD for clinicians to meet the needs of diverse populations (Drozˇ Rek, 2007; Joyce & Berger, 2006; Marsella, 2010; Summerfield, 2004). This goal can be achieved by embedding interdisciplinary culturally responsive content into psychologists' trauma training. This includes integrating material on the cultural perspectives of different populations impacted by trauma, asking students to reflect on their own background and culture, challenging the common ideology of avoidance and somatic symptoms in PTSD, and introducing a variation of trauma responses and how that is impacted by culture. The classroom should also include content on social, economic, and political factors in addition to conversations on power and privilege. Mattar provided NCTSN as an example of trauma competencies and curriculum that are culturally competent and can be utilized to inform classroom content and trauma training for psychologists in training. Lastly, Mattar suggested that psychologists address the need to adapt intervention models for specific populations with

whom they work. The following two foci shift from the classroom into research and systemic perspectives that inform interventions and techniques taught in the classroom.

The other two foci are research and organizational structure. Although these are not directly tied to the classroom, they impact what is being taught to students. The gap in research can be addressed by increasing the overall cultural competence of psychologists while they are in training programs, attending to culture in the research process by integrating qualitative research methods that capture the nuance of individual experience, and requiring researchers to be knowledge about the communities they are studying (Mattar, 2011). Culturally sensitive trauma psychologists reflect on how their clinical practice and research challenge or reinforce the systems of oppression that impact diverse clients and are sensitive to their role in that system (Mattar, 2011). Mattar (2011) ended by recommending organizations that train trauma psychologists and provide services to individuals that have experienced trauma examine diversity and cultural inclusivity at all levels of their institution. Mattar's (2011) recommendations are not classroom, field placement, or diagnosis specific. They are broad considerations for psychology educators constructing curriculum for graduate students concerning trauma. Other psychologists have focused on trauma preparation in context of field placement and classroom structure.

Training in field placement. The need for professionals that have received training in trauma is in high demand, and the structure provided by a doctoral or internship programs offers resources that make it possible to provide this type of training in a systematic way (Gold, 1997; Litz & Salters-Pedneault, 2008). Professionals receiving training from conferences and workshops may not be provided the depth or breadth of information necessary to effectively support these population (Courtois, 1997). Gold (1997) stated that professionals should not

worry about premature specialization by exposing students to trauma specific work during their training program because ultimately the foundation of the work is founded in sound clinical practice that can be generalized after the field placement experience if the student decides not to pursue trauma specific work in the future.

The Behavioral Science Division of the National Center for PTSD (NCPTSD) houses a specialty training program for psychology students interested in learning more about trauma work with veterans. After an extensive application process, interns and practicum students are trained to work with veterans diagnosed with PTSD due to exposure to combat-related violence and other war traumas (Litz & Salters-Pedneault, 2008). NCPTSD is a part of a training and research organization operated by the VA; its supported organizations train the largest number of trauma psychologists in the country (Litz & Salters-Pedneault, 2008).

The training practices of the organization focus on evidence-based practice, flexibility, and independent creative thinking. Curricula cover content areas of history of war and war trauma, models of PTSD and related disorders, risk and safety management, self-care, assessment, intervention, and research (Litz & Salters-Pedneault, 2008). Training modalities used in this setting are lectures prior to students being assigned a caseload which include topics such as introduction to the veteran population, the clinician administered PTSD scale, client issues related to PTSD, and lethality assessment. In addition to lectures, interns participate in clinical supervision with two supervisors once a week (Litz & Salters-Pedneault, 2008). Students also could present case presentations weekly to request feedback on challenging cases or demonstrate a clinical skill. The final aspect of the training model is the integration of research symposia where students can learn from national and international trauma researchers and are

encouraged to incorporate the empirical knowledge into their clinical practice (Litz & Salters-Pedneault, 2008).

The NCPTSD-BSD training programs have many strengths including resources, a diversity of training modalities and content areas, and access to a clinical population for consistent applied training opportunities. The challenges for this organization are in some ways unique to the program and in others challenges that overlap all trauma training. At the time of the article Litz and Salters-Pedneault (2008) stated that there were no outcome data to display the effectiveness of the training program outside of the overall data collected for accreditation purposes. Additionally, few trainees had the opportunity to practice exposure therapy despite its status as one of the treatment recommendations for PTSD. The supervision component of the program was only evaluated through feedback trainees provided about their supervision at the end of their internship. This omits the opportunity for interns to provide feedback mid-process and potentially impacts the course of the feedback they are receiving (Litz & Salters-Pedneault, 2008). A final area of challenge was recruitment of diverse trainees, an issue related to a more general issue faced by the psychology profession. Overall the comprehensive NCPTSD-BSD training program provides foundational knowledge, group and individual supervision, and skills practice to enhance graduate student competency to work with individuals who have experienced war trauma. Nova Southeastern University created a similar program to provide a comprehensive learning experience focused on trauma for students with a different population, adult survivors of sexual abuse.

In 1996 in response to the need for adequate services, the ACA Presidential Task Force on Violence and the Family recommended that psychology programs develop curricula, field experience, and graduate training that prepares psychologists to support families. Gold (1997)

outlined a model for training psychologists to work with adult survivors of childhood sexual abuse in a doctoral practicum or internship placement. This model was created through a synthesis of literature on abuse trauma and addressed knowledge and skills necessary to work successfully with this population. The Sexual Abuse Survivors Training Program (SASP) was located at Nova Southeastern University Community Mental Health Center with the goal of empowering clients through a collaborative treatment process. This facility was designed to provide group and individual counseling services facilitated by doctoral level practicum and interns to women and men over the age of 18 who are adult survivors of children sexually abuse (Gold, 1997).

Before beginning clinical work at SASP, students were provided a list of assigned readings to ensure they have basic knowledge of trauma and therapy specific to survivor treatment. The required reading includes texts on the trauma of incest, diagnosis and treatment of dissociative symptoms, and cognitive behavioral therapy to support individuals diagnosed with personality disorders (Gold, 1997). Additionally, students attended a three-hour weekly supervision and staffing meeting that focuses on discussion, feedback, and case presentation. Each trainee had one hour of individual supervision weekly or biweekly depending on developmental level. In general, the SASP program structure was very similar to the NCPTSD-BSD program structure (Litz & Salters-Pedneault, 2008) with one defining feature. The SASP students had 90-minute monthly processing meetings to address the distress trainees were feeling concerning client work. These meetings were one of the most important components of the SASP training program to help students understand, process, and monitor symptoms of vicarious trauma and compassion fatigue (Gold, 1997).

Both SASP and NCPTSD-BSD programs provided foundational knowledge of the population and specific issues related to trauma for that population; regular group and individual supervision which included case review and skills presentations; and a controlled setting where the program provided consistent access to a target population to enhance student training. For programs that do not have access to a training clinic, the bulk of learning occurs in the classroom. The following sections review techniques utilized to teach trauma in psychology classrooms that do not have a dedicated field placement component related to trauma.

Training in the classroom. Black (2006) presented a model for teaching about trauma theory and practice based on resourcing, titration, and reciprocal inhibition. This model was intended to be utilized in a university setting with graduate students over a 6-week period. Black (2006) noted that one of the main challenges for psychologists is exposing students to traumatic material during the learning process without increasing the risk of vicarious trauma from the course content. To address this issue, the author created a 6-week course on trauma that was piloted at the University of Victoria in 2005 with a class of 15 second-year graduate students who had completed coursework in theory, fieldwork, and self-care (Black, 2006).

The instructor designed the course to take into consideration the impact that "traumatic material might have on graduate students in the class" (Black, 2006, p. 268); specifically, there was a focus on preventing students from feeling overwhelmed by the content. The class met twice a week and included lecture, discussion, reflection, group presentations, and papers focused on various topics related to trauma. Black (2006) mirrored his classroom after the core principles of trauma counseling which included instilling personal choice and a sense of control in the classroom. Students were instructed that they would monitor and control the amount of traumatic material they were exposed to in the classroom. They were encouraged to take breaks

through leaving the classroom or turning their head if they felt they were beginning to become overwhelmed. Additionally, the instructor gave students descriptions of traumatic material prior to being exposed to them (Black, 2006). This created a predictable environment where students could opt in or out of content without being surprised in the classroom.

Furthermore, Black (2006) incorporated concepts of resourcing, titration of exposure, and reciprocal inhibition into his classroom. Resourcing was integrated into the course by projecting calming photography, playing videos of people laughing, and asking students to provide activities that they engage in when they are distressed. This material was interspersed as a break from the trauma content and was encouraged for students to utilize whenever necessary during the class. By incorporating these techniques into the classroom, Black (2006) was able to elicit an experience where students could use this material in real time to soothe their distress in the classroom while modeling how resourcing may be used with clients.

The concept of titration is based on the concept that clients (and students) should be exposed to measured amounts of traumatic experience broken up by periods of resourcing and grounding. This intermittent and intentional exposure is meant to decrease chances of re-traumatization and engage students in a cognitive process during trauma exposure (Black, 2006). An example given is pausing a movie in class to discuss the importance of intermittent exposure to traumatic experience while working with clients, again to parallel the process in the classroom with clinical practice.

Reciprocal inhibition is used in cognitive behavioral therapy to explain the phenomenon of pairing exposure to relaxation. Black (2006) postulated that with the increased performance anxiety already associated with graduate level training, educators should integrate relaxation and stress reduction into the course material so students are able to engage with traumatic material in

a less stressful way. Black noted deep breathing and taking students outside as two examples to incorporate this concept into the classroom.

The initial pilot of this course was confirmed a preliminary success via anecdotal evidence (Black, 2006). In a follow-up article, Black (2008) collected quantitative data from nine counseling psychology students who were enrolled in this trauma counseling elective The 14 items of the questionnaire aligned with 7 thematic categories:

> 1. Criterion A for PTSD, 2. Sense of groundedness during course, 3. Intrusive symptomology, 4. Beliefs about the world, 5. Perceived necessity of exposure to trauma material, 6. Personal and professional sense of competence, 7. Personal sense of safety in the world. (Black, 2008, p. 43)

As in the previous work, students met for 3 hours, twice a week over the course of 6 weeks. Course content included lecture, discussions, media presentations, exposure to traumatic imagery, skills demonstrations, trauma narratives, and trauma survivors as guest speakers (Black, 2008). Black integrated in a choice/voice/control technique adapted from Herman (1997) which provided choice in the classroom, a voice for all students to be heard, and as much control in the hands of students as possible. Assignments for the course included reflections on trauma literature, small group presentations, a research paper, and a case analysis of a popular film character with a history of trauma (Black, 2008).

Results of Black's (2008) study are preliminary due to sample size and the nature of self-report data. The majority of students felt it was necessary to be exposed to traumatic material (*n* = 7) in the course. Although, many students reported no intrusive thoughts due to the course material, over one-half experienced unwanted images of courses material at least once. All students indicated being able to stay grounded during the course and an increased sense of ability

to deal with trauma in their personal and professional lives. Despite limitations, Black (2008) was the first to examine pedagogy of a trauma for graduate level counseling psychologists.

Newman (2011) also taught a graduate level course on traumatic stress and authored a reflective conceptual article describing the experience. The aim of the course was to increase knowledge about traumatic stress, increase ability to critically evaluate trauma-related knowledge and practice, support students in developing an informed opinion on controversial subjects in trauma studies, encourage students to communicate information through professional means, and increase affective and intellectual awareness along with capacity to practice in the field of traumatic stress (Newman, 2011). The course met for three-hour class periods over a fifteen-week semester. Both basic and advanced ideology and techniques were addressed through a rigorous reading load which included texts such as *Trauma and Recovery* (Herman, 1992), *Principles of Trauma Therapy* (Briere & Scott, 2006), *The Etiology of Hysteria* (Freud, 1896/1984), *Handbook of PTSD: Science and Practice* (Friefman, Keane, & Resick, 2007), and additional articles as necessary.

The course began by focusing on foundational knowledge of the field of trauma including history, various trauma, compassion fatigue, and trauma related diagnoses. Next, the course moved into conceptual and theoretical frameworks. Discussion, class activities, and visual representation of models including "...developmental, psychological, cultural, attachment, cognitive-behavioral, dissociation, and psychoanalytic approaches…" (Newman, 2011 p. 237) were utilized to convey course content. Students spent time critically evaluating the models on cultural competency, testability, and any potential treatment limitations.

Over the following weeks, students learned about epidemiology, assessment, psycho-biology, psychophysiology, and the physical health impact of trauma. They discussed various

tools and critiqued epidemiology articles (Newman, 2011). The course then shifted into specific trauma exposure based on clinical and research topics that students may encounter including war, sexual violence, physical abuse, or intimate partner violence. The final weeks of the course focused on intervention and treatment and was largely driven by the interest areas of the class.

The syllabus clearly stated that students may experience some anxiety or discomfort about the material, reminded students of clinical resources, and provided some tips previous students used to manage affective processing aspects of the course (Newman, 2011). Newman stated that it can be helpful to remind students that, statistically speaking, there are several survivors sitting in the room. Students were also introduced to the concept of vicarious trauma early in the course to create an open and ongoing discussion about the impact trauma can have on helpers. Newman encouraged students to reflect on and monitor their own emotional reaction throughout the semester so that they can provide the highest quality care to clients. In addition to the affective component, the course was designed to encourage intellectual tolerance. As the instructor, keeping classes predictable with time limits, breaks, and adherence to the syllabus can help keep survivors in the course and students in general feel comfortable safe throughout the semester.

Although course designs were different here are many commonalities between Black (2006; 2008) and Newman (2011). Each course attended to the impact of the traumatic material in a different way. Black (2006/2008) structured his course to offer intermittent exposure to traumatic material building in mental and physical breaks to decrease student anxiety. Newman (2011) provided an explicit warning in the syllabus prior to the course beginning allowing students to understand the expectations of the course and how to seek help if necessary. Both

instructors provided a structured framework that ensured consistency of expectations and course material.

Additionally, there was opportunity for student input in both classrooms. Black (2006; 2008) asked students to provide coping strategies and ways to de-escalate that he integrated into the course material, and Newman (2011) used a pre-course survey to understand the needs of the students and tailor intervention and specific trauma sections of the course. Finally, both instructors stressed the need for the classroom to be a training ground for professionalism. Black (2006; 2008) mirrored his classroom from best practices in clinical trauma practice to provide students with a space to learn and utilize techniques that can be introduced to clients. Newman (2011) encouraged students to explore affective and intellectual components of the content being mindful that there were probably survivors in the room. With that reminder comes accountability that all students are functioning in a space where the respect and dignity of their classmates is imperative, just as it is in the therapeutic relationship with clients. As these scholars in the field of psychology have focused on trauma education in the classroom, the literature in the field of social work also primarily describes in-class teaching strategies of stand-alone courses and infusion across educational curriculum.

Social Work

The literature on teaching trauma theory and practice in social work is largely conceptual. Seasoned educators authored these articles which provided recommendations gathered from their years of experience in the classroom (Abrams & Shapiro, 2014; Cunningham, 2004; Gilin & Kauffman, 2015; Graziano, 2001; Marlowe & Adamson, 2011; Miller, 2008). In all, there is the limited empirical literature on the efficacy of these practices (Strand, Abramovitz, Layne, Robinson, & Way, 2014; Wilson & Nochajski, 2016). The social work literature on trauma

education diverges into two pedagogical categories: stand-alone trauma courses and trauma-specific or trauma-informed content infused across the curriculum.

I divide this section into those subcategories to provide an overview of those separate ideologies for teaching trauma theory and practice in social work programs. As I illustrate below, stand-alone courses featured several methods of learning theory including case-based design (Abrams & Shapiro, 2014; Cunningham, 2004; Graziano, 2001), problem-based learning (Strand, Abramovitz, Layne, Robinson, & Way, 2014), and student-centered learning focused on relational context (Miller, 2001). Infusion models did not include learning theory as part of their theoretical frame.

Stand-alone trauma courses. Abrams and Shapiro (2014) postulated that a case-based, clinically focused course on trauma theory and practice is the most effective method for preparing students to work with this population. Case discussions created active practice situations that allowed students to apply and adapt concepts, practice decision making skills, and communicate with colleagues. The authors proposed simulations to recreate ambiguous situations students would face in the field, allowing them to work through complicated alternatives in the safety of the classroom. The authors argued that case material helped supplement inconsistent preparation in field experiences and increased student confidence for the challenging work involved in clinical social work with individuals who have experienced trauma (Abrams & Shapiro, 2014).

The content in this course was broad and covered a wide range of topics including historical overview of trauma, trauma theory, interventions and treatment modality, and neurobiology of trauma. The course also covered specific traumatic experiences such as war,

historical trauma, childhood sexual abuse, natural disasters, domestic violence and rape, and mass violence (Abrams & Shapiro, 2014). Self-care was one of the final topics covered.

Throughout the semester, instructors continued to offer cases of their clinical practice to clarify complex topics in the classroom and model vulnerability (Abrams & Shapiro, 2014). Additionally, students learned how to organize and de-identify clinical cases to share with their classmates while focusing on the importance of the therapeutic alliance to intervene successfully. Students shared their cases each class meeting and class discussion followed to ask questions, offer suggestions, share resources, offer encouragement, and illuminate course content (Abrams & Shapiro, 2014). Through these class discussions, students learned to recognize signs of vicarious trauma and utilize self-care strategies as prevention in their own clinical work. Finally, the instructor incorporated guest speakers to expose students to first-hand accounts survivors' stories.

Much like the case-based model suggested by Abrams and Shapiro (2014), Graziano (2001) suggested utilizing case studies to enhance student learning for graduate level social work students in a casework course. Although this course was not specific to trauma, the author covered trauma content in each class and dedicated one class period to teaching trauma theory and practice. The author presented a case at the beginning of the course to which the students applied various theories, including trauma theory.

The instructor designed the single course period dedicated to trauma theory and practice to first introduce the concept and history of trauma, provide examples of situations or events that were typically perceived as traumatic, discuss trauma reactions and symptoms using case study, and address vicarious trauma. Graziano (2001) noted the importance of utilizing student disclosure of traumatic events in class as a teaching moment while validating the courage it took

to share a vulnerable experience in front of the class. The author advised instructors to ensure the course did not turn into a group therapy session, monitor the level of anxiety and discomfort, and manage a classroom that is safe for all students.

Graziano's (2001) recommendation to maintain a safe and supportive space to process student experience and trauma content is parallel to Miller's (2008) experience teaching a course on childhood sexual abuse over a period of eight years. Miller used these extensive experiences to offer a wealth of knowledge based on her reflective experience as an educator. Exposing students to traumatic material in the classroom requires students to "develop of range of necessary adaptations" (p. 161) which could include dissociation, disorganization, difficulties with reading course material, and disengagement. Additionally, the content can cause vicarious trauma which impacts students' worldview and sense of safety. Miller (2008) recommended:

> ...beginning the course with discussion of the material's emotional impact and conceptual challenges; normalizing a range of powerful reactions to the study of trauma, specifically childhood sexual abuse trauma; acknowledging that trauma study may unsettle students' vulnerabilities, earlier losses or disruptions, related issues, or their trauma histories; contextualizing a range of dissociative reactions to trauma study, regardless of abuse history; maintaining an ongoing assessment of class members as the material progresses, and continually checking in with class; setting clear boundaries of safety for the class in tone, pacing, and balancing of interaction; having students submit weekly journal entries, for student assessment of reactions to trauma material; anticipating students' difficulty as the material deepens; identifying the classroom as a learning environment, with necessary attention to one's own reactions, and clearly distinct from a therapeutic context; and

> addressing the class using language that acknowledges and assumes that both male and female students may be survivors of childhood sexual abuse. (p. 172)

In the same conceptual style, Cunningham (2004) suggested several guidelines to reduce or alleviate the risk of vicarious trauma for social work students exposed "to trauma cases through reading and classroom discussion" (p. 305). This article was "based on anecdotal teaching examples from the author and her colleagues" (p. 314). Cunningham postulated there was sufficient evidence to show that clinicians are negatively impacted by the traumatic information shared by clients, and it is plausible to assume that students could be negatively impacted by the traumatic material presented in class. To mitigate the potential impact, Cunningham (2004) proposed fifteen guidelines for educators. The following list includes a summary of the guidelines (Cunningham, 2004, p. 308 – 314):

1. Introduce the concept of vicarious trauma as a framework to help students understand their reactions
2. Educate students about trauma theory so that they understand their clients' reactions
3. Encourage students to share feelings and responses to any material shared in class
4. Embed strategies on how to deal with the adverse impact of trauma such as supervision, reading material, and self-care approaches
5. Normalize responses and encourage the use of professional strategies to deal with the impact of trauma
6. Introduce students to case material within the safe environment of the classroom to reduce the risk that they will be shocked my traumatic material when they are in the field
7. Introduce case material in a summary style of avoid overexposure to graphic details
8. Screen case material submitted by students prior to dispersing it to the entire class

9. Discuss cases that students may have already been exposed to, like those in the media
10. Prior to students presenting case presentations discuss how the format and tone used to present information can impact the reaction of the listeners.
11. Keep in mind that students that have strong emotional reactions in class may impact the group dynamic as a whole
12. Even though instructors are able to mitigate the distress of students, some level of distress is helpful to provide learning opportunity in the classroom on trauma reaction and intervention.
13. Give students enough time to process emotional reactions that happen in the classroom.
14. Choose to process students' emotional reactions cognitively or emotionally.
15. Remind students that the material was difficult and could stir up thoughts, feelings, or reactions during the week; present coping strategies to deal with the impact of material between class sessions.

Four of the five articles (Abrams & Shapiro, 2014; Cunningham, 2001; Graziano, 2001; Miller 2008) focused on stand-alone trauma courses that relied on the authors' wealth of experience teaching these courses. Although the reflective nature of contribution and collective experiences represent strengths, the pieces were limited in attention to the impact on student learning. The authors utilized no measures of student satisfaction, goal attainment, and content application or retention to measure the impact of various techniques in the classroom. Strand, Abramovitz, Layne, Robinson, and Way (2014) were the first to use standardized measures to attempt to quantify the impact of a trauma course on social work students.

Strand et al. (2014) described teaching trauma theory through problem-based learning within a master's in social work course for advanced students. Course content was adapted from

the NCTSN Core Curriculum on Childhood Trauma and integrated video demonstrations from the TF-CBT online course (http://tfcbt.musc.edu). The instructor organized the students into small groups during class to explore five cases and work together to critically evaluate additional information that would be necessary to support clients featured. Additionally, students read professional journal articles that directly applied to client developmental level and type of trauma explored in the cases. The authors manualized course design to ensure consistency of content across all courses and integrated a consultation process where all instructors spoke on a regular basis about the course.

Strand et al. (2014) taught this course seven times in four different social work programs to 148 total students. They assessed success of the course through a pre-post assessment questionnaire consisting of 29-items "...on demographics, history of trauma training, experience working with trauma-exposed children and youth, perceived self-confidence in carrying out trauma-focused practices, and personal reactions to the course" (p. 128). The authors reported a mean pretest score of 4.04 (SD = 1.59) and a posttest score of 7.42 (SD = 0.96) on a 10-item self-confidence scale, reporting a statistically significant improvement ($p < .001$; cohen's d = 2.57). Additionally, students responded to 10 items concerning the structure and design of the course on a 5-point Likert scale (1 = strongly disagree; 5 = strongly agree). A strong majority of students (90%) "reported that they agreed or strongly agreed with 6 out of 10 of the statements specific to the" (p. 131) problem-based-learning format including: "course instruction being active and engaging; the learning process increasing students' ability to apply trauma treatment concepts; and the course material was appropriate" (p. 132).

The positive feedback from students on course design and increase in self-confidence concerning trauma specific content show that this format of teaching trauma theory holds

promise for the field of social work. Limitations of this study included lack of a control or comparison group and heavy reliance of self-report.

Four out of the five stand-alone courses suggested the use of case-based instruction as a method of classroom instruction to enhance student learning (Abrams & Shapiro, Graziano, Cunningham, & Strand et al.). Additionally, all courses introduced students to a broad range of content including trauma theory, intervention, types of trauma, symptomatology, and self-care as preventative practice for vicarious trauma (Abrams & Shapiro, 2014; Graziano, 2001; Miller, 2008; Cunningham, 2004; Strand et al., 2014). The limitations of the of four conceptual articles are the lack of empirical evidence displaying the efficacy of these teaching practices in a trauma course (Abrams & Shapiro, 2014; Graziano, 2001; Miller, 2008; Cunningham, 2004). Further research is necessary to rigorously examine the teaching practices suggested by Abrams and Shapiro (2014), Graziano (2001), Miller (2008), and Cunningham (2004) to see which aspects of course design is most effective for student learning. The following subsection examines infusion models that do not rely on a single course but encourage integration of trauma across multiple courses in a program.

Infusion across curriculum. Gillin and Kauffman (2015) stated that exposure to traumatic material is an integral and necessary part of preparation for social work practice with clients and hypothesized that students' personal history of trauma would impact their risk of experiencing vicarious trauma in the classroom. The authors studied 162 MSW students in their final semester and found that 78% of students reported at least one Adverse Childhood Experience (ACE), and 27% of students reported four or more ACEs. Considering these findings, Gillin and Kauffman recommended 13 strategies to reduce the risk of adverse traumatization when teaching about trauma. The authors intend these strategies to be utilized

across courses to help students become aware and manage feelings of distress when exposed to traumatic content.

1. The signs and symptoms of vicarious trauma should be taught including risk factors; the impact vicarious trauma has on physical, behavioral, cognitive, and spiritual; ability to recognize in one's self if those symptoms occur.
2. Psychoeducation to students concerning the ability to various forms of media and course assignments to cause distressing, emotions, thoughts, and somatic responses.
3. Small group self-care exercises in class to all students to set goals, report on progress, difficulties, or meeting goals.
4. Teach skills for self-regulation following case presentations and educational videos that include details of a client's traumatic experiences (e.g., deep breathing, guided imagery, mindfulness meditation)
5. When showing videos with trauma content instructors can show the video with the lights on, provide specific content about the video prior to showing it, and give permission for students to step out of the classroom during the video.
6. Exposure to the concept of vicarious resilience (Hernandez, Engstrom, & Gangsei, 2010)
7. Introduce clients to the concept of intellectual containment by utilizing a theoretical frame to buffer against feeling overwhelmed by a client's emotional experience
8. Take time in the classroom to engage in conversations about the existential nature of traumatic experience, and provide students space to wrestle with the different questions concerning why individuals each other and themselves
9. Encourage the use of journals to reflect on course content and assignments. These practices can increase self-awareness and can be utilized to record self-care strategies.

10. Students should understand the concept of growth after a traumatic event to help them act as “keepers of hope (pp. 391)” for clients who may believe they will never recover.
11. Discuss empathy that the need to be mindful not to over-identify with clients who have experienced a traumatic event
12. Understand that activities outside of the counseling session such as advocacy and engaging in research can also support clients who have experienced a traumatic event.
13. Integration of material teaching the lasting negative impact of trauma across the entire social work curriculum. Providing resources for self-care in multiple courses, providing resources for affordable counseling services, stress management seminars for students, infuse an understanding of vicarious trauma into all courses. (Gillin & Kauffman, 2015, pp. 389-392)

Marlowe and Adamson (2011) suggested that social work curricula be trauma-informed, with the need to infuse and embed trauma content across many areas, use research-informed teaching, and challenge anecdotal and popular perceptions about trauma. They encouraged researchers and students to critically evaluate how their own experiences impacted their work with clients. Further, they recommended that trauma curriculum address cultural, historical, and biological perspectives on trauma in efforts to shift toward viewing traumatic experiences from a holistic perspective which incorporates “structural inequalities; unjust social policies; and the domains of power” (p. 631). The authors recommended exposing students to theories of strengths, resilience, and growth to support the notion that not all individuals exposed to potentially traumatic events experience long term adverse symptoms. The authors stressed the importance of an integrated approach that allowed students to see the interconnectedness of trauma in various social work processes and interventions across the curriculum.

Wilson and Nochajski (2016) conducted a program evaluation after implementing curriculum changes regarding prevalence of trauma, principles of trauma-informed care, clinical self-care, appropriate boundaries, collaboration with clients, empowerment, client-centered and strengths-based interventions, and evidence-based practice. One year after the TIC curriculum was implemented, the authors used a pre-post assessment using a local scale that assessed "knowledge, attitudes, self-efficacy, and behavioral intentional to implementing TIC approaches in practice" (p. 592).

The authors reported that for the questions pertaining to TIC knowledge and attitude, the vast majority of the students answered the questions correctly and had positive attitudes toward TIC behaviors. For both sections the scores were much higher than the authors anticipated, leading them to speculate whether they were true indicators of TIC knowledge and attitudes or indicative of general best practices in social work. Mean scores of first-year students compared to advanced-year students showed greater increases in self-efficacy over the course of the semester, resulting in an almost equal level of self-efficacy concerning the content after one semester of exposure. The authors assessed the final scale, behavioral intervention, through two case-based scenarios requiring students to report what behavior they would utilize to demonstrate TIC with the case client. For both cases, advanced-year students were more likely to choose TIC approaches than first-year students; however, first-year students showed greater increases in choosing a TIC approach.

Wilson and Nochajski (2016) concluded that the specific model of TIC curriculum impacted student self-efficacy and behavioral interventions but did not impact knowledge and attitudes toward TIC approaches within their program. There were several limitations to this program evaluation including utilizing a more advanced group of students as a comparison

group, the inability to determine which specific curriculum adjustments impacted students, uncertainty whether knowledge and attitude questions were specific to TIC, and the small number of students who remembered their unique code to match the pre-post assessments. Despite limitations, the results seem to suggest that the TIC curriculum as described by Wilson and Nochajski (2016) increased intended student behavior and self-efficacy concerning TIC approaches. Further research is needed to draw conclusions concerning student attitudes and knowledge concerning TIC practices while utilizing the proposed curriculum.

This section reviewed the conceptual and empirical literature on teaching about trauma in the field of social work. Methods of instruction included both didactic and experiential in stand-alone courses and courses that infuse trauma content across the curriculum (Abrams & Shapiro, 2014; Graziano, 2001; Strand et al., 2014; Wilson & Nochajski, 2016). Case studies were utilized to help students connect foundational knowledge to simulated client experiences (Graziano, 2001). Furthermore, a balanced exposure to both the distress and resilience that can result from trauma exposure was suggested (Marlowe & Adamson,2011). Instructors covered a wide range of topic areas including trauma theory, interventions, and the biological basis of trauma (Abrams & Shapiro, 2014; Graziano, 2011). The literature reviewed in this section stressed the need for educators to focus on creating a safe and predictable learning environment, in addition to providing resources for students to learn how to manage feelings of distress in the classroom (Cunningham, 2004; Gillin and Kauffman, 2015; Graziano, 2011; Miller, 2008). The following section will review the literature on trauma education that is not specific to a discipline but includes broad recommendations for any educator teaching trauma content.

Non-discipline specific considerations for trauma education. Although McCammon identified as a clinical community psychologist, her book chapter on teaching trauma in

academic settings is meant for any helping professional interfacing with trauma content which she described as a "...painful type of pedagogy, as it results in teacher and students becoming sadder but wiser " (1999, p.107). The information in this chapter is a culmination of personal experience and a review of the teaching literature. Throughout this chapter McCammon asked the overarching question… "how can I be sensitive to the fact that many of my students have been exposed to the traumatic events and effects included in the curriculum, and still keep a focus on the educational goals of the course?" (p. 108).

In this reflective conceptual piece, McCammon (1999) provided suggestions for how to approach trauma topics and student reactions in the classroom. The instructor should: (a) create a safe environment in the classroom but be wary of creating a "confessional" tone; (b) disclose what will be taught each class-period and any media material that will be used; (c) consider the emotional intensity of course material including case studies, lecture topics, and assignments; (d) provide information regarding support resources on and off campus; (e) promptly respond privately to students that disclose information in class; (f) empathically respond and relate the material to the topic in the case of in-class disclosure; (g) include information on theory, treatment, and intervention to instill hope of recovery; (h) employ a debriefing process for students; and (i) consider the impact that teaching about trauma has on the educator. These suggestions mirror many of the discipline-specific recommendations heard throughout this section and further underscore the need for intentionality in course design and environment.

Substance abuse specialists represent one final group of clinicians that has published literature on trauma training. Substance abuse clinicians have varied educational backgrounds including counseling, psychology, or social work and may hold degrees associate, bachelor's, or master's degrees. Bride, Hatched, and Humble (2009) examined the educational preparedness of

individuals certified in addictions to work with clients who have experienced traumatic events. Bride et al. (2009) mailed surveys to a random sample of National Association of Alcohol and Drug Addiction Counselors (NAADAC) members, and a total of 242 surveys were returned. Less than one-half held a discipline specific clinical license (e.g., licensed professional counselor, licensed clinical social worker, licensed psychologist), and 84% were state or nationally certified in substance abuse or addictions.

Bride et al. (2009) reported that 39% of respondents had taken academic coursework pertaining to trauma, 19% had a fieldwork experience involving trauma, and 82% had completed continuing education training focused on psychological trauma and interventions. The authors concluded that most substance abuse counselors were not being exposed to trauma theory and practice during their formal academic or field placement training, but they were receiving training through continuing education experiences. Bride et al. (2009) acknowledged that the survey did not inquire about the quality, depth, amount, or content that was being received through continuing education.

Chapter Summary

After providing the history of trauma research in the helping fields, I presented three sets of educational training competencies and seven sets of professional competencies related to trauma in the helping fields. I analyzed these sets of competencies thematically to better understand consistencies and divergences. Following the analysis, I discussed the mission and philosophical foundation of each discipline and agency to provide context for how the competencies align with the organization that created and endorsed them. The next section reviewed the conceptual and empirical literature on trauma education in the fields of counselor education, psychology, and social work. This section highlighted the dearth of literature in

counselor education on teaching trauma content, and the overall sparse empirical literature on trauma education in the helping fields. In Chapter Three, I describe my research methodology and how my study aims to increase the understanding of trauma education in the field of counselor education.

CHAPTER THREE: METHODOLOGY

Due to the complexity of classroom dynamics and uniqueness of instructor philosophical perspective, I chose qualitative research methodology for this inquiry. Multiple case study design was most appropriate for capturing a holistic understanding of teaching methods while drawing comparisons between instructor content choice and methods. Through this inquiry, I hoped to gain a better understanding of how CEs designed and facilitated significant learning experiences regarding trauma theory and practice. Specifically:

1. How do counselor educators choose which trauma content to address in master's level trauma theory and practice courses?
2. Which teaching methods do counselor educators utilize to facilitate significant learning experiences in master's level trauma theory and practice courses?

In the following sections, I introduce qualitative research in general and case study methodology specifically; I then discuss how I applied the methodology within the present study.

Qualitative Research

Qualitative research is a broad term for research focused on examining social relations (Merriam, 1998; Flick, 2014) and aiding in understanding meaning behind human actions (Schwandt, 2007; Stake, 2001). Researchers can use qualitative design to describe any social inquiry that utilizes "data in the form of words" (Schwandt, 2007, p. 248). As a method, qualitative research allows researchers to examine phenomena under study without reducing "...to single variables: rather, they are represented in their entirety in their everyday context" (Flick, p.15). The overarching goal of qualitative research is to "discover and explore the new" while taking into "...account that viewpoints and practices in the field are different because of the different subjective perspectives and social backgrounds related to them" (Flick, p.16). At the

essence of qualitative research is a drive to find the defining quality or unique features of a phenomenon.

Foundational features of qualitative research include authenticity, context, and action. First, authenticity is a researcher's attempt to generate as correct an understanding of the person or phenomenon as possible (Schwandt, 2007). The researcher achieves direct contact with participants through interviews and observations. Continued practice of reflexivity on the part of the researcher is an additional aspect of authenticity. In qualitative research, "the subjectivity of the researcher and those being studied becomes part of the research process" (Flick, 2014, p. 17). Researchers state their subjectivity and relation to the research topic before engaging in research and continue to document their reactions, feelings, and actions in the field as an integral part of remaining authentic through the inquiry process (Preissle, 1988).

Second, when researchers make interpretations, it is important to remember that participants are nestled in the context of their environment (Schwandt, 2007). By exploring and binding the context of the inquiry, researchers can place research findings within the context of culture, previous life events, tradition, and other contextual features that may impact participants. The third foundational feature of qualitative research is action. In qualitative research, the researcher aims to understand participants' experience as they engage in social actions. Through this exploration, the researcher assumes that "behavior is purposive, intentional, and goal-directed, not simply a physical response to a stimulus" (Schwandt, 2007, p. 2). The researcher seeks to uncover meaning that participants attach to their behaviors and assumes that behaviors are a complex web of multiple variables that can only be examined as a whole. Due to this contextual feature, qualitative researchers often use a constructivist framework (Stake, 2010). The constructivist paradigm assumes that there is a multiplicity of realities, researchers collect

data most authentically within naturalistic settings, and researchers make meaning through interactions with participants (Lincoln & Guba, 2000).

Qualitative research is distinct in two main ways. First, the qualitative researcher uses himself or herself as "an instrument" to conduct interviews, observations, and "...often intentionally playing a subjective role in the study…" (Stake, 2001, p. 20). Second, qualitative research aims to understand, not to explain (Stake, 2001). There are many ways qualitative research seeks to increase understanding. One of the most common types is case study which provides a method for researchers to study complex phenomena within their contexts (Baxter & Jack, 2008) and was the best approach for answering my research questions.

Case Study

Case study is one of the most frequently used qualitative research methods which allows the researcher to study complex phenomena that are not easily quantifiable by using a variety of data sources and a holistic approach (Hancock & Algozzine, 2017; Yanzan, 2015; Yin, 2013). "This ensures that the issue is not explored through one lens, but rather a variety of lenses which allows for multiple facets of the phenomenon to be revealed and understood" (Baxter & Jack, 2008, p. 544). Hancock and Algozzine (2017) listed three characteristics that define case study:

> a. "Case study research typically focuses on an individual representative of a group, an organization or organizations, or a phenomenon, b. The phenomenon, person, or organization is studied within its natural context with careful consideration given to the bounding of space and time, b. Case study research utilizes quotes, narratives, interviews, and various other techniques to develop a rich description from a variety of sources". (p. 379)

Researchers utilize a case study approach when they are attempting to answer a how question, cannot or do not wish to manipulate participants' behavior, want to incorporate contextual influences into the study, and when boundaries between the studied and the context in which it is nestled is unclear (Yin, 2003).

Yin (2003), Stake (1995), and Merriam (1998) proposed three predominant approaches to case study research. The current inquiry blended Merriam's (1998) single-case study design grounded in a literature review and Stake's multiple case study analysis (2006). The blend of the two styles of case study capitalized on the structure provided by Merriam (1998) in her single case data collection methods and Stake's (2006) detailed analysis method for multiple case design.

Stake. Stake believed that all qualitative researchers should approach their work from a constructivist and existential viewpoint where knowledge is "constructed rather than discovered" (Stake, 1995, p. 99). From a Stakian viewpoint, the qualitative researcher gathers interpretations from the case and expects that readers of the case will also have their interpretations of the information presented by the researcher. From this vantage point "there are multiple perspectives or views of the case that need to be represented, but there is no way to establish, beyond contention, the best view" (Stake, 1995, p. 108).

Stake (1995) viewed case study as a method to explore complex systems (cases) and believed that researchers cannot precisely define case study given the multiplicity of perspectives. There are four main characteristics of Stakian case: "holistic, empirical, interpretive, and emphatic" (Yanzan, 2015, p. 139). Stake believed in flexibility during the research process. From this perspective, there are two types of case study: those in which the case is central (intrinsic case study) and those in which the issue is central (instrumental case

study) (Stake, 1995). Stake (1995) strongly believed that researchers cannot structure a case study from the beginning due to the fluid and constructive nature of qualitative inquiry. Furthermore, the research questions should guide the data collection as the "problem areas become progressively clarified and redefined" (Stake, 1988, p. 22).

Stakian (1995) case study does not denote a point when data collection should begin. There is an openness to oscillating between study design and data collection throughout the entire process as the new data impact how the inquiry process proceeds. Data collection methods are less defined in Stakian case study with most data being "impressionistic, picked up informally as the researcher first becomes acquainted with the case" (Stake, 1995, p. 45). Due to this ambiguity, Stake emphasized the skillset of the researcher as central to constructing and executing effective case study inquiry (1995). Additionally, he excluded use of any quantitative methods and used purely qualitative data.

Aligning with the fluid nature of the data collection methods, Stakian (1995) data analysis mostly relies on researcher interpretations during simultaneous data collection and analysis. Although the primary data analysis tool is the researcher's intuition, Stake did not entirely disregarded use of theoretical frameworks during this process. Rather, researchers can use theoretical frameworks to minimize misinterpretations (Stake, 1995). Regarding data validation, Stake shifted slightly from his purely constructivist perspective and urged the researcher to explore "alternative explanations and [have] discipline" (Yazan, 2015, p. 147). To do this Stake (1995) recommended member checking, protocols, and procedures that demonstrate an effort to "increase credence" (p.112) to the interpretation. Merriam's (1998) approach to case study combined a systematic and explicit nature yet embraced the tradition constructivist perspective shared by many qualitative researchers, including Stake.

Merriam. Merriam's believed that reality is based on how individuals interact with their "social worlds" (1998, p. 6) and that there is no objective reality, but that individuals view reality through multiple interpretations. From this perspective, qualitative researchers are attempting to understand the meaning that people construct through interaction and how people make sense of the world and their experiences (Yanzan, 2015). Merriam viewed a case as a "thing, a single entity, a unit around which there are boundaries" (1998, p. 27) and had a much broader conceptualization on what would qualify as a case than Stake. In Merriam's perspective, researchers can call something a case if they detail their phenomena and draw distinct boundaries to delineate the limits of the inquiry.

Merriam conceptualized case study as "an intensive, holistic description and analysis of a bounded phenomenon such as a program, an institution, a person, a process, or a social unit" (1988, xiii). She postulated that the researchers should frame the research design beginning with the use of an in-depth literature review to guide the inquiry. Within this method, Merriam outlined a step-by-step process which included conducting a literature review, constructing a theoretical framework, identifying a research problem and crafting research questions, and selecting the sample through purposive sampling methods.

Merriam (1988) provided detailed instructions on data collection methods. She described techniques and procedures for interviews, observations, and document analysis. Once researchers collect data, Merriam (1988) stated that data analysis is the process of consolidating multiple sources of data and making meaning of the information. Aligning with the data collection and analysis beliefs of Stake, Merriam's case study design required simultaneous collection and analysis of data with refinement and increase in scrutiny of data as the study progressed (Merriam, 1988).

Merriam aligned with Stake (1995) in believing that the researcher must gather enough information for the inquiry conclusion to make sense to the reader, thereby "increasing credence of the interpretation" (Yazan, 2015, p. 147). Merriam (1998) recommended triangulation, member checks, long-term observations, peer examination, participatory research, and disclosure of research bias as ways to increase validity in case study research. Additionally, techniques to increase trustworthiness included "explanation of the investigator's position with regards to the study, triangulation, and use of an audit trail" (Yazan, 2015, p. 150).

The following sections will describe in more detail the steps to research design recommended by Merriam (1998) and Stake (2006) utilized for this inquiry. Merriam (1988) understood the utility of case study in educational settings. She championed the need for a thorough review of the literature review and a theoretical framework to guide the inquiry. Due to the nature of dissertation research, an in-depth literature review and a theoretical framework were necessary to guide my research process. Additionally, due to my constructivist perspective on learning and the unique qualities I hope to capture in the classroom, a single case study would not suffice. A subset to case study design is the use of multiple case studies which can deepen understanding of a single phenomenon while also drawing parallels and divergence between various cases. Researchers can use Stake's (2006) recommendations for multicase study research design to preserve unique qualities of individual cases, while also drawing broader implications across cases to better understand.

Multiple Case Study

Researchers utilize multiple case study design to offer a contrast between cases and a richer understanding of the *how* than a single case can offer (Baxter & Jack, 2008; Swanson & Holton, 2005). In choosing cases for a multiple case study, researchers can represent a range of

interest, qualities, extremes, or ideal types to generate a depth in similarity and contrast that can be used to better understand the phenomena without losing the uniqueness of each case. Researchers call this comparative dynamic *cross-case analysis* which they achieve through a nested, parallel, or sequential process (Thomas, 2011).

When designing a multiple case study, it is essential for data comparison that data collection methods across cases remain consistent. Researchers choose the cases based on a shared characteristic which bounds them together (Stake, 2006). When researchers present data after collection, they can present cases individually and offer a multicase analysis leading to generalization of themes. Researchers often utilize the inclusion of multiple case studies to increase external validity and generalizability of findings (Merriam, 1998). Multiple case study design increases data depth but also demands increased resources from the researcher such as time and data storage methods (Baxter & Jack, 2008).

Stake (2006) believed that in multiple case study research the single case is interesting only because it is part of a larger group of cases which are of interest. These cases share a commonality and are "categorically bound" (location 529). The collective phenomenon or characteristic that binds the cases together that researchers' study in a multiple case study is the *Quintain* (Stake, 2006). Multiple case study aims to better understand the Quintain. Researchers first identify the Quintain and then look for single cases to see similarities and differences in individual cases to better understand the Quintain as a whole (Stake, 2006). Stake (2006) cautioned the researcher to consider the differences between a search for generalization and a search for causality. The Quintain is a complex system, and the aim of the inquiry is to better understand "sequence and coincidence of events (location, 661). Stake clearly stated that multiple case research is an appropriate research methodology for doctoral dissertations with the

student as the director and responsible party for data collection and analysis (Stake, 2006). Furthermore, Stake (2006) believed that multiple case studies are so complex that researchers should complete data interpretations in a team format, with writing of a cohesive multicase report completed by one individual instead of a team. To analyze multiple cases, Skate (2006) took a more procedural approached than with a single case study and laid out a step-by-step process that allowed within-case analysis to lay the foundation for the cross-case analysis.

Merriam (1998) recommended the following steps in constructing a single case study: (a) constructing a theoretical framework, (b) conducting a literature review, and (c) identifying a research problem. These first three processes are not necessarily linear but feed off each other to create a firm foundation to inform the research process. After a foundation has been created Merriam (1998) and Stake (2006) recommended the following steps to complete the research process: (a) selecting a sample, (b) collecting data, (c) analyzing data, (d) reporting data. Much like the first three processes described by Merriam (1988), there is a fluid nature to data collection and analysis that allows the researcher to be responsive to the participants. I will describe this reciprocal nature of data collection and analysis further in the following sections.

Constructing a theoretical framework. The theoretical frame of a study grows out of the orientation or perspective the researcher brings to the inquiry (Merriam, 1998). Furthermore, the researcher's discipline influences the trajectory and emphasis of a research study. Merriam stated that “this disciplinary orientation is the lens through which you view the world” (1998, p. 45) and impacts every aspect of the research study. Through the framework of the study, researchers draw on a variety of concepts rooted in their disciplinary orientation including vocabulary, theorists, models, concepts, and terms from the specific domain. Researchers use these concepts to generate the research problem and questions, guide data collection and analysis

techniques and interpret findings (Merriam, 1988). To gain a full understanding of the concepts that impact the theoretical framework of the study, Merriam (1988) postulated that a thorough review of the literature is an essential component of any case study.

There is controversy between Stake (2006) and Merriam (1988) on the utility of a theoretical frame. Stake (2006) believed that conducting a literature review and approaching the study with an established theoretical frame can create bias in the researcher. Merriam believed that the theoretical frame decreases researcher influences due to grounding the study in literature from the field instead of the researcher's personal beliefs. From this perspective, researchers establish the theoretical frame early in the study through the process of a thorough review of the literature.

Conducting a literature review. Constructing the theoretical frame, conducting the literature review, and identifying the research problem are not linear processes. These three essential parts of case study research are dynamic as researchers refine and incorporate literature into questions that originally drew them to the topic. In turn, a more robust picture and clear theoretical frame takes shape (Merriam, 1988). The first step in a literature review is to understand the gap in the research, envision the depth with which the topic area has already been researched, and gain a rich understanding of the topic of interest. Understanding the literature surrounding a topic area is imperative because “the value of any single study is derived as much from how it fits with and expands on previous works as from the study’s intrinsic properties” (Cooper, 1984, p. 9).

The literature review serves many important purposes, and there is a debate in the case study community when the literature review should occur (Yazan, 2015). Stake (2006) believed that conducting a thorough literature review prior to data collection influences researchers, just

as establishing a theoretical frame would. Merriam (1988) believed that the literature review is the foundation for the rationale to begin the study.

From the perspective of Merriam, the literature review is one of the beginning steps in the research process and serves many distinct purposes. First, it provides a foundation for how the researcher may contribute to the existing knowledge, it illuminates the gap. Second, it creates a rationale for the theoretical framework proposed for the inquiry. Third, it sets the stage for how researchers will conduct the research inquiry including the questions asked, methods used, and data analysis strategy. Finally, having a thorough understanding of the existing literature allows the researcher to present a rationale and hypothesis for how the study will advance discussion on the topic area by drawing confirmation or divergence from existing literature. Merriam (1998) stressed the essential nature of the literature review in the case study research design process and added that a thorough literature review includes topics within and outside the field of the researcher that may impact study design and theoretical framework. Together, the literature review leads to a clearer understanding of the research problem.

Identifying a research problem. Identifying the research problem begins by surveying what is interesting and impactful for the researcher. Additionally, the research problem can come from the literature or current political and social issues. This spark of curiosity is the "core of the research problem or problem statement" (Merriam, 1998, p. 58). Researchers create a problem that they can explore through research methods by reviewing of the literature.

Once researchers sculpt a clear research problem, they begin to identify the sample that would be most appropriate for understanding the research problem. In multiple case study, the research questions aimed at better understanding the Quintain, the binding that holds the multiple cases together (Stake, 2006). From Merriam (1998) and Stake's (2006) perspective, purposeful

sampling (Patton, 1990) is the most obvious choice for choosing single cases that will contribute to the researchers better understanding of the Quintain.

Selecting the sample. For researchers to understand which individuals, organizations, or places may be the most helpful in understanding the Quintain, Patton (1990) argues that "sampling lies in selecting information-rich cases to study in depth" (p. 169). Furthermore, when conceptualizing what a case is Merriam (1988) believed that the phenomenon must have a theoretical or actual boundary by time or quantity to qualify as a case. From this perspective, there must be a limited number of people available to interview, time that the phenomenon happens, space that the phenomenon takes up, or amount of data that can be collected. Additionally, Stake (2006) stated that a case is a noun, not a verb, and constitutes an entity or a thing.

Combining these definitions for this inquiry meant that case study sampling could include an individual, organization, or phenomenon if it has natural boundaries and is a rich source of information for the inquiry in question. Furthermore, if the researcher selects a phenomenon as the case, it is the noun that is the case, not the verb. For example, for this present inquiry the case was the instructor in contrast to CE decision-making. The selection of the case provides "opportunity to examine functioning, but the functioning is not the case" (Stake, 2006, location 470).

After the potential case has been determined, the next step is for the researcher to decide what not to include by binding the case (Baxter & Jack, 2008). Creswell (2003) suggested binding a case by time and place, Stake (1995) suggested by time and activity, Miles and Huberman (1994) suggested by definition and context, and Merriam (1998) suggested by natural boundaries. Regardless of how the case is bound, a major pitfall of case study research is

attempting to examine a case that is too broad or has too many variables (Stake, 1995; Yin, 2003). The importance of binding is to ensure that the scope is within reason (Baxter & Jack, 2008). Taking into consideration that from the perspective of Merriam (1988/1998), researchers select cases due to natural boundaries, the binding of the case should fall along lines of time, space, and quantity as part of the original inclusion criteria for selecting cases.

When selecting the cases for a multiple case study, Stake (2006) stated that benefits will be limited if fewer than four single-cases are examined, or more than ten single-cases are examined. In a multiple case study, the cases are typically already partially known to the researcher, and the job of the researcher is to choose which cases will help better understand the Quintain. Stake recommended three criteria for selecting cases (Stake, 2006, location 814)

1. Is the case relevant to the Quintain?

2. Does the case provide diversity across contexts?

3. Does the case provide good opportunities to learn about complexity and contexts?

To understand how the Quintain changes in different environments, researchers should aim to select cases that are both typical and atypical. Once researchers select cases, then data collection can begin.

Collecting data. Interviews, observations, and analysis of documents are all commonly used in case study research (Creswell, 2013; Flink, 2014; Stake, 2006). To understand the holistic nature of the case, researchers must employ data collection techniques that increase breadth and depth of understanding. For case study design specifically, researchers are seeking to understand "ordinary happenings in each case" (Stake, 2006, location 924) through various data collection methods. Data collection methods utilized are determined by how the researcher defines the Quintain and the theoretical frame of the study.

Prior to collecting data, the researcher must have a firm understanding of the research problem and theoretical frame that drives the process. Researchers can collect these data on-site through formal and informal interactions with people and through examining documents that contribute to an understanding of the context of the case. Stake (2006) believed that direct observations and learning from others' observations are the most vital forms of data collection in case study research. Furthermore, researchers can corroborate reports of observations through records and artifacts (Stake, 2006).

Utilizing multiple sources of information is essential in case study research because "no single source of information can be trusted to provide a comprehensive perspective" (Patton, 1990, p. 244). Researchers can validate multiple sources of information collected during fieldwork and cross-check findings. They do not need to use all strategies for data collection evenly; oftentimes one form of data is the primary source while other forms are secondary sources of data (Merriam, 1998). Stake (2006) provided an outline of data collection for each case and suggested researchers adapt it to the needs of their case (Figure 3.1).

Analyzing data. As previously mentioned, data collection and analysis happen concurrently in case study research (Merriam, 1998). Additionally, for multiple-case case study, researchers analyze single-cases first, with the cross-case analysis following (Stake, 2006). This section begins with how researchers analyze single cases and ends with details for cross-case analysis. After collecting the first interviews, observations, or documents, the researcher refines the next stage of the inquiry and the research questions. This interactive process is what Merriam (1998) believed produced reliable, valid, and trustworthy findings that align with the information collected from the case. "Rigor in qualitative research derives from the researcher's presence, the

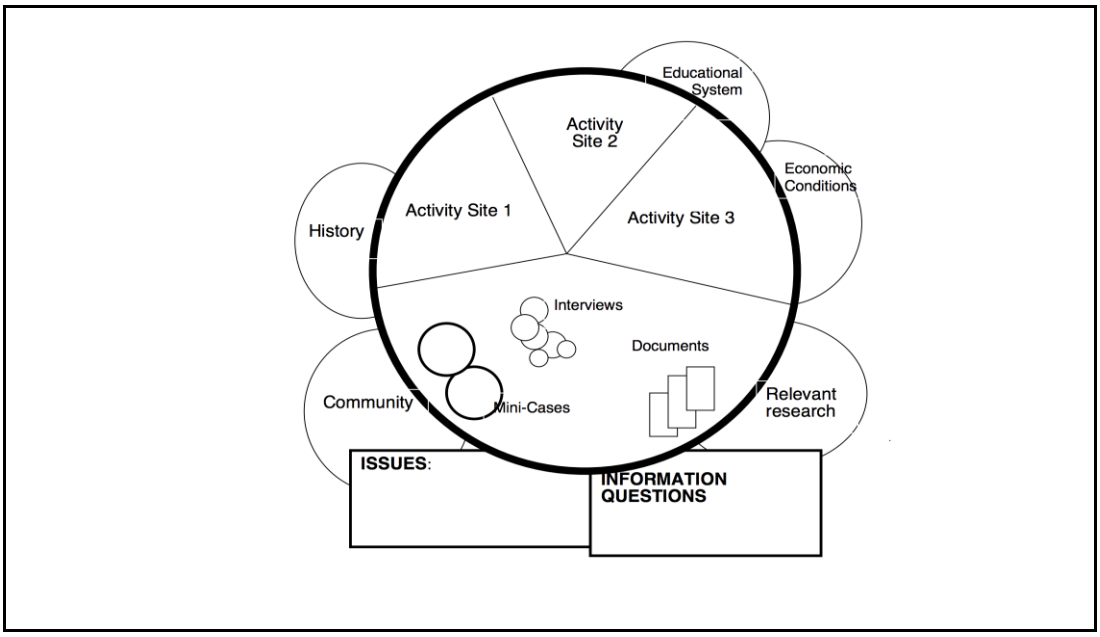


Figure 3.1. *Multiple Case Study Analysis*. Stake, R. E. (2006). Guilford Publications. Reprinted with permission of Guilford Press (Appendix M)

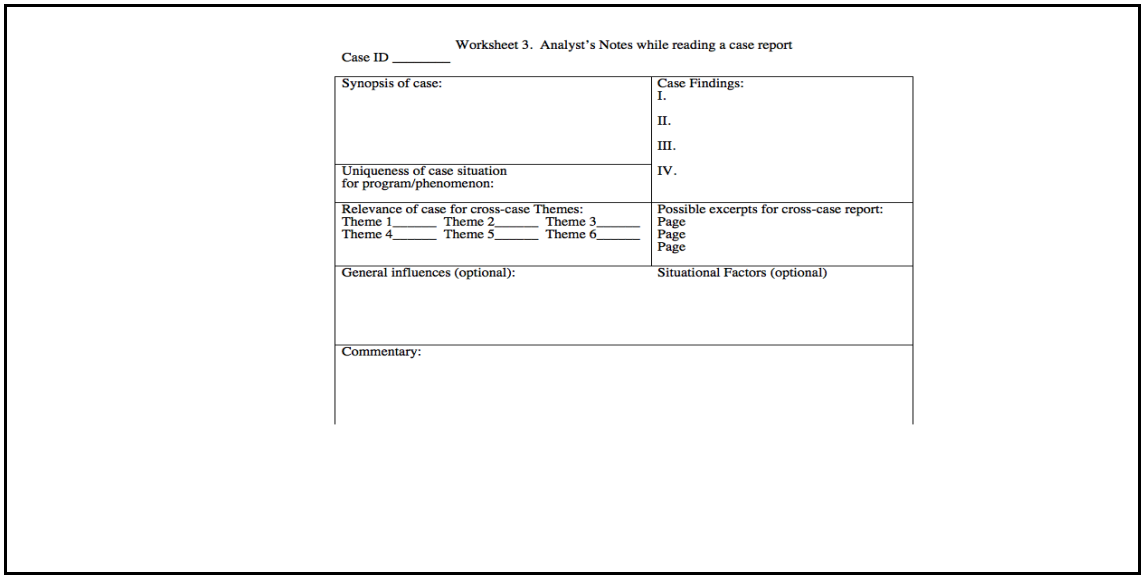
nature of the interaction between researcher and participants, the triangulation of data, the interpretations of perceptions, and rich thick description" (Merriam, 1998, p. 151).

There are several ways to analyze qualitative case study data including "ethnographic analysis, narrative analysis, phenomenological analysis, content analysis, analytic induction" (p. 157), and constant comparative method. Merriam (1998) detailed each of these methods and attended to the advantages of analyzing and collecting data concurrently. She went as far to state that there are very few *right and wrong* ways to conduct qualitative research but analyzing data while collecting it may be the only aspect of qualitative research that researchers must do for it to be *right* (Merriam, 1998).

When analyzing single cases with the intention of utilizing the results for cross-case analysis, the researcher is responsible for identifying themes that are grounded in the research questions and align with the Quintan early in the study (Stake, 2006). Researchers write these

themes and are not necessarily the focal point of the study but should be referenced during analysis. While analyzing single cases that will be utilized for multicase cross-case analysis, researchers should keep systematic notes (Figure 3.2) of each case that include an overall synopsis of the case, uniqueness of the case, how relevant the case is to the themes, case findings, possible quotes of excerpts from the case, and commentary on the process for that particular case (Stake, 2006). Systematic analysis of the single cases allows for systematic analysis of the multiple cases.

Single-case triangulation. Researchers utilize triangulation to ensure that information gathered from single-cases is not misinterpreted by the researcher or readers of the report (Stake, 2006). Member-checking during the data analysis process is one way to ensure that information gathered to better understand the case and the Quintain is representative. Additionally, repetition



Worksheet 3. Analyst's Notes while reading a case report

Case ID _____

Synopsis of case:	Case Findings: I. II. III. IV.
Uniqueness of case situation for program/phenomenon:	
Relevance of case for cross-case Themes: Theme 1_____ Theme 2_____ Theme 3_____ Theme 4_____ Theme 5_____ Theme 6_____	Possible excerpts for cross-case report: Page Page Page
General influences (optional):	Situational Factors (optional)
Commentary:	

Figure 0.1. *Analyst's Notes while Reading a Case Report.* Stake, R. E. (2006). Guilford Publications. Reprinted with permission of Guilford Press (Appendix M)

throughout the data analysis process by having multiple individuals view transcripts, videos, or other artifacts collected is a triangulation method.

Stake (2006) stated that any data researchers analyze that is critical to the main Assertion of the inquiry or is controversial should be triangulated. Triangulation is any method employed by the researcher during data analysis that utilizes "multiple perspectives to clarify meaning or verifies repeatability of an observation or interpretation" (Stake, 2008, p. 133). Specifically, the multiple data sources in multiple case study allow for the researcher to triangulate themes and presumptions through verification of multiple sources (Stake, 2006).

Cross-case analysis. In addition to individual analysis of single-cases, the researcher completes a cross-case analysis to better understand the aggregate of the data based on the binding issue of the single cases (Stake, 2006). The researcher must keep in mind that the cross-case analysis focuses on understanding the Quintain and how it manifests across the identified cases. When cross-case analysis is complete, the researcher can make assumptions about the Quintain based on multiple in-depth perspectives gained from the context and data of each single case.

Cross-case analysis begins by reading the analyzed single-case study reports and applying the overall case report to a theme-based description of the Quintain. Stake suggested outlining the themes of the Quintain which should directly align with the research questions, reading through all the cases, and creating a summary of each case to reference during analysis (Stake, 2006). To do this, researchers create a second case analysis sheet (Figure 3.2) for each case to utilize alongside the first one which includes any contextual information the researcher may have missed during the first analysis. The second case analysis sheet is not as detailed as the first, only capturing broad strokes of the case and missing information which can include

information gathered from member-checking. Through this process, the researcher begins to see where the Quintain themes are represented in each case and begins to map (Figure 3.3) representation of the themes in each case for cross-case analysis. This process of refining the themes of the Quintain is very important because the researcher must be able to find which cases offer a depth of information for each theme (Stake, 2006).

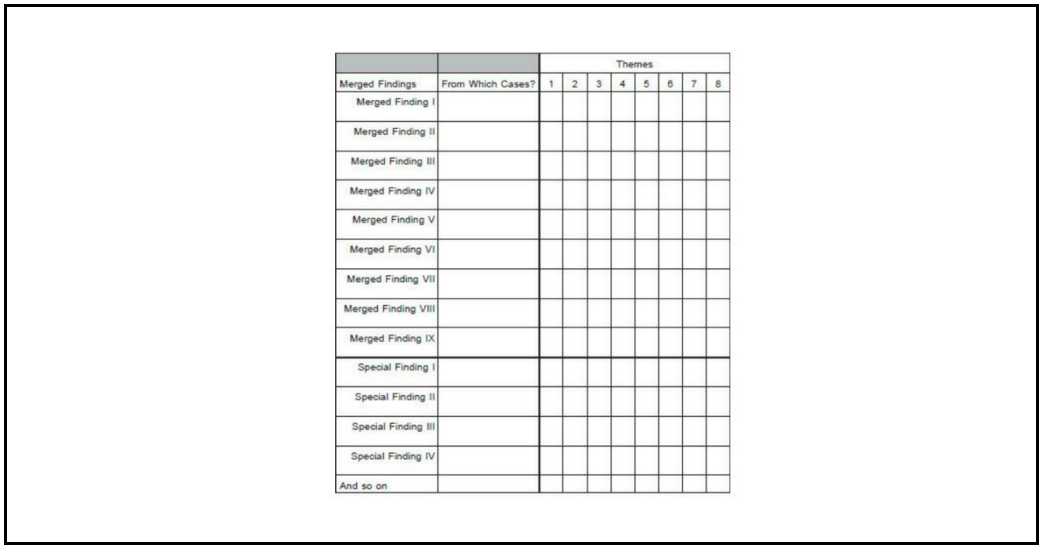
After researchers understand the overall representation of each theme for the Case, they look at specific Findings for each case and collapse them into clusters based on similarities. The researcher writes each individual Case Finding on a card with information supporting that Finding from the Case. Then, the researcher sorts the Findings into clusters based on similarities. Even if Findings are contradictory, if they concern a similar topic, the researcher should group

The utility of the Cases	Case A	Case B	Case C	Case D	Case E
Original Multicase Themes					
Theme 1					
Theme 2					
Theme 3					
Theme 4					
Theme 5					
Added Multicase Themes					
Theme 6					
Theme 7					

Figure 0.2. *Stake's Rating of Expected Utility of Each Case for Each Quintain Theme***.** Stake, R. E. (2006). Guilford Publications. Reprinted with permission of Guilford Press (Appendix M)

them together. Then, the researcher identifies the clusters with the strongest support from the individual Case Findings and gives that Merged Finding a name. Note that some of the individual Case Findings may not be used. Consider and rank each of the Merged Findings on how they align with the themes of the Quintain. This analysis of how the Quintain theme aligns with each Merged Finding from the single-cases will be the basis for cross-case *Assertions* in the final multicase report. Researchers utilize these Merged Findings to understand multicase themes called Assertions. To make Assertions, the researcher needs concrete Findings from each case and not just the overall synopsis of the case to align with Quintain themes (Stake, 2006).

The final step is documenting Assertions that the researcher drew from the multiple case analysis by examining the overall relationship between each case and the themes, and the specific relationships between individual Case Findings and the themes (Stake, 2006). The researcher can begin to write tentative Assertions anytime during the analysis, but all Assertions should represent multiple case findings supported by evidence within the cases.



		Themes							
Merged Findings	From Which Cases?	1	2	3	4	5	6	7	8
Merged Finding I									
Merged Finding II									
Merged Finding III									
Merged Finding IV									
Merged Finding V									
Merged Finding VI									
Merged Finding VII									
Merged Finding VIII									
Merged Finding IX									
Special Finding I									
Special Finding II									
Special Finding III									
Special Finding IV									
And so on									

Figure 0.3: Stake's Map on which to make Assertions for the Final Report. Stake, R. E. (2006). Guilford Publications. Reprinted with permission of Guilford Press (Appendix M)

Reporting data. After researchers collect and analyze all data, they make meaning from the various data sources (Merriam, 1998). They do this through organization and consolidation of data to ensure that it feels like a cohesive whole and makes sense to the reader. To disseminate information gathered from a case, the researcher must begin with a clear outline of the problem including the literature, theoretical frame, research questions, and purpose of the study. A description of the sample is helpful to understand the context of the inquiry (Merriam, 1998). The activities of the Case are expected to be influenced by the context of the Case; thus, it is extremely important to dedicate a significant amount of energy describing the context of each Case (Stake, 2006). This should include how the researcher selected the sample, data sources and demographic information. Researchers will report data on every single Case, on the cross-case analysis, and on the cases in relation to literature.

The final multicase report includes a positionality section which details the researcher's philosophical orientation and potential bias of which the reader should be aware (Priessle, 1988). The researcher utilizes quotes, images, and other artifacts from data collection throughout the report to support the Findings, but they should not be so common that they burden the reader. In general, researchers should report data in an organized fashion that creates a gestalt of the Case and displays the in-depth and holistic nature of case study design (Merriam, 1988/1998). To increase the depth and breadth of the case study, researchers can also use multiple cases to display divergence and similarity. In addition to the reporting of the single case, the researcher must also present the multicase report which focuses on the concept or idea derived about the Quintain (Stake, 2006).

Strengths and limitations. Due to the depth and breadth of the data collection methods, case study design is ideal for examining "complex social units consisting of multiple variables"

(Merriam, 1998, p. 41). The results of a case study offer a rich and thick description of phenomena nestled within a larger context. The same aspects of case study that make it appealing for complex problems can also cause significant time and monetary hardship for the researcher.

Depending on the size of the case, devoting time and energy to collect the amount of data to create a thick description can take a tremendous amount of time (Baxter & Jack, 2008). The quality of case study research is also intertwined with the integrity of the researcher. High-quality data collection and analysis require a dynamic process that involves the researcher remaining attuned, attentive, and responsive to the data (Merriam, 1998).

In qualitative research, the researchers are the primary tool for data collection (Creswell, 2013; Merriam, 1998) and invaluable to the research process. With such a large amount of data collected, it is up to the researcher to discern which data to present in the final report (Guba & 1981). Ethical case study researchers paint a holistic picture of the case including those aspects that aligned with and those that may diverge from the interests of the researcher. Despite limitations inherent in any research approach, Merriam states case study is an ideal research methodology for applied settings, including education (1998). She noted, "educational process, problems, and programs can be examined to bring about understanding that in turn can affect and perhaps improve practice" (Merriam, 1998, p. 41). The following section demonstrates how scholars in education and social science have utilized multiple case study research.

Multiple case study in education and social science. Case study has been a large part of educational and social science research for many years to understand programs, policies, educators, techniques, and specific populations (Merriam, 1998). In counseling, multiple case study design has been used to better understand phenomena such as non-suicidal self-injury

(Wester, Downs, & Trepal, 2016), narratives of adaptation and resistance in immigrant women (Yakushko & Morgan-Consoli, 2014), individuals who are mentally ill and homeless (Helfrich, Simpson, & Chan, 2014), the supervision alliance (Burke, Goodyear, & Guzzard, 1998), trauma-focused counselor competency (Rectanus, 2017), and resiliency in adult children of divorce (Thomas, 2009). Researchers have used multiple case study to better understand education in engineering (Baher, 1999), nursing (Green, Johansson, Rosser, Tengnah, & Segrott, 2008), high school education for children with intellectual disabilities (Dore, Dion, Wagner, & Brunet, 2002), and educator satisfaction for high school band teachers (Shaw, 2014). Additionally, they have used it in psychology to better understanding service delivery for victims of rape (Campbell & Ahrens, 1998) and child development related to coordination disorders (Miyahara & Wafer, 2004).

The above articles and dissertations had a wide variety in design with the mean of 6.4 cases examined and a range of 2 to 22. Green et al. (2008) analyzed 22 single cases, which is much higher than the other multiple case study articles and dissertations examined. With that outlier omitted, the mean number of cases examined was 4.1 with a range of 2 to 8 cases. Data collection included a combination of interviews, surveys, videotapes, focus groups, artwork, and observation with all authors using a minimum of two data sources. A list of these articles, the number of cases examined, the data points collected, and the publication type (e.g., dissertation or article) is available in Appendix C.

Summary

This section outlined qualitative research and case study approach ending with the strengths and limitations of this type of qualitative research design and applications in social science and education research. I focused on Merriam's (1998) and Stake's (2006) approach to

single and multiple case study design including an emphasis on theoretical framework, a review of the literature, case selection, data collection, data analysis, and data reporting. I included information on multiple case study as a way of increasing external validity and generalizability of the findings. The next section describes the multiple case study proposed in the current study.

Current Study

My research study explored how CEs facilitated significant learning in master's level trauma theory and practice courses for counselors. I chose multiple case study methodology for this inquiry because course offerings and context can be unique for each program. This approach allowed me to examine multiple in-depth perspectives of my research questions in a systematic way while increasing generalizability and external validity. In my Cases, I examined how CEs constructed and taught master's level trauma theory and practice courses. I wanted to gain a deeper understanding of the meaning CEs ascribed to course content selection and methods of instruction. In the rest of the chapter, I describe the theoretical frame, case selection, data collection, and data analysis procedures to aid in the understanding of my two research questions:

1. How do counselor educators choose which trauma content to address in master's level trauma theory and practice courses?
2. Which teaching methods do counselor educators utilize to facilitate significant learning experiences in master's level trauma theory and practice courses?

Theoretical Frame

I utilized Fink's *Taxonomy of Significant Learning* (2013) as a theoretical frame for understanding course content and design in trauma counseling courses. Specifically, I utilized Fink's understanding of learning and integrated course design as my Quintain themes. Fink

described six domains for the different types of learning in higher education (a) foundational knowledge, (b) application, (c) integration, (d) human dimension, (e) caring, and (f) learning how to learn.

Fundamental knowledge "refers to the students' ability to understand and remember specific information and ideas" (Fink, 2013, p. 34). *Application* refers to students learning how to engage with the material and educators using action-oriented student learning to develop new skills. *Integration* refers to students learning how to view connections between ideas, settings, domains, or other learning experiences. *Human dimension* is when students learn "the personal and social implications of what they have learned" (Fink, 2013, p. 35). *Caring* involves a change in the student in how to reflect on feelings, values, interests and indicates an intrinsic change for the student. The final dimension is *learning how to learn* which is when students learn how to be better students and educators teach the process which encourages them to be self-directed learners (Fink, 2013). Fink stressed that this model is not hierarchical and is relational (Figure 3.5) and interactive which is what I believed made it a good fit for research in counselor education. There was no value on which type of learning was better than another; in contrast, a mixture of the types of learning was most appropriate because utilizing one type of learning often enhances another. It is with the frame in mind that I approached my Quintain and case selection as I hoped to better understand themes in course content and course design.

Quintain

The Quintain for my current inquiry was trauma courses intended for master's level graduate students in counselor education. This Quintain was the "arena" or "umbrella" (Stake, 2006, location 545) for the cases I studied. The instructors of the courses belonged to the Quintain as they were the primary decision makers for course content and course design. Course

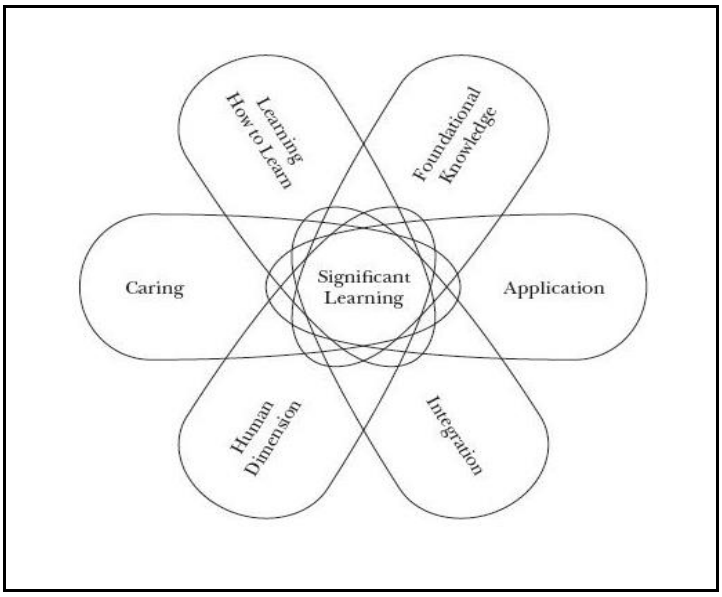


Figure 0.1: *Fink's Interactive Nature of Significant Learning*. Fink, L. D. (2013) The Interactive Nature of Significant Learning Figure 2.2 in Creating Significant Learning Experiences: An Integrated Approach to Designing College Courses (p. 37). Wiley. Kindle Edition. Reprinted with permission of Wiley Books (Appendix N)

instructors for master's level trauma courses in counselor education served as single-cases to aid in understanding the Quintain.

Case selection. As a researcher, I selected Cases to better understand the Quintain as a whole (Stake, 2006). As indicated above, course instructors for the trauma courses comprised the single-cases I analyzed to better understand the Quintain. Instructors must have taught three-credit hour trauma courses in CACREP accredited programs between Fall 2017-Fall 2018. In some cases, instructors combine crisis and trauma content in a single course. To meet the inclusion criteria for this study, instructors must have taught three-credit hour courses composed mostly of trauma content. I selected CACREP accredited programs due to the emphasis of trauma content in the CACREP standards examined during the literature review. CACREP accreditation standards are only applicable for required courses in counseling programs. If the

programs offered the trauma course as an elective, it would not need to fulfill the same accreditation requirements as required courses. I included instructors who (a) had participated in the course design including selecting course material and (b) were able to submit course syllabi and course artifacts for analysis.

Additionally, I sampled courses taught in geographically different areas and in on-campus and virtual format. I utilized purposeful network sampling (Patton, 1990) to identify CEs for participation in this study. The participants in the study were bound by the course they taught, and the specific semester indicated on the syllabus they submitted. I examined three Cases to offer depth in each individual case and opportunity for cross-case analysis. This number aligned with the median number of cases identified in other education and social science multiple case study dissertations (Thomas, 2009; Reyes, 2007; Rectanus, 2017), articles (Wester, Downs, & Trepal, 2016; Doré, Dion, Wagner, & Brunet, 2002; Shaw, 2014; Baher, 1999; Green et al., 2008), and Stake's (2006) recommendations. A combination of the Quintain bounds and case inclusion criteria create participant recruitment criteria which were:

1. Counselor educator who has taught a face-to-face, hybrid, or online:
    a. Three-credit hour trauma course intended for master's level counselors in CACREP Accredited or CACREP Aligned program between Fall 2017 and Fall 2018
    b. Most of the course content was focused on trauma
2. Counselor educator was the primary instructor for the course
3. Counselor educator was able to submit the course syllabi, reading lists, and assignment descriptions

Given the importance of context in case study design, I include attention to participant demographic information and context within each individual case report presented in Chapter 4.

Procedures

Data collection and analysis happen simultaneously in qualitative research (Merriam, 1998). It was a dynamic process where data I collected impacted the study design and I analyzed data promptly and continuously throughout the study. I collected data through interviews with instructors; analysis of syllabi, and other course artifacts (e.g., course assignment descriptions); and an instructor and course context questionnaire which I developed and will discuss in greater depth later in this section.

Recruitment and selection. I contacted CEs via email from a list of instructors who had indicated they have taught trauma content to master's level students. I generated this list from a feasibility inquiry made by the researcher in fall 2018 to get a sense of how many instructors would be teaching trauma courses in spring 2019. I sent a feasibility email (See Appendix D for traumatology interest network email) to the ACA Traumatology Interest Network and to colleagues to see if they were aware of trauma courses being taught (See Appendix E for email to colleagues). Based on responses to that inquiry, I determined it was not feasible to bound all courses to those in process in Spring 2019 and adjusted methodology accordingly. I responded to those who expressed interest by letting them know I would be back in touch once the IRB and my committee approved this project and I was ready for recruitment. I sent the Instructors on this list an informed consent which included inclusion criteria, time commitment, and data collection methods included in this study (See Appendix F for Recruitment Email). Additionally, I sent a recruitment email on CESNET (the counselor education listserv), the ACA Traumatology

Interest Network, and professional contacts to ensure a wide variety of available cases were considered for inclusion.

In the recruitment email, I included a link to the Participant Screening Demographic Form (Appendix G) which began with an electronic informed consent. After participants indicated that they agreed to participate, they progressed to the screening form. The Participant Screening Demographic Form included region of the country in which their program was located, course format (i.e., face-to-face, online, hybrid), whether the course was a trauma-specific course or a course with trauma content, and types of artifacts they were able to submit (e.g., PowerPoint, case studies, instructor notes). Additionally, at the bottom of the form there were instructions to submit course syllabi. Instructors submitted their course syllabus with the screening form to ensure that courses were mostly trauma content prior to case study selection. A total of seven CEs responded to the screen survey.

I selected three cases with priority to regional variations, trauma-specific courses, and instructors who were able to provide a depth of information on the course design process. I began reviewing participant surveys immediately after I sent the recruitment email. Emails were sent to all participants thanking them for offering to participate if they had not been selected (Appendix H). I recorded in my researcher notes my rationale for choosing these three cases. A separate email (Appendix I) was sent to participants selected to participate to schedule a time for the initial interview and provided a link to the Instructor and Course Context Questionnaire (Appendix J).

Data collection. I collected and analyzed data concurrently throughout the spring 2019 semester. I collected data in two rounds of interviews, course artifacts, and demographics from the course instructors. I decided to refrain from collecting information from students because

"Quintains are often better understood by looking at the way problems are handled than by looking at efficiency or productive outcomes" (Stake, 2006, location 631). Prior to collecting data for this current inquiry, I piloted the data collection protocol with a member of my dissertation committee. This member did not fit the inclusion criteria due to teaching in a helping field outside of counseling, but from this pilot I was able to receive feedback on my data collection and analysis methods prior to recruiting participants. Procedures regarding collection for each data source are discussed below.

Instructor and course context questionnaire. I distributed an open-response questionnaire to participating instructors in the email that informed them that they had been selected as one of the Cases for this study. The open-response questionnaire aided in the understanding of the context of the case. Understanding how the Quintain functions in different contexts is central to multiple case study design (Stake, 2006) and is why I chose to utilize an in-depth questionnaire in addition to the interviews. I split the questionnaire into three parts: (a) information about the instructor, (b) information about the program (c) information about the course (Appendix H).

Included in the information about instructors was: amount of teaching experience, learning or teaching theory/philosophy, how they described themselves as instructors, preferred methods of course instruction, how many times they had taught the trauma course, and certifications or training that had contributed to expertise in this topic. The second section included information about the program: when was the program accredited by CACREP, how long has the program had a trauma course, how the trauma course came to be, how the course fit into the larger counseling program, who taught the trauma course, and any local events that had impacted the course. The final aspect of the survey was about the trauma course and included:

when the course was taught, teaching methods utilized in the course, how the course was situated in the holistic program design, what content was covered in the course, how many students were in a typical section of the course, and use of teaching assistants in instruction.

Interviews. Interviews were one of the most essential aspects of data collection for this research study due to their ability to collect information that was not possible to observe (Merriam, 1998). In this case, interviews allowed me to explore the meaning-making and decision-making process of course instructors. I conducted semi-structured interviews with the instructors twice in the research process. The first interview focused on course content and design, homing in on *what* content the instructors were teaching. The second interview focused on instructor methods or process, homing in on *how* the instructors were teaching the content.

The interviews were semi-structured, with a list of open-ended questions and probes to allow participants to expand on their answers (Merriam, 1998; Roulston, 2010). Semi-structured interview questions were most appropriate because I was attempting to gather a rich description of how educators decided on and enacted their learning goals within the context of course design and delivery. This included feelings, perceptions, meaning-making, decision-making process, and understandings concerning the design and methods of the trauma course (Merriam, 1998; Roulston, 2010).

During interviews, I aimed to view myself as a "student of the interviewee" (Roulston, 2010 p. 17), learning as much from participants' descriptions of their experience as possible and using questioning to elicit richer details to gain a robust understanding. While constructing the I-guide I took careful consideration to avoid double questions, leading questions, and yes-no questions to reduce confusion, minimize imposing bias and maximize the flow of information from participants during interviews (Merriam, 1998). Instructors were asked about their course

design, content choices, teaching methods, and teaching process during the two interviews that were approximately two weeks apart. Interviews lasted 45-60 minutes and were video recorded utilizing the online video conferencing software Zoom. An I-guide for both interviews is in appendix K and L. After I completed the interviews, they were transcribed verbatim and de-identified; data analysis methods are described in the preceding section. In addition to interviews, I examined course artifacts.

***Artifacts*.** Merriam (1998) described documents as a ready-make data source not susceptible to the same disruption that interview, or observation can cause. For this study, I examined various course documents including "written, visual, and physical material relevant to the study at hand" (Merriam, 1998, p. 112). From this perspective, *documents* included any material created to aid in the facilitation of the trauma or crisis course.

For the current study, I collected syllabi from each participating instructor and analyzed through conceptual content analysis for frequency and presence of concepts within the document either explicit or implied (Merriam, 1998; Neuendorf, 2002). Additionally, I collected descriptive information from the syllabi including course procedures, content, and the course calendar. Instructors were asked to submit course syllabi with the screening survey, additionally instructors were asked to submit course artifacts such as assignment descriptions that were not included in the syllabus. A visual representation of data collection for each case is below (Figure 3.6).

Data management. Data management is one of the primary challenges of multiple case study research due to a large amount of data that the researcher collects. I kept all data from each case in separate secure Google Drive folders. I immediately submitted audio files after interviews into the respective Google Drive folders. Later, I submitted all audio files to Rev

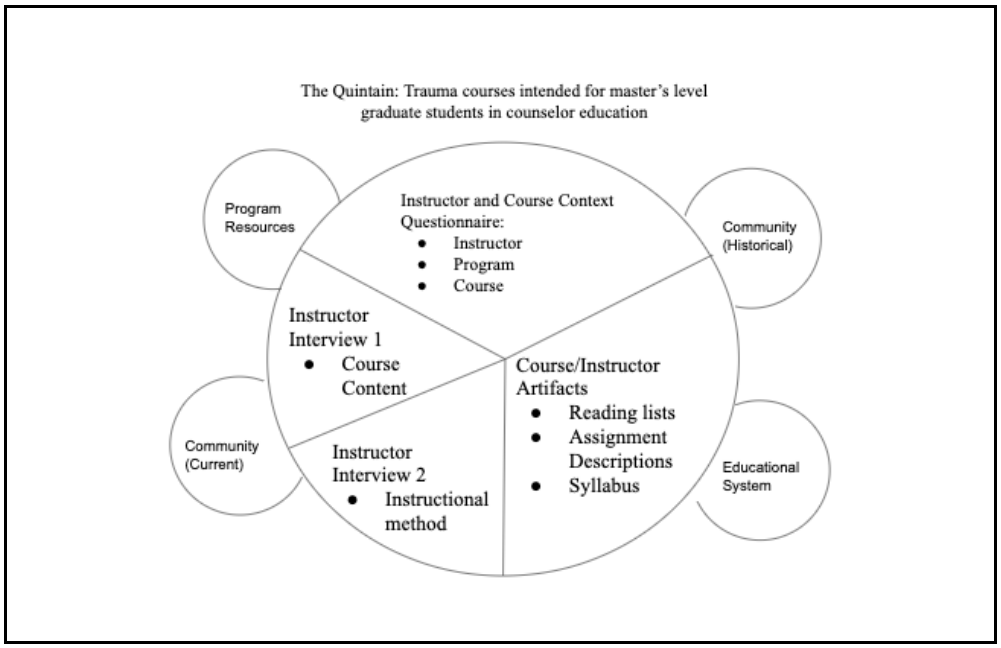


Figure 0.2: *Stake's Visual Representations of Data Collection for Current Study.* Adapted from Multiple Case Study Analysis, by Robert E. Stake (p. 5). Copyright 2006 by The Guilford Press. Reprinted with permission of Guilford Press

(www.rev.com) for transcription through their secure online portal. Upon return, I verified transcripts and de-identified including names of people, schools, events that may link final data to participants. Finally, I clearly labelled all interviews, artifacts, and demographic information with the case number to ensure de-identified documents stay with the correct case.

Data Analysis

Data were analyzed for each single-Case and in a cross-case analysis for the Cases as a whole. Although I conducted an in-depth analysis of individual Cases, the overarching aim of multiple case research is to better understand the Quintain (Stake, 2006). I utilized Stake's five steps of analysis which include within-case analysis, across-case analysis, comparison with the literature, writing the case report, and checking for validity. Additionally, I worked with a co-

coder during single-case analysis because “to be reliable, coding should be replicable” (Morse, 2018, p. 796) for semi-structured interviews.

Single-case analysis of instructor and course context questionnaire. I emailed participants the link to *the instructor and course context questionnaire* when I confirmed the date and time of the initial interview. I analyzed questionnaires inductively (Merriam, 1998), and I incorporated them into the overall thematic analysis of the Case (Flick, 2014). I reviewed the entire survey prior to coding. I used open coding (Saldana, 2015) as I took notes in the margins, underlined, and circled significant terms and repeated words and phrases. While coding I used both in vivo and descriptive labels (Saldana, 2015). “This process involves the simultaneous coding of raw data and the construction of categories that capture relevant characteristics of the documents’ content” (Merriam, 1998, p. 160). While analyzing data I took notes on the *analyst’s notes while reading a case report* worksheet for that specific case, I utilized the worksheet throughout the analysis process. Concurrently I sent the co-coder the *instructor and course context questionnaire* to code. I instructed the co-coder to code utilizing the same method. Additionally, the co-coder took notes on the *analyst’s notes while reading a case report* worksheet and keep the worksheet through the analysis process for that specific case.

Single-case analysis of interviews. The co-coder and I analyzed interviews utilizing thematic conceptual content analysis (Carley, 1990). We monitored frequency and presence of concepts through conceptual content analysis (Carley, 1990; Neuendorf, 2002). To analyze interviews, I: (a) sent the de-identified transcript to the co-coder for concurrent coding, (b) reviewed the data and create codes, (c) coded a second time and compare codes for patterns and categories, (d) developed themes, (e) completed the analyst’s notes while reading a case report worksheet.

I reviewed the data by examining the full transcript and any memos I wrote during the interview. I coded transcripts in the order I conducted the interviews which provided the opportunity to amend the interview protocol for future interviews if necessary (Merriam, 1998; Stake, 2006). Stake (2006) recommended approaching analysis with some coding categories created based on the established themes of the Quintain while also recording any themes that arose from the data. I used open coding to note terms that seem significant by the participant and any words or phrases the participant repeated (Saldana, 2015). As with the questionnaires, the co-coder and I used both in vivo and descriptive labels (Saldana, 2015). While analyzing data, the co-coder and I took notes on the *analyst's notes while reading a case report* worksheet (Figure 3.2). The same process was completed for both the first and second interview for each Case.

Single-case analysis of artifacts. I collected course artifacts after interview one and prior to interview two to allow clarification and discussion regarding artifacts, apart from the syllabi which instructors submitted during the pre-screening survey. I reviewed syllabi during the pre-screening survey to ensure at least 50% of content was trauma and systematically analyzed them with the remainder of the course artifacts. The co-coder and I added codes based on emerging themes in the study which was reflective of the responsive nature of data collection and data analysis indicative of Merriam (1998) style case study. Analytic memo writing took place to document the coding process (Saldaña, 2015).

I reviewed all artifacts prior to coding. The co-coder and I coded the artifacts in the order that instructors submitted them, which aligned with the order of the interviews. I utilized the codebook created from the interview, keeping the codebooks of each case separate, and using open coding to note significant terms and repeated words or phrases. Coding was both in vivo

and descriptive (Saldana, 2015). While analyzing artifacts I took notes on the same *analyst's notes while reading a case report* worksheet (Figure 3.2) utilized during interview coding. The co-coder did the same with the artifacts and took notes on the same *analyst's notes while reading a case report* worksheet (Figure 3.2) they started during the interview.

Upon completion of the analysis of each Case, I debriefed with the co-coder to assess if we needed to make any adjustments prior to beginning the next interview. With the information provided by the co-coder and myself, I completed the final case report for each interview. Finally, I sent the final case report to participants for member-checking, offering participants two weeks to respond to the inquiry. All three of the participants responded to the member-checking email affirming the information presented in the case was representative of their experience. The co-coder and I completed individual Cases month by month to allow for minor adjustments in the protocol as themes emerged and were refined (Merriam, 1998; Stake, 2006).

Cross-case analysis. Cross-case analysis followed Stakes (2006) recommended steps. First, I utilized single case reports to determine overall fit with Fink's (2013) six components of significant learning. Next, I explored additional multicase themes that emerged across cases and merged individual case findings into clusters with similarities. I then examined merged findings from the single case reports in relation to the Quintain themes. The single case study report Findings and Quintain themes matched were utilized to create Assertions about the themes across cases. Assertions were grounded in the evidence from the cases examined. Finally, I compared the final multicase Assertions to the literature reviewed on the trauma competencies, teaching about trauma in the helping fields, and Fink's Significant Learning (2013). The following paragraphs include greater detail regarding this process.

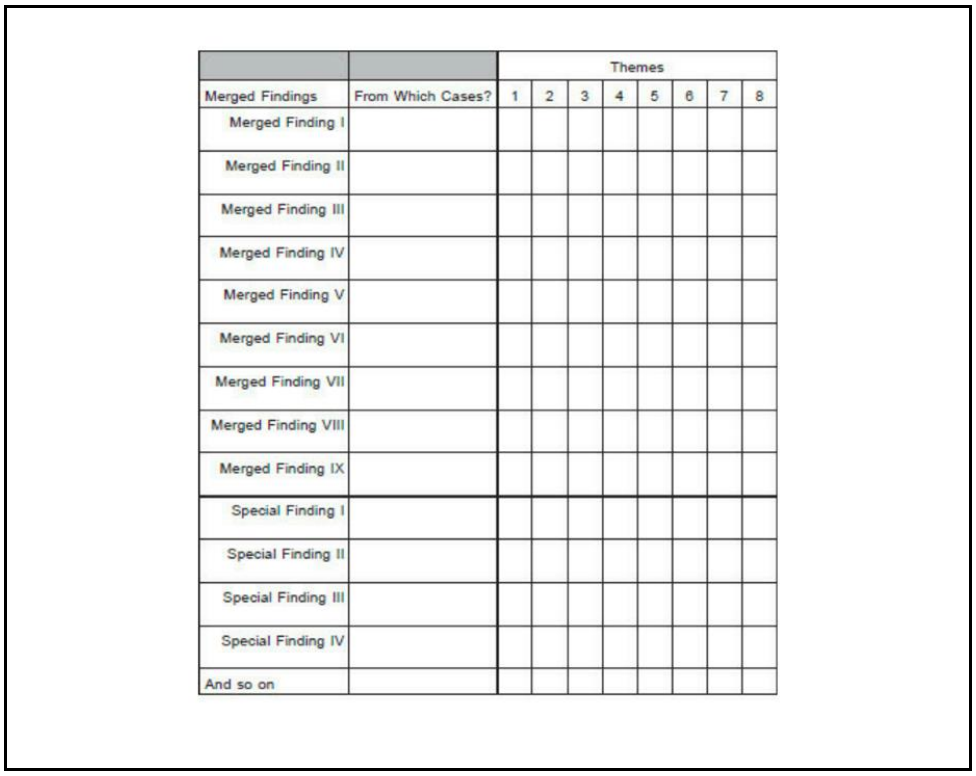
Cross-case analysis began by gathering each case report from the single-case studies. Keeping the Cases separate, I reviewed each case individually. After I reviewed each case, I utilized the *estimates of the ordinariness of the situation of each case and estimates of manifestation of multicase themes* (Figure 3.7) *in each case* worksheet to determine how each case fits with the multiple-case themes and record any additional themes that arise across Cases. Additionally, I noted any cases that appeared to be outliers based on themes that arose from other cases.

Next, I examined case by case which specific findings supported the multiple case themes and began to merge individual Case Findings into clusters. I merged the individual Case Findings by sorting the Findings based on the information from the individuals Cases that supported each Finding. I placed them in clusters based on similarities. Then, I used *A Matrix for Generating Theme-Based Assertions from Merged Theme Findings Rated Important* (Figure 3.8) to begin to explore which of the Merged Case Findings align with the multiple case themes. Finally, I unitized the *analyst's notes while reading a case report* worksheet (Figure 3.2) completed by the co-coder and myself to guide which excerpts, general influences, situational features, and excerpts support the Findings, and thus support the Merged Findings.

Next, I made Assertions across the Cases. To do this, I utilized The *Multi-case Assertions for the Final Report* worksheet (Figure 3.9) to collect the Assertions and document what evidence from each Case supported that Assertions. The *analyst's notes while reading a case report* worksheet (Figure 3.2) were utilized and each case was reviewed again to ensure that all information was included in the final report. I compared the final multicase Assertions to the literature reviewed on trauma competencies, teaching about trauma in the helping fields, and Fink's Significant Learning (2013).

	Case 1	Case 2	Case 3
The uniqueness of the case			
Original Multicase Themes			
Foundational Knowledge			
Application			
Integration			
Human Dimension			
Caring			
Learning How to Learn			
Added Multicase Themes			
Theme 6			
Theme 7			

Figure 0.3: *Stake's Estimates of Ordinariness of the Situation of Each Case and The Manifestation of Multiple Case Themes in Each Case* . Adapted from Multiple Case Study Analysis, by Robert E. Stake (p. 5). Copyright 2006 by The Guilford Press. Reprinted with permission of Guilford Press (Appendix M)



		Themes							
Merged Findings	From Which Cases?	1	2	3	4	5	6	7	8
Merged Finding I									
Merged Finding II									
Merged Finding III									
Merged Finding IV									
Merged Finding V									
Merged Finding VI									
Merged Finding VII									
Merged Finding VIII									
Merged Finding IX									
Special Finding I									
Special Finding II									
Special Finding III									
Special Finding IV									
And so on									

Figure 0.4: *Stake's Map on which to make Assertions for the Final Report*. Stake, R. E. (2006). Worksheet 5B in Multiple Case Study Analysis. Guilford Publications. Reprinted with permission of Guilford Press (Appendix M)

#	Assertion	Evidence in Which Cases
1		
2		
3		
4		
5		
6		
7		

Figure 0.5: *Stake's Multi-case Assertions for the Final Report*. Stake, R. E. (2006). Worksheet 6 in Multiple Case Study Analysis. Guilford Publications. Reprinted with permission of Guilford Press (Appendix M)

I completed the final multicase report. The report began with the context of each individual Case, which collective bound the multicase report. The context included situational information that impacted the multicase themes. Later, I introduced which specific findings aligned with each theme and how I made the Assertions. I stated the final Assertions for the cross-case analysis. The report included these Assertions and evidence from each case supporting why I included the Assertion in the final case report. The final case report ended with a discussion of how the assertions compare to the literature.

Researcher Positionality

The researcher is the primary tool in qualitative research and can be a major influence on the inquiry (Merriam, 1998; Preissle, 2008; Schwandt, 2007). Early in the research study, researchers must identify their relation to the inquiry and assumptions they have concerning the inquiry (Merriam, 1998; Schwandt, 2007).

I identify as a counselor, and I have spent most of my career working with individuals who are currently in crisis or have experienced traumatic events. I began working for a crisis phone-line while I was completing my bachelor's degree and continued to work in inpatient psychiatric facilities, residential treatment facilities, mobile crisis, correctional facilities, and at an alternative school until I concluded clinical work to focus on doctoral study in 2018. I did not take a trauma or crisis course while I was in my master's program, and I felt very underprepared to work with this population. To combat feelings of being underprepared, I attended as many trauma and crisis workshops as I could. I was and continue to be worried about the content instructors teach in professional development workshops focused on trauma and crisis, especially those provided at conferences with no accrediting body oversight.

I have taught a crisis course which I did not design and had limited trauma content. I have presented on the topic of trauma and trauma in education numerous times over the past five years. Teaching and trauma are two topics that are central to my identity as a CE, and I approach this inquiry with two key assumptions: (a) Instructors are intentional when building courses and are even more intentional when the content is sensitive. (b) Trauma content is sensitive because exposing master's level students to traumatic content can cause distress.

Throughout this inquiry I was mindful of the implications of my assumptions in how I engaged with participants, constructed the I-guide, and followed the protocol. I utilized a researcher journal and analytic memoing (Saldana, 2015) to monitor my thoughts, feelings, reactions, and decision-making process throughout data collection, analysis, and report writing. The journal and memos were a tool to aid in the monitoring of my subjectivity throughout this inquiry. In addition to monitoring my subjectivity and engaging in continuous reflexivity (Tracy, 2010), I implemented additional steps to increase study trustworthiness.

Trustworthiness

Stake (2006) stated that repetition, corroboration through multiple data sources, multi-person research teams, and meticulous note taking throughout the research process increases trustworthiness in case study research. Additionally, Merriam (1998) agreed that multiple sources and multiple methods can aid in the confirmation of findings. I used data source triangulation through multiple interviews, artifact collection, and examination of demographic information. These various sources of information helped provide a deeper understanding of the single cases, which in turn leaded to a clearer picture of cross-case themes to support Assertions (Stake, 2006).

I also worked with a co-coder during single-case analysis to increase the reliability of transcript and artifact coding. The co-coders role was to analyze the instructor and course context questionnaire, course documents, and participant interviews concurrently with me. We met weekly to discuss codes, categories, themes, trends, and reactions. The co-coder also monitored my subjectivity, reading the final documents to ensure the quotes, themes, and interpretations represented the information originally presented in the data sources. During cross-case analysis, I created the final report alone as Stake (2006) believed that the final report is the job of one person who has a clear understanding of the project from beginning to end which created continuity in the inquiry and increased validity.

Furthermore, I emailed participants the summary of their single case to elicit questions, insights, criticism, or feedback prior to cross-case analysis. Participants had two weeks to return the case with questions, comments, or feedback prior to cross-case analysis beginning. All three participants responded to the member-check email stating that they read the Case and had no additional information to add affirming that it represented the information they submitted.

Summary

This section detailed qualitative research, case study and multiple case study methodology, and the current study. I utilized an integration of Merriam's single-case study design (1998) and Skate's multiple case study design (2006) to examine the Quintain: trauma courses for master's level students in counselor education. The Quintain was examined through three CEs who have recently taught a trauma course to engage in two interviews, complete an instructor and course context questionnaire, and submit course artifacts. All data were collected and analyzed within-case, cross-case, and in reference to the literature. Throughout the process, I engaged in reflexivity, worked with a peer coder, member-checked, and utilized data point corroboration to increase study trustworthiness.

CHAPTER FOUR: INDIVIDUAL AND MULTICASE FINDINGS

The focus of this chapter is to present the Findings for the three individual Cases (pseudonyms); (a) Jade, (b) Jimmy, and (c) Alex. These Findings are from the analysis of the instructor and course context questionnaire, interviews, and course documents gathered from each instructor to better understand each Case. Overall, this chapter seeks to provide evidence to answer the research questions guiding the study: (a) *How do counselor educators choose which trauma content to address in master's level trauma theory and practices courses?* and (b) *Which teaching methods do counselor educators utilize to facilitate significant learning in master's level trauma theory and practice courses?* For each individual Case I describe the pertinent contextual information about the instructor and the course, the individual Case Findings, my interpretation of the course design, the individual case limitations, and a conclusion. This chapter ends with a multicase Report. The multicase report reflects my analysis of the three individual Case Findings and their relationship to the Themes of the Quintain. The multicase report includes the teaching and learning activities, and assessment and feedback methods of all three courses, in addition to the Assertions and a conclusion.

Case One: Jade

This case study aimed to understand how Jade choose the content in her trauma course and how she used that content to create significant learning experiences for master's-level counseling students. As detailed in Chapter Three, I utilized four forms of data to create this case report: an open-ended questionnaire about the instructor, course and community; the course syllabus; one 51-minute interview focused on course content; and a second 52-minute interview focused on course teaching methods. The first section of this case report includes contextual information collected from that questionnaire. Next, I analyzed Jade's syllabus examining the

structure and content included in the document. This case ends with my interpretation of how Jade chose content and utilized methods in her trauma course.

Instructor and Course Context

The participant described the information I present in this section in the instructor in course context questionnaire and in the initial interview. Some aspects of it may appear non-linear, the reader should approach this information as a conversation providing context for the Findings presented after this section. The aim of this section is to add background information to aid the reader understanding the interpretations presented late in this chapter within the context of the Case. The following section includes pertinent information about the instructor of the course, Jade, and her educational and clinical background. Additionally, I expand on the counseling program in which Jade taught and the community in which the University is located. The section ends with an overview of the course including the texts that were used, content covered, instruction methods.

Instructor. Jade was a 36-year old cisgender woman who identified as Caucasian or White. At the time of the inquiry, she had been a professional counselor for nine years and a CE for three years. Prior to her current employment, Jade took a graduate-level course in trauma and completed clinical training at sites focused on trauma, grief, and loss, including a private practice specializing in trauma. At the time of the interview, she was employed as a tenure-track assistant professor who taught this trauma course two times at her current institution and multiple times while in her doctoral program as a teaching assistant and an adjunct instructor. Jade considered trauma to be her primary specialty area.

A large part of Jade's identity as a counselor and CE was her integration of Feminist Theory. Jade was transparent with her students stating in the interview that she was "very upfront

about my bias as a feminist and as somebody who believes firmly in development and complex trauma." These views framed the way she approached trauma content and her teaching emphasis.

Program. The counseling program in which Jade worked had approximately 70 clinical mental health and school counseling students. The trauma course was an elective for students enrolled in their second or third year of the program and was not a program requirement, although Jade reported the faculty "certainly feel that it should be a required class" and "it's not currently required, but we're in the process of changing that because increasingly there are licensure boards that are requiring a course in trauma and crisis." At the time of the inquiry, the course had been taught twice at the university (i.e., summer 2018 and fall 2018) and was planned for spring 2019. Jade created the course at this institution and taught the summer, fall and spring sections. The counseling program was completing a CACREP self-study at the time of the inquiry and had been focused on integrating and effectively meeting the CACREP standards, including attention to trauma in the required, core curriculum and in this selective course.

Community. The community in which this course was taught had approximately 70,000 people and was described by Jade as being both urban and suburban. The types of traumatic events that were most commonly seen in the community were related to substance use, developmental complex traumas (i.e., direct or indirect exposure to physical, emotional, sexual abuse at a young age), and natural disaster. Jade described the populations most impacted by traumatic experience as "substance users" and "young people." When prompted to expand on this Jade stated that her community "in particular has been hit really hard by the opioid crisis, which has disproportionately affected the young people in the community." She went on to say that "it's very striking, the number of overdose deaths in [northwest region] county, and they've

sharply increased. Something like by seven times, by 700% over the past couple years." In addition to the opioid crisis, Jade's community was also impacted by flooding.

Jade stated that the city she taught in is one of the largest in the state, which means "it's relatively well resourced." Jade described community resources as follows:

> all of your traditional community resources, there are community mental health agencies, some of which our students do practicum and internship. There are several organizations that service homeless populations and other underserved populations in the community that, of course, also have become resources for survivors of trauma. The hospital is a huge treatment facility, and we have students placed there as well.

Because students are placed at many of these sites for internship and practicum, Jade and other faculty members in the program realized that "the emergency room and the behavioral health unit at the hospital have become sort of a primary place where substance abuse treatment is being triaged. That's a huge resource to the community." Additionally, the program had a student placed at the college counseling center which she stated provided a "window into what types of cases are being seen, and complex trauma and high acuity cases are becoming more and more common." In general, Jade believed that her community was struggling with increasing diversity and felt that there was a gap in services for minority populations. She stated that she is not "aware of a lot of targeted resources toward Latino families, other immigrant or refugee families, and those populations are really growing."

Course Overview. This Case focuses on a single semester of Trauma and Crisis Intervention which was a survey style summer course in which 10-20 students typically enrolled. The maximum number of students that could enroll in the course was 25, and the course was restricted to master's level counseling students. The course was taught in a hybrid format which

included four weekend classes (Friday and Saturday) and three weeks of online instruction over the course of one month. This seven-class summer course was taught face-to-face the first weekend; online the third, fourth, and fifth week; and face-to-face the last weekend. Jade expressed that she

> really likes that model. It allows me to build rapport in person, in the face-to-face meeting times, but at the same time it allows for some space for some students to be able to process some of the deeper content on their own, and their own time.

The primary instructional methods for the course were lecture, experiential activities, group projects, in-depth discussion questions, case examples, service learning, and guest speakers. There was no teaching assistant for this course.

Jade detailed the structural and procedural elements of the course in a 6-page syllabus. The syllabus was comprised of required university and program information such as course description, objectives, outcomes, and an academic integrity statement. In the syllabus, Jade described the course as providing "the counseling students with an introduction to research, theory, and practice within the field of trauma counseling." The course broadly covered "the historical evolution of the field; biopsychosocial underpinnings of trauma and trauma spectrum disorders; issues in diagnosis, assessment, and intervention from a culturally diverse framework; and a synthesis of best practices as they are currently evolving." The course was a "survey course on trauma, theory, practice, and intervention," and "the goal of it, really, is to be *the course* for trauma and crisis intervention" in their program.

Jade described teaching methods in this course as nestled within a "developmental and systematic approach" that aimed to "provide a counseling perspective on the knowledge base from the multiple disciplines that contribute to the field of traumatology." This statement

acknowledged that trauma education is multi-disciplinary and that the aim is not to recreate the wheel or ignore the contributions of other allied fields, but to examine that information from the developmental and wellness lens of the counseling profession.

The general flow of this course began with foundational knowledge and contextual information, and then moved into application of the information through various case studies, guest lectures, and a media-based assignment, and built on itself to culminate in an integration assignment. Jade interspersed reflective and mindfulness elements throughout the semester.

For the first couple weeks of the course, Jade provided background information and an overview "of the differences between trauma, stress, crisis, disaster; defining all those terms in the lecture." Then, she introduced concepts of "neuropsychology, neurobiology, and psychopharmacology," "assessment and diagnosis," and "controversies in diagnosis like developmental and complex trauma." Finally, she introduced "historical, cultural, and gender perspectives of trauma" and "theoretical models." This foundational information was the first half of the course. After that Jade "slowly goes into more specialty areas" which she stated are "varied from semester to semester depending on what I'm interested in…who's available… and what's feeling very present at the time." Although the specialty areas shifted from semester to semester, Jade always taught "about disaster, mental health, and crisis intervention in schools." There is a detailed chart of the topic areas that Jade taught and the methods utilized to teach them in Table 4.1. This table includes the topic areas and teaching methods within the context of the unit. It offers information on the general flow of content throughout the semester and how each unit is organized. Table 4.2 details the required readings in isolation. Some of these readings were displayed in the course syllabus but were not assigned to a specific unit which is why all required readings we displayed in a separate table.

Table 4.1: Topic areas Jade taught, and the instructional method utilized during the module for each week based on information provided in the syllabus.

Topic Areas Taught	Instruction Methods Utilized During Each Module (required materials)
Class 1 (face-to-face): In the first week, the instructor covered introductory material, syllabus review; an overview of extreme stress and psychological trauma; contextual dimensions of trauma such as history, culture, and environment; and adjunctive treatments such as movement and yoga	The concepts in this lesson were taught by the use of three required readings; Herman (1992, 2015) the entire book, Levers (2012) Chapter 1- An Introduction to Counseling for Trauma: Beginning to Understand the Context of Trauma; Chapter 2- Historical Contexts of Trauma; Chapter 17- Racial and Ethnic Intolerance: A Framework for Violent and Trauma; Chapter 18- Understanding and Responding to Sexual and Gender Prejudice and Victimization, and van der Kolk (2014) Chapter 16- Learning to Inhabit Your Body: Yoga. Additionally, a guest speaker taught about resilience yoga.
Class 2 (face-to-face): In the second week, the instructor covers neurobiology and psychopharmacology; assessment and diagnosis of trauma and related disorders; treatment models, evidence-based practice, and trauma-informed care; and family systems, attachment, and intergenerational trauma.	The concepts in this lesson were taught using two books chapters; Jones & Rybak (2017) Neurophysiology of traumatic stress in Foundations of Case Conceptualization and Levers (2012) Chapter 3- Theoretical Contexts of Trauma and Counseling. Additionally, students were required to read four articles; Courtois (2010) Complex trauma, complex reactions: assessment and treatment, van der Kolk (2009), Marotta (2010) Integrative systemic approaches to attachment-related trauma, and Brothers (2014) Traumatic attachments: International trauma, dissociation, and the analytic relationship. The DSM-V (APA, 2013) chapters on Trauma and Stress-Related Disorders; Borderline Personality Disorder; and Dissociative Disorders was also assigned.
Week 3 (asynchronous-online): In the third week, the instructor covers comorbidities including personality, dissociative, and	These concepts were taught with the use of two articles; Fox, Bell, Jacobsen & Hundley (2013) Recovering identity: A qualitative investigation of a survivor of

Table 4.1. Continued.

Topic Areas Taught	Instruction Methods Utilized During Each Module (required materials)
substance use disorders; and Feminist approaches and critiques	dissociative identity disorder; and Najavits (2002) Detaching from emotional pain (grounding). In addition to two book chapters Levels (2012) Chapter 13- Elder Abuse and Brown & Ballou (1992) A feminist critique of the personality disorders.
Week 4 (asynchronous-online): In the fourth week, the instructor covers biofeedback; and large-scale disasters and crisis intervention.	This material is taught with three book chapters; van der Kolk (2014) Chapter 15- Letting Go of the Past: EMDR; Chapter 19- Applied Neuroscience: Rewiring the fear-driven mind with brain/computer interface technology, and Levers (2012) Chapter 22- Natural Disasters and First Responder Mental Health. Additionally, Norris et al., (2002) 60,000 Disaster Victims Speak: Part I. An Empirical Review of the Empirical Literature, 1981—2001 and 60,000 Disaster Victims Speak: Part II. Summary and Implications of the Disaster Mental Health Research are assigned.
Week 5 (asynchronous-online): In the fifth week, the instructor covers community-based and ecological interventions and strategies; and crisis intervention in schools.	These topics are taught with an article; Collins & Collins (2005) Crisis and trauma: Developmental-ecological intervention and a book chapter Levers (2012) Chapter 20- School Violence and Trauma.
Class 6 (in class): In the sixth week, the instructor covers the integration of intersession learning; ethical issues in trauma treatment; and sexual trauma and working with adult survivors of child sexual abuse.	These topics are taught with four required readings; three book chapters, Levers (2012) Chapter 30- Ethical Perspectives of Trauma Work; Chapter 31- Vicarious Trauma; Chapter 7- Sexual Trauma: An Ecological Approach to Conceptualization and Treatment; and an article by Ullman, Nadjowski, and Filipas (2009) Correlates of serious suicidal ideation and attempts in female adult sexual assault survivors.
Class 7 (in class): In the seventh week, the instructor covers military trauma including combat, moral injury, and military sexual assault; ethnic conflict, political violence and terrorism; working with immigrants, refugees, and torture survivors; and further directions in research.	These topics are taught with two articles, Suris and Lind (2008) Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans; Wisco, B., Marx, B., May, C., Martini, B., Krystal, J., Southwick, S., & Pietrzak, R. (2017) Moral injury in U.S. combat veterans: Results from the national health and resilience in veterans study.; and three book chapters in Levers (2012) Chapter

Table 4.1. Continued.

Topic Areas Taught	Instruction Methods Utilized During Each Module (required materials)
	23- Genocide, Ethnic Conflict, and Political Violence; Chapter 25- The Impact of War on Military Veterans; Chapter 26- Disaster Behavioral Health: Counselors Responding to Terrorism. Additionally, a guest speaker taught about working with immigrants, refugees, and torture survivors.

Table 4.2: Jade's Required Readings

Type	Required Course Reading
Books	Herman, J. (1992, 2015). *Trauma and recovery.* Basic Books: New York. Levers, L.L. (2012). *Trauma counseling: Theories and interventions.* Springer: New York. van der Kolk (2014). *The body keeps the score.* Penguin Books: New York.
Articles	Brothers (2014) Traumatic attachments: International trauma, dissociation, and the analytic relationship Courtois (2008) Complex trauma, complex reactions: assessment and treatment Collins, B., & Collins, T. (2005). Crisis and trauma: Developmental-ecological intervention. Boston: Lahaska Press. Fox, Jesse, Bell, Hope, Jacobson, Lamerial, & Hundley, Gulnora. (2013). Recovering identity: A qualitative investigation of a survivor of dissociative identity disorder. *Journal of Mental Health Counseling*,*35*(4), 324-341 Norris, F., Friedman, M., Watson, P., Byrne, C., Diaz, E., & Kaniasty, K. (2002). 60,000 Disaster Victims Speak: Part I. An Empirical Review of the Empirical Literature, 1981—2001. *Psychiatry, 65*(3), 207-239. Norris, F., Friedman, M., & Watson, P. (2002). 60,000 Disaster Victims Speak: Part II. Summary and Implications of the Disaster Mental Health Research. *Psychiatry, 65*(3), 240-260. Suris, A., & Lind, L. (2008). Military Sexual Trauma: A Review of Prevalence and Associated Health Consequences in Veterans. *Trauma, Violence, & Abuse, 9*(4), 250-269. Ullman, S. E., Najdowski, C. J. (2009). Correlates of serious suicidal ideation and attempts in female adult sexual assault survivors. Suicide and Life-Threatening Behavior, 39, 47–57. Wisco, B., Marx, B., May, C., Martini, B., Krystal, J., Southwick, S., & Pietrzak, R. (2017). Moral injury in U.S. combat veterans: Results from the national health and resilience in veterans' study. *Depression and Anxiety, 34*(4), 340-347.
Book Chapters	Brown, L. S. (1992). A feminist critique of the personality disorders. In L. S. Brown & M. Ballou (Eds.), *Personality and psychopathology: Feminist reappraisals* (pp. 206-228). New York, NY, US: The Guilford Press. Dissociative disorders. (2013) In American Psychiatric Association. *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed., pp. 291-307). Arlington, VA: American Psychiatric Association. Jones, Rybak, and Russell-Chapin (2017) Neurophysiology of traumatic stress in Foundations of Case Conceptualization

Table 4.2. Continued.

Type	Required Course Reading
	Najavits (2002). Detaching from emotional pain (grounding). *In Seeking safety, a treatment manual for PTSD and substance abuse* (pp. 125-136). New York, NY: The Guildford Press. Marotta (2010) Integrative systemic approaches to attachment-related trauma. In P. Erdan & T. Caffery (Eds.), *Attachment and family systems: Conceptual, empirical and therapeutic relatedness* (pp. 225-240). New York: Brunner-Routledge Personality disorders. (2013) In American Psychiatric Association. *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed., pp. 663-666). Arlington, VA: American Psychiatric Association. Trauma and stress-related disorders. (2013) In American Psychiatric Association. *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed., pp. 265-290). Arlington, VA: American Psychiatric Association.

Individual Case Findings

In this section I describe the individual Case Findings. I first introduce Jade's course goals which is the overarching aim of the course. I then detail the teaching and learning activities in the course. These activities include all in-class teaching methods that use in her course. The next section describes assessment and feedback methods which include all course assignments that were graded. I organized these descriptive Findings based on a review of course artifacts such as syllabi and assignment descriptions in addition to the interviews with the course instructor. These Findings do not reflect thematic analysis but are reported in an attempt to stay as true to the participant's self-report of course design in interview and course documents.

Course goals. Jade's course goals were two-fold: (a) students should demonstrate they meet the CACREP standards as stipulated in the course syllabus, and (b) students have basic foundational knowledge and competence to be able to work with survivors of trauma. Jade stated:

> I think everybody needs to have that basic foundation, so that's what I want them to be able to take away, to be able to sit with somebody who's experienced trauma, to understand how that connects and intersects with other identities that they have with other parts of their lives, and to have a basic understanding of what to do in a crisis situation as well, and how to intervene. I think they need this information when they're going into their practicum and internship experiences.

Jade justified these course goals by stating, "we know that 90% of the population meetings criterion A [for post-traumatic stress disorder], and I think that's an understand estimate" and the anecdotal information that "almost all of our students are working with populations that are at risk, at increased risk for trauma, so I think it's necessary." She went on to state that this is part of the reason why the department is moving toward making this a required course.

Teaching and learning activities. When asked about her teaching philosophy Jade explained she "tries to teach very similarly to the way I supervise" which she described as "consistent with the integrative developmental model of teaching and supervision." She described this developmental approach as student-centered and responsive to the needs of students. She also recently attended a universal design teaching training and has become very mindful of "catering to different learning styles." Overall Jade's teaching philosophy was impacted by the belief that she is

> doing a little bit more than just teaching in counseling courses, and there's definitely a relational component to what I'm doing, so sort of trying to provide a safe holding environment for students, especially in this class where they can process if they need to,

and yet trying to model appropriate boundaries and really trying to model what that relationship would look like between counselor and a client as well.

The teaching and learning activities in the course were influenced by the amount of content in the course, Jade reported that she put the "lecture-heavy classes on the online weeks because I can narrate those lectures and post them, and they can have some time to digest them" at their own pace. Additionally, she took into consideration the content that was being taught when she decided on teaching activities. For the neurobiology and neurophysiology class she felt "like I needed to see their faces in order to see if they" were understanding what she was saying. She did a lot of "reading of non-verbals in order to check in with students and see what they're getting, to try and get a sense of who, especially in this class, may be having a reaction to the material," and she believed being attuned to students in this way was very important.

Jade also gauged student prior knowledge about the content to guide the teaching and learning activities. She acknowledged that some students came from psychology backgrounds where they had taken advanced neuroscience courses; this content was completely new for other students. She attempted to attend to the developmental needs of students in that capacity also while constructing both didactic and experiential activities. The teaching and learning activities utilized in this course included lecture, mindfulness, face-to-face, and online discussion, case study, role play, guest speakers, and outside content and media materials. The following sections describe the way Jade facilitated these activities and the goals Jade hoped to achieve by integrating them into the course.

Mindfulness. For didactic lessons that were very content heavy, Jade interspersed experiential activities. For the neuroscience lecture, Jade had students participate in an experiential mindfulness grounding activity at the beginning and end of class. Jade noted how

she tried “to get students to experience...what I was actually talking about in the class, and also process a little bit about what those exercises are like for them.” Jade viewed mindfulness concepts as a very important aspect of this course and often used them to support students in self-regulating in the classroom, to intentionally pace the course to break up content heavy lessons, and as an experiential component to learn more about interventions.

Discussion. On face-to-face days, Jade utilized small and large group discussion. She had taught this course twice at her current institution and found that the size of the class impacted these discussions, with class sizes of approximately 20 being a “bit too big.” Jade viewed the purpose of these small group discussions as to allow students that need a “little bit more time to formulate what they want to say” to be able to participate without feeling pressured. She tried to be attentive to student needs by doing “small group discussion if there’s a big question that we need to talk about.” She described instructing students to “take a minute and talk about this with your partner and then let me know what you came up with.”

Jade stated that “online discussions are great as well because they have a very extensive prompt they can respond to” which allows for rich and diverse discussion. These online discussions often had a video, article, or some sort of media prompt; students could choose from a series of questions when responding. For example, Jade asked students watch *Healing Neen,* a 50-minute documentary style film. After watching, Jade asked students to respond to one of two prompts. Jade explained in the interview that, “one relates to historical cultural pieces of her traumatic background, which is like extensive. She had substance abuse, incarceration, every ACE you can imagine.” The other prompt addressed “the historical cultural piece where they can respond directly based on the week’s material, which was how she meets criteria for either

an existing diagnosis or for some other proposed diagnosis." Jade was purposeful in offering multiple open-ended prompts which allowed for various responses.

Jade also used small group discussion to facilitate in-class learning. She provided the example of an in-class activity in which students worked in groups to look at the PTSD diagnosis over time.

> ...different groups look at the DSM criteria for PTSD over time. Some of them had DSM three, some DSM four, some DSM five, and then one group had ICD-10. They were trying to think about ... That was the class on historical perspective, so they were trying to think about what was going on at the time, why was it conceptualized in this way, what was missing, and the evolution of it.

This type of group work had a two-fold purpose. It helped students understand the contextual element of diagnosis and supported collective problem-solving in a small group format about the controversial topic of diagnosis for trauma-related distress.

Case study. Jade utilized case study both formally and informally throughout the course. Jade used this method to stimulate discussion by putting "a case study up for the students to think about and then usually in small group discussion format talk about." For informal case studies, she utilized her own clinical experiences to present examples to the classroom and found that students responded well to those clinical examples, especially if they were from her recent clinical experience.

Role play. Jade explained "I don't do a ton of role-playing in this class. It's not super intervention heavy." This is an example of the instructor aligning teaching methods to the course goals. Although role plays are commonly utilized in counseling courses as an instructional method, this course was much more of a practice and theory class. An exception to this was the

incorporation of practice suicide risk assessments. Jade explained that she made this decision "from a developmental place based on what I think this particular group needs and if there's an interest in suicidality." She incorporated extra time for suicide risk assessment practice even though it was typically addressed in other courses such as counseling skills.

Guest speakers. For this course, Jade had three guest speakers. The first specialized in trauma-informed yoga and "gave a brief lecture about the evidence for yoga...talked a little bit about neurobiology...and led the students through a brief yoga exercise." Jade realized during this lesson that the neurobiology section of the guest lecture would have been more impactful if it was after her lecture on the brain. Noting the mismatch in pacing brought up an important point about ensuring that the content presented by guest lecturers was appropriately paced with other content in the course.

The second guest lecturer was a specialist in biofeedback who provided an asynchronous online lecture. This adaptation accommodated students because they were still able to receive the content from the guest lecturer that was outside Jade's expertise even though the guest could not be there in person. It allowed Jade to keep this lecture for future classes if necessary and is another example of her ability to leverage the hybrid format of the course to create learning experiences when face-to-face interaction was not possible.

The final guest lecturer worked at a local community agency that "primarily does its work with a variety of populations, but heavily immigrant and refugee population, heavily Central American, North African, and West African." This guest was able to speak to the particular types of trauma that could be experienced by these populations. Jade reflecting on the power of having a guest share direct experiences, noted "the students love that. She's doing the work. She also supervises, so it was a good networking opportunity for any student who lived in

that area." Additionally, the guest speaker was not originally from the United States and was also able to speak to her "experience as an immigrant having very little language skills when she first got here." Through this experience, students were able to network with a local provider, potentially connect with a future supervisor, hear therapeutic perspectives from a practicing clinician, and gain a unique perspective on the specific needs of the populations with whom she works.

In addition to these guests, Jade invited a guest speaker to cover the topics of "interpersonal violence and crisis intervention for sexual violence" in the course in the spring. She stated, "she's an expert. It's one of my areas, but she is an expert beyond what I could possibly share with students." Jade explained that calling on guest speakers "fills gaps for me" and provided someone "who is more of an expert in the area." In all, guest speakers allowed students to hear from a variety of practitioners in the field and begin to understand a breadth of trauma-specific services.

Outside resources and media. In addition to guest speakers and in-class activities, Jade attended to needs of school counselors in the program by having students review a crisis plan from one of the local school districts and watch a webinar from American School Counseling Association (ASCA) about *13 Reasons Why*. Jade stated that children and adolescents were a gap in her knowledge area, and she was intentional about trying to build in content and invite school-counselors-in-training to share their experiences with the class. She explained that

> the school counseling students and others who have worked with children and adolescents always have great case examples to bring in, because they're really seeing this, how so often these kids are diagnosed with ADD, ADHD, with ODD, when really what they're seeing is the ACEs.

She was excited to invite these conversations into the classroom and allow students to share their experience where it may bring more depth to areas with which she is less familiar. Additionally, she wanted to invite one of her school counseling colleagues to lecture on the topic of crisis and trauma in the schools.

Jade utilized Media throughout the course to enhance student learning. Jade incorporated several sources of media including: a) documentaries such as *Healing Neen* to facilitate discussion and contextualize classroom topics, b) *TedTalks* such as Nadine Burke Harris's talk on ACEs to enhance course content, and c) syndicated podcasts such as *This American Life*, *Snap Judgement*, and *Reveal* as case study exercises. Jade tried to be intentional about the amount of traumatic material to which students were exposed. For example, she talked about her hesitation to assign *13 Reasons Why*.

> I think what's more interesting is the controversy around it and how do we talk about these issues with youth and adolescents and why were they so interested in this show. I left it as optional whether they wanted to. I did tell them where they could see this particular scene that I wanted them to think about, which is when the main character, Hannah, comes into the school counselor's office and he does such a crap job of sitting with her and assessing for risk. It's very triggering. Many parts of that show are very triggering, so I didn't feel right about ... That's an issue with class overall. For some reason for that show, in particular, I decided to leave it optional. I just felt there were other ways for us to talk about it through the ASCA, but I did tell them where the scene was that I was referring to so they could watch it if they wanted to.

As she explained, she assigned this series as an optional assignment but asked students to watch a specific part of the series to better understand the dynamic between the school counselor

and the student. Jade stated that she was able to have students learn what they needed to by watching the ASCA webinar, instead of exposing them to potentially triggering content that had no clear connection to the course goals as a learning activity. Finally, Jade used the HBO series *In Treatment* because "there are all these different clients that he worked with that are relevant. It's not perfect, but I think it's one of the better TV portrayals of therapy," which allowed students to have access to a broad range of fictional client experiences to better understand course content. In addition to the course teaching and learning activities, Jade used graded components of the course to facilitate significant student learning.

Assessment and feedback. There were five graded components of this course: in-class attendance and participation, online participation and discussion questions, reflective journals, a film reaction paper, and the integration project which was originally an independent assignment and has been transitioned into a group assignment.

In-class attendance and participation. Jade stated that she opened her course by reminding students that the content they would be discussing was difficult, but that she still held high expectations for participation in class. She provided an example of how she opened the first day of class.

> We're going to be very mindful of our own reactions in this course because I think they start almost immediately. When we're going over the syllabus, I already sort of, if I'm really scanning the room, you can already see students' reaction to ... anticipating different topics. So, I immediately am asking students to be mindful of their own reactions. I have a strict attendance policy in most of my classes, and I have it in this one too, but I also say, "I want you to take care of yourself. If you need to get up and excuse

> yourself at any point, no questions asked. And at the same time, part of what we're learning here is how to be able to tolerate this material and sit with it."

One of the other strategies she used to encourage participation with the content even when it is difficult, was to introduce topics related to practitioner distress (e.g., vicarious trauma, secondary traumatic stress, and burnout) within the first class or two. Additionally, she was intentional in having self-care activities interspersed throughout the face-to-face courses, such as having her guest lecturer on trauma-informed yoga on the first day of class.

Online participation and discussion sets. I previously discussed the online participation and discussion sets as an integral teaching and learning activity due to the hybrid structure of the course. Jade also used them as an assessment tool for the course. The online learning activities were assigned the weeks between the face-to-face meetings and required students to review readings and online lectures in addition to posting a minimum of three times on a discussion board.

Jade explained that "part of the reason why I really like the hybrid format of this class because it allows for those more extensive online discussions." The online discussion sets allowed students to demonstrate they understood the foundational knowledge that was presented in the lectures and reading by referencing "directly to one of the readings and have some questions about that." They also encouraged students to apply the information through critical thinking exercises such as responding to media prompts or case studies. Additionally, students reflect on the content presented and their own experiences such as the prompt for the ASCA *13 Reasons Why* discussion that asked students, "What did that bring up for you?" encouraged "them to think about their own experiences, professional experiences," and asked if they could "think of a time when this came up in your work?" Finally, the discussions provided a platform

for students to integrate information by reading peers' responses and understanding of the material to create well thought out responses. In addition to the ongoing discussion sets, students also had reflective journals due throughout the semester.

Reflective journals. The reflective journals were intended to increase self-awareness and self-evaluation, which Jade believed were critical parts of the counselor training process. Students were required to complete three reflective journals, the first was due after the first face-to-face weekend, the second was due after the third online week, and the third was due after the final face-to-face weekend. Jade told students that she wanted them

> to be able to merge your course learning, something you read, something you heard in class, something you watched in one of the films or the shows that we watched, with your own reactions or your own experience whether it's personal or professional.

Jade reported that students struggled with this ambiguity and wanted prompts to guide them through this assignment. Jade utilized this assignment to home in on student values, interests, feelings, and what they were learning about themselves and others. Additionally, they should have demonstrated that they learned some of the information and ideas from the classroom and how that connected to different realms of their life. Jade mentioned

> one of the students had a great quote that was something like, "I'm realizing that you're not only teaching us how to work with clients who have experienced trauma, but how to handle working with clients who have experienced trauma". And I went like, "Yes, you get it."

Of all the assignments in the course, the reflective journals had the most potential for students to share their own personal trauma histories. Jade saw this assignment as a good way to "teach about boundaries" and how students should process what they share. She tried to teach

them how to think through and only sharing reactions that were relevant to the class, rather than disclosing their entire trauma history. She also reminded students that she is a mandatory reporter and had Title IX responsibilities if they wrote something in the journals that required her to connect them to services on campus.

Film reaction paper. The film reaction paper was an "assignment that's totally designed around watching media related to trauma." The class voted on three or four movies, and each student was required to choose one of those movies. The assignment required them to write a 6 - 8-page paper, and "answer a series of question which are basically a contextual question, historical, cultural, development, and also systemic." There was also an option to do a

> more case-related angle where they pick one particular character. They make a provisional diagnosis if that's appropriate, or they at least talk about the signs and symptoms of trauma they're seeing, and then they have to think about a particular treatment model that they would use if they were working with that character.

Students were able to tie in outside information for this assignment, and Jade aimed to assess their ability to apply and integrate information, while also teaching them to be self-directed learners. Jade noted that learning about a character while they are embedded in a much larger contextual story also mirrors the counseling relationship, where clinicians must be able to work with and within the complicated lives of their clients.

Integration project. The final assignment was the integration project. This was originally designed to be an independent presentation but was transitioned into a group project for future renditions of the course. For this project, students chose to create a training module or prevention program that was grounded in research regarding a topic of their choice. After they were

completed the assignment, students were able to share what they created with the class. Jade stated that she wanted

> it to be a product that they could really use because if they do a good job on it and it relates to the population at their site, for example, I thought they could actually use this and it could be a good resource for their sites and a contribution that they could make.

Jade explained that the overarching goal of this assignment is

> To have that product that they could take away, but also that they are applying the knowledge that we've learned in class. Since this is a Master's program, and particularly in a Master's level class I think that piece is so important to make it very applied to practice. I think it becomes a way that they can actually talk about, "Okay, what did I learn about how I could prevent or at least be more aware of non-suicidal self-injury and adolescents in schools or something like that?" Presenting to me how do we know that this is going on, what do we do about it, what are the treatment approaches? Taking that material and not just regurgitating it to me but being able to apply it to a particular setting. Right? They could say, "Okay, well this is how I would present it if I was presenting it to my colleagues at a community agency or my colleagues at the middle school. This is the information that they would need, or this is the information that parents need." Being able to actually apply it to that particular setting.

This assignment allowed students to learn about the needs of others and apply course information to a specific population to create real change in a work setting. It also required students to inquire independently about a subject and was the only assignment in the course that required use of outside sources.

Interpretation of Jade's Course Design

This section is my understanding based on the above-presented case information of how Jade chose which trauma content to address in her class and which teaching methods she utilized to create significant learning experiences. I found three themes and three major impacts on course design in the interviews and course documents concerning how Jade choose the content for the course and the way that she taught the material. The three themes were: (a) *Responsiveness to student developmental level*, (b) *Awareness of contextual factors and current events*, (c) *Embracing and capitalizing on instructor expertise and limitations*. Additionally, there were three major structural and situational factors that impacted course content and course development. The three factors were: (a) *Hybrid format of the course*, (b) *CACREP accreditation*, (c) *Instructors relationship with her faculty mentor*. These three factors will be explored in more depth after the themes.

Responsiveness to student developmental level. Jade identified her teaching philosophy as integrative and developmental, which provided a framework to be responsive to the developmental needs of her students. She stated: "I teach very similarly to the way that I supervise, which I would describe as consistent with the integrative developmental model of teaching and supervision. I tailor, my teaching style, to the developmental level of my students." Additionally, Jade reported that she was "mindful of catering to different learning styles". Her own theoretical conceptualization of trauma was heavily rooted in a Feminist perspective which also aligned with a contextual and developmental understanding of the phenomenon. She stated, "I am very up front about my bias as a Feminist, and as somebody who believes very firmly in developmental and complex trauma."

This theme impacted the way that Jade paced content in her course, beginning with a theoretical, developmental, historical, and contextual understanding of trauma and moving into interventions and specific types of trauma later in the course. In addition, the pacing of the assignments in the course was developmental in nature beginning with discussion questions and reflective journals, moving into a more complex application assignment, and ending with an integration project that could be utilized with clients. Jade allowed students to choose the content that was most relevant to their interest areas. Choice was apparent in almost every assignment: multiple prompts for discussion questions, open-ended nature of the reflective journals, choosing movies for the film paper, and an integration project which was specific to the population with which students wanted to work.

On a micro-level, Jade stated that she attended to non-verbal cues from students as can be seen in her choice to address neurobiology and neurophysiology face-to-face and in her general approach to facilitation as evidenced when she said

> I do a lot of reading of non-verbals in order to check in with students and to see what they're getting, to try and get a sense of who, especially in this class may be having a reaction to the material.

Furthermore, Jade took into consideration the holistic developmental level of the class when tailoring course content. This is apparent in her choice to reinforce suicide risk assessment despite coverage in other courses and her attentiveness that this may be the first-time students are asked to process this amount and depth of trauma content.

> ...we're increasingly seeing research about this, that students seem to be traumatized by the trauma course, and I think we have to be very sensitive to that, that 90% of the population has experienced trauma, which means 90% of your students probably have

> experienced trauma, too. So, everybody's coming in with their own stuff, and you can watch students, if they're being triggered as they're processing through and thinking about their own lives. So, I've increasingly addressed that, and talk about it in the first night, and I'm increasingly incorporating self-care, and especially mindfulness strategies, to kind of break up the heavy content. I think that's another reason why the hybrid format works so well, because it does allow for me to kind of model some of those strategies in class, but then for the students to take them home with them and try to use them and start moving through the material on their own.

In addition to emphasizing responsiveness to students' developmental level, Jade also took into consideration contextual and situational factors in course design and content.

Awareness of contextual factors and current events. There were many contextual and current event factors that impacted what Jade taught and how she taught it. Jade called on guest speakers from the community to help students better understand specific content areas outside her expertise and to connect students to trauma professionals in their community. By bringing in content experts who were also local experts, Jade was able to help students better understand the needs of their community. Furthermore, "guest speakers are a mix of helping students understand the resources in the area, but also diving into specialty populations and specialty interventions."

In addition to working to meet community needs, Jade's department was responding to the need that local licensure boards were beginning to require education in trauma-related topics for both school counselors and mental health counselors. Although this course was just one piece in a larger programmatic plan to meet the needs of counselors in the community and ensure that they were graduating counselors able to meet the licensing requirements for the region, it

seemed to impact the way that Jade saw this course as a staple in the core curriculum for minimum competency in the field of counseling.

Jade also integrated current events into her course in efforts to highlight the prevalence and impact of trauma-related topics. For example, she brought in a guest speaker to talk about the impact of trauma on refugee populations in response to the immigration topics that were in the media last summer. She stated: "We had great conversations over last summer about attachment, about working with immigrant and refugees, because everything that was going on with the family separation crisis, and I had a guest speaker come in and speak on that topic." Because she realized many of her students would be working in urban areas, she had students watch a documentary about a woman living in poverty who had experienced multiple traumatic events. Similarly, Jade created assignments that pushed students to explore how their understanding of trauma, trauma response, trauma intervention, and trauma-related diagnoses were situated within the larger context impacted by the zeitgeist at the time they were created, who created them, and what population they were intended for as was seen in the PTSD activity described previously. Finally, Jade mentioned the geographic location of the community multiple times during the interview, indicating that she had a deep understanding of how distribution of resources for urban and rural communities impacted the way that they respond to traumatic events and intervention. This signaled that geographic context was a very important concept when designing this course and preparing the next generation of counselors to work in that region. Despite noting concerns related to the opioid crisis in her community, there was no specific content that was mentioned in the interviews that directly attended to that contextual factor for her community. The final theme that impacted the way that Jade chose, and taught trauma content was her expertise and limitations as the instructor.

Embracing and capitalizing on instructor expertise and limitations. Key aspects of Jade's teaching style and philosophy were humility and transparency. Due to the course being survey-style, covering a broad range of topics with limited depth, Jade understood and embraced that she was not an expert on every topic. Jade stated, "In any survey course there's always going to be some areas that you feel a little bit less expert in." One of the gaps that she noted for herself was her lack of experience working with children and adolescents, so she continued to strive to find a way to deliver this content in as much depth as she could, calling on guide speakers and designing field-based work for students as was seen in her approach to reviewing school-level crisis intervention plans. Jade also reported that she continuously encouraged school counselors in the class to share how the content aligned with the experience at their clinical placements or the information they were learning in their other courses.

Although sexual assault and sexual violence were among Jade's specialty areas, she invited a guest lecturer who had even more experience than her to speak on the topic. Jade stated, "... she is an expert beyond what I could possibly share with the students, so I thought it would be cool to have her come and talk this semester." There was a humility to Jade's teaching style and an understanding that for students to truly understand complex, difficult, and often painful content, they needed to hear from more than just her.

Jade was also straightforward about her theoretical understanding of trauma through a developmental and feminist lens, which impacted the way she approached clinical diagnosis with individuals who have been impacted by traumatic experiences. Jade stated that she explained to her students:

> I am ... I very much come from the sort of Courtois school of attachment and feminist reference to complex trauma. That's the way I work, so that's what I'm going to talk to

> you about, because that's what I know. But we're also going to talk about other approaches, and I'm going to try to bring in guest speakers who might work differently from me. And certainly, we're going to talk about the evidence-based treatment models.

Due to her transparency, she opened the learning environment allowing students to challenge her viewpoints, explore where the limitations of it may be, and reflect on if it aligns with their worldview.

These next three areas (a) *hybrid format for the course,* (b) *educator mentorship of the instructor,* and (c) *CACREP accreditation of the program* were discussed during the interviews but did not necessarily continue as themes. They are included in the case because all these areas had a significant impact on course design and shaped what Jade taught and how she taught it. These impacts also link back to contextual factors mentioned at the beginning of the case: course, instructor, and program.

Hybrid format. The online and face-to-face format of the course allowed for Jade to form student relationships and for the students to have space to titrate their own exposure to the content. The hybrid format impacted everything from content pacing (e.g., Jade's preference for teaching certain topics like neuroscience in person) to how Jade assessed content through online discussion forums. Jade capitalized on the format by intentionally pacing lecture heavy topics on the online weeks so students could listen to the recorded lectures in their own time. Additionally, she believed that this format for teaching trauma was ideal, because it allowed for instructors to still monitor student progress with face-to-face classes, while also recognizing that the nature of the content may require more out of class time to process. Jade stated:

> I really like that model. I think it allows me to kind of build rapport in person, in the face-to-face meeting times, but at the same time allows for some space for some students to be able to process some of the deeper content on their own.

The hybrid format also allowed Jade to build lessons with webinars, videos, media, and recorded guest lecturers for topic areas that were outside of her expertise.

Educator mentorship. Jade described a strong relationship with her mentor prior to her current position. She modeled the class after the course originally designed by her mentor, and her mentor seemed to have influenced her philosophical understanding of trauma from a developmental and contextual perspective. Procedurally, Jade carried over content including course readings and pacing from her mentor's version of the course. Jade stated:

> I have to disclose that the model of the course is really heavily based on the course that was originally developed by my advisor at my doctoral program, [advisors name], and she was able to test it over many years. I haven't varied too much from that general, sort of, framework that we talked about, where the foundational knowledge is kind of provided in the beginning.

She also learned from her mentor the importance of placing an emphasis on how the content is being taught to ensure students do not experience excessive amounts of distress or become traumatized during the experience. This was one of the reasons Jade incorporated self-care and mindfulness into the course, including why she discussed practitioner distress on the first night. From a philosophical perspective, Jade deeply respected her mentor's opinion and aligned with her on how to conceptualize trauma response within the context of identity, history, and environmental factors.

CACREP. The final factor that impacted course design was that the program was up for CACREP accreditation in the coming year. Jade stated, "we're so CACREP focused right now because we're in the process of scheduling our self-study, so we've been very careful about that." This process required faculty to be mindful of the content being taught in their courses and ensure that it aligned with designated CACREP standards for the course. Although this course is not required, thus it does not meet core curricular standards for CACREP, the instructor was still heavily influenced by the upcoming accreditation and the long-term goal of adding this course as a requirement for all students. As such, Jade structured the course to provide opportunities for students in all specialty areas to be exposed to content as stipulated by the CACREP Standards. Jade reported:

> Trauma and crisis, you know, it's mentioned so many times in the 2016 CACREP standards, both generally, and in all the specialty areas. So, what I take from that is that I also need to think about how this applies for, well we don't really have rehabilitation counselors or doctoral students in our program, but we certainly have clinical mental health, school counseling, and students who are interested in working in college counseling centers.

When asked which trauma standards are utilized to frame this course, Jade stated that the CACREP standards and the ACA *Code of Ethics* were the guiding standards. This statement is also important when taking into consideration the stated goals of the course to "provide a counseling perspective on the knowledge base from the multiple disciplines that contribute to the field of traumatology." This statement recognized that the content in the course is from a diversity of fields, but with a firm footing in CACREP and the ACA *Code of Ethics,* Jade was

able to place this information within a framework that ensures that information is presented in a way that is applicable for professional counselors-in-training.

Individual Case Limitations

From the artifacts examined and the interviews, it was difficult to fully understand what types of trauma were addressed in this course. One of the limitations of only utilizing the course syllabus and reading list for artifacts with a hybrid or online course is that the material is housed in the online platform and is not necessary as detailed in the syllabus. This current study does not examine the online course artifacts and thus was limited in assessing which types of trauma were addressed at what frequency throughout the semester. Additionally, video and media embedded in online lectures or in face-to-face lectures as teaching and learning activities were not outlined in the syllabus, so my understanding of the types of content being taught in this course is limited to topics apparent on the syllabus and via instructor self-report.

Individual Case Conclusion

This case study aimed to better understand the unique factors that impacted how Jade chose which content to teach in her trauma and crisis intervention course and which methods she utilized to create significant learning experiences for her students with the trauma content. Jade chose and taught the content for a variety of reasons including the developmental level of her students, contextual factors and current events, her own expertise and limitations as the instructor, the hybrid structure of the course, the guidance she received from her mentor, and the framework provided by CACREP standards. These themes and factors combined to create an extremely interactive and dynamic course for "students to be introduced to research, theory and practice within the field of trauma counseling" (syllabus) in her master's level trauma and crisis course.

Case Two: Jimmy

This case study aimed to understand how Jimmy choose the content in his trauma course, *Concepts in Trauma-Informed Counseling,* and how he used that content to create significant learning experiences for masters-level counseling students. As detailed in Chapter Three, I utilized four primary forms of data to create this case report: an open-ended questionnaire about the instructor, course, and community; the course syllabus; one 53-minute interview focused on course content; and a second 62-minute interview focused on course teaching methods. Additionally, Jimmy provided descriptions of homework assignments and pictures of the online modules detailing the content that was addressed and the methods he utilized the teach the content. The first section of this case report includes contextual information collected from that questionnaire. Next, I analyzed Jimmy's syllabus examining the structure and content included in the document. This case ends with my interpretation of how Jimmy chose content and utilized methods in his trauma course.

Instructor and Course Context

The participant described the information I present in this section in the instructor in course context questionnaire and in the initial interview. Some aspects of it may appear non-linear, the reader should approach this information as a conversation providing context for the Findings presented after this section. The aim of this section is to add background information to aid the reader understanding the interpretations presented late in this chapter within the context of the Case. The following section includes pertinent information about the instructor of the course, Jimmy, and his educational and clinical background. Additionally, I expand on the counseling program in which Jimmy taught and the community in which the University was

located. The section ends with an overview of the course including the texts that were used, content covered, instruction methods.

Instructor. Jimmy was a 38-year old cisgender man who identified as Caucasian or White. At the time of the inquiry, he had been a professional counselor for eleven years and a CE for four years. Jimmy had no formal graduate-level training in trauma and had worked as a professional counselor supporting children with documented cases of abuse. At the time of the interview, he was employed as a tenure-track assistant professor who taught this trauma course three times at his current institution. Jimmy considered trauma to be a secondary specialty area.

Jimmy's research and scholarship interests focused on "early childhood grief responses as well as research concerning LGBTQ issues in counseling supervision." Additionally, his clinical experience was "broad having worked as a counselor and supervisor in community mental health clinics, in-home intensive settings, community advocacy agencies, and private practice." As an educator, Jimmy strived to create a collaborative space and wanted students to take responsibility for their own learning by seeking out the answers to their questions. Ultimately, he wanted students to experience the love and passion he had for the field of counseling, and through modeling, hoped to elicit the deep respect he had for the field in his students.

Program. The counseling program in which Jimmy worked in had approximately 250 clinical mental health and school counseling students. The program also offered a trauma certificate to be completed concurrent with the master's in counseling or as a post-master's option, which allowed anyone to enroll in the course for in-state tuition. The certificate counted as 45 hours of training which would allow students to meet the qualifications for the International Association for Trauma Professionals Certification/Endorsement.

The trauma course of focus for this case study was an elective and the second course in the program sequence for a trauma certificate. There was a required crisis course which was a prerequisite for this course, and two courses that succeed it to complete the trauma certificate. This course is taught in 8-week sessions, which means students were able to finish the three required courses for the trauma certificate in 24-weeks concurrent with their graduate student coursework. Due to this, Jimmy stated that all students who took this first course on trauma also completed the other two courses. Jimmy taught all three of these trauma courses for the program. This course focused on introducing students to trauma-informed care, while the other courses in the certificate focused on more advanced concepts such as complex trauma and trauma specific experiential interventions. Jimmy was unsure how many times this course has been taught or how long it had been in existence.

Community. The community in which this course was taught had approximately 43,000 people and was described by Jimmy as rural. Jimmy reported that the types of traumatic events most commonly seen in this community were farming accidents, fires, car accidents, and abuse. When speaking about the populations that were impacted by traumatic events in his community. Jimmy stated that "we still do see a disproportionate amount of violence or trauma towards people of color. But in terms of their traumas, farming accidents is something that is kind of unique to this area." He went on to say that, it is not "uncommon to have students who have lost loved ones or individuals who they went to high school with, either have been dismembered or have been killed altogether." Additionally, at the time of the inquiry, the area had recently had a shooting that took place. Jimmy was part of the response team and explained

> When I was doing some trauma processing with some student teachers who were very close to the site, one of the first things that came out of their mouth was, 'Well, we might

> have a shooting, but it's somebody's outside shooting their gun and they're drunk. But we don't have shootings where someone goes in with the intention to kill'…so whereas they were familiar with guns and they understood that concept and there's a culture there, it's not the same culture.

This course was an asynchronous online course with students enrolled from various locations and disciplines. Due to this, the community that Jimmy's institution was based in did not seem to have a large impact on the content that was taught. The community resources available to individuals that had experienced traumatic events included private practice counselors and the free counseling clinical on campus, but they were not an emphasis in the course.

Course overview. The *Concepts in Trauma-Informed Counseling* course was an intervention focused course in which 25 - 35 students typically enrolled. There was no maximum number of students allowed in the course, and it was not restricted to only counseling students. Jimmy explained,

> crisis course is a required course for everyone in our program, so they've already taken one course. And so, for the others, they take it as the electives. We do have about 80% of everyone in these courses is master's level students, and then the rest are what we call students at large, which are people who are just pursuing the graduate degree or the graduate certificate.

Additionally, because the course is open to non-degree seeking individuals outside of the helping fields, he stated that

> we have school administrators who are interested in this, and because it does require a pre-learned body of knowledge about what counseling is and those relationships, we have to start there. If an administrator does not have that information, more often than not they

> don't. They just don't. They have a different skill set. And so I've recently started to deny entry to school administrators because this is a class designed to work with clinicians or professional helpers, not necessarily administration.

This course was taught in an online asynchronous format to make it accessible to non-degree seeking students, and it was offered twice a year. It was taught in 8-week modules with the weeks starting on Monday at 12:00 AM and ending on Sunday at 11:59 PM. The primary instructional methods for this course were project-based learning, readings, and videos. No teaching assistant was utilized for this course.

Jimmy detailed the structure and procedural elements of the course in an 8-page syllabus. The syllabus was comprised of the required university and program information such as attendance policy, academic misconduct statement, statement of equal treatment, information for students with disabilities, and copyright policy. In the syllabus, Jimmy described the course as, "roles and responsibilities of counselors and other helping professionals in post-traumatic exposure intervention" stating that it "covers the types of potentially traumatic events, effects of trauma, assessment issues and potential outcomes, and common elements of treatment interventions for trauma." The course broadly covered theories related to traumatic stress events, recognizing the ways that traumatic events impact humans, literature and online resources pertaining to trauma response and traumatic events, intervention and assessment, and effective trauma treatment. Due to the intensive 8-week format, the syllabus stated that it required approximately 90 hours to complete, which equaled approximately 11.25 hours of lecture, activities, homework, and reading per week.

The general flow of the course began with foundation knowledge concerning what trauma is and theories of development. Then, Jimmy moved into integrating general knowledge

about trauma and how that applies to distinguishing evidence-based interventions. Next, students applied this material to working with individuals who were actively struggling to manage distress. Jimmy then shifted into the application of interventions such as psychoeducation-based interventions, cognitive interventions, and working with clients in long-term counseling. The course ended with the impact of vicarious trauma on the helper.

The course began with an introduction of what trauma is and how what distinguishes it from general distress. Jimmy stated that they begin with the question

> "What is trauma?" Capital T, lowercase t, really to set that stage, because we continue to have this discussion, that you understanding what we're talking about when we're talking about trauma, and that it's not…everything a human being experience is not traumatic. And even when we use the word traumatic, it may not meet the definition of trauma.

After the introduction, he then discussed trauma across the lifespan asking the question, "How does it impact clients early on? So, what is it, and then that development foundation." Then, he introduced the ethical implications of working with individuals that have experienced traumatic events, "What does our ethical code say and how it relates to trauma." In the same unit, he also addressed assessment and trauma, stating "how do we specifically assess for trauma if and when that time comes?" Students were exposed to the *Difficulties in Emotional Regulation Scale*, *Children's Perceptual Alteration Scale,* and trauma history checklists. Jimmy stated:

> ...this is designed for working individuals and I want them to have resources that may fit their population. And so even giving them that information that there are specialized assessments for individuals in this population is what we're looking for there with assessment.

These first three modules created the foundation for the intervention-based lessons which were the focus of the next four weeks. Jimmy began by asking the question "How do you understand that trauma-informed work is supported in literature?" He wanted to help students understand "what is evidence-based and what is working and what is working in certain populations, as compared to what is a book that is being discussed on a morning talk show." Next, he introduced what he called "trauma first aid." This included mindfulness and grounding techniques, strategies that he believed were necessary for counselors-in-training to know "if someone comes in and presents with trauma and they start to escalate." The next unit covered psychoeducation focused on "how to help a client choose information that helps inform what's going on." After that, he introduced "cognitive interventions" such as "Socratic questioning...thought challenging, and things along those lines." Additionally, Jimmy introduced "the therapeutic work zone and how we as counselors help our clients into that therapeutic work zone." He explained

> Whereas if we keep things superficial or if we supported superficiality too long beyond relationship-building piece, then we're not really benefiting, or not serving our clients, because we haven't helped them address why they came to us. But at the same time, we as clinicians can overstimulate a client and go above the level of therapeutic work where they're in a panic or they're in that fight, flight, or freeze piece. So, this week is designed to help them understand their role in helping the client enter into that therapeutic work zone.

In the following week, there was not a lot of new content addressed because Jimmy stated that week coincided with when the students had a large paper due. Instead of introducing new content, Jimmy had students utilize the Curran (2013) text, *101 Trauma-Informed Interventions:*

Activities, Exercises, and Assignments to Move the Client and Therapy Forward, to identify interventions that aligned with their theoretical orientation, which allowed students to identify and research specific interventions that may support their specific population of interest and their own therapeutic style. Jimmy ended each of the trauma courses he taught with a lesson on vicarious trauma. For this course specifically he had students create a self-care project which will be discussed further when I explain the teaching methods for this course. Table 4.3 displays a week-by-week analysis of the content taught in the course and the instructional methods utilized to teach it, Table 4.4 details the texts for this course.

Individual Case Findings

In this section I describe the individual Case Findings. I first introduce Jimmy's course goals which is the overarching aim of the course. I then detail the teaching and learning activities in the course. These activities include all in-class teaching methods that use in his course. The next section describes assessment and feedback methods which include all course assignments that were graded. I organized these descriptive Findings based on a review of course artifacts such as syllabi and assignment descriptions in addition to the interviews with the course instructor. These Findings do not reflect thematic analysis but are reported in an attempt to stay as true to the participant's self-report of course design in interview and course documents.

Course goals. Jimmy stated multiple goals for his students including: (a) a foundational understanding of the clinical definition of trauma and how that differed from the colloquial use of the term, (b) an understanding of how trauma impacts clients across the lifespan (c) a foundational understanding of trauma interventions, and (d) an understanding that change happens in the helper when they function in a trauma-informed way. Jimmy stated: "I want them

Table 4.3: Topic Areas Jimmy taught, and the instructional method utilized during the module for each week based on information provided in the syllabus.

Topic Areas Taught	Instruction Methods Utilized During Each Module (required materials)
Unit 1: What trauma is	The concepts in this lesson were taught by four required readings; Briere & Scott (2014) Chapters 1- What Is Trauma?; and Chapter 2- The Effects of Trauma; Levers (2012) Chapters 1- Introduction to Counseling Survivors of Trauma: Beginning to Understand the Context of Trauma and Chapter 2- Historical Contexts of Trauma.
Unit 2: Trauma across the lifespan	The concepts in this lesson were taught using four required readings; Levers (2012) Chapters 8- Trauma Experienced in Early Childhood, Chapter 9- Trauma Experienced in Adolescence, Chapter 10- Treating Adult Trauma Survivors, and Chapter 12- Elder Abuse.
Unit 3: Ethics and assessment in trauma counseling	These concepts were taught through the use of three chapters; Briere & Scott (2014) Chapter 3- Assessing Trauma and Post-traumatic Outcomes, Levers (2012) Chapters 27- Assessment in Psychological Trauma: Methods and Intervention and Chapter 30- Ethical Perspectives on Trauma Work; and Herman (1992) Part 1 which includes Chapter 1- A Forgotten History, Chapter 2- Terror, Chapter 3- Disconnection, Chapter 4- Captivity, Chapter 5- Child Abuse, and Chapter 6- A New Diagnosis. To process the Herman (1992) chapters students record a reflection and post it on the discussion board, they are required to respond to each other's posts within two weeks.
Unit 4: Introduction to trauma-informed clinical interventions	The concepts in this lesson were taught through three chapters; Briere & Scott (2014) Chapter 4- Central Issues in Trauma Treatment; Levers (2012) 28- Models of Treatment Intervention: Integrative Approaches to Therapy and 29- Strategies and Techniques for Counseling Survivors of Trauma.
Unit 5: Trauma-informed clinical interventions part 1	The concepts in this lesson were taught through three book chapters; Briere & Scott (2014) Chapter 5- Psychoeducation; Chapter 6- Distress Reduction and Affect Regulation Training, and Chapter 7- Cognitive Interventions; Herman (1992) Part II which includes Chapter 7- A Healing Relationship, Chapter 8- Safety, Chapter 9- Remembrance and Mourning, Chapter 10- Reconnection, Chapter 11- Commonality. To process the Herman (1992) chapters students record a reflection and post it on the discussion board, they are required to respond to each other's posts within two weeks.
Unit 6: Trauma-informed	These topics were taught with two book chapters; Briere & Scott (2014) Chapters 8- Emotion Processing and Chapter 9- Increasing Identity and Relational Functioning.

Table 4.3. Continued.

Topic Areas Taught	Instruction Methods Utilized During Each Module (required materials)
clinical interventions part 2	
Unit 7: Treating Acute Trauma	This material was taught with one book chapter; Briere & Scott (2014) Chapter 11- Treating the Effects of Acute Trauma.
Unit 8: Vicarious traumatization and the importance of self-care	These topics were taught with three book chapters; Levers (2012) Chapters 31- Vicarious Trauma, Chapter 32- Therapist Self-Care: Being a Healing Counselor Rather Than a Wounded Healer, and Chapter 33- Trauma and Supervision.

Table 4.4: Jimmy's Required Readings

Type	Required Course Reading
Books	Briere, J., & Scott, C. (2014). *Principles of trauma therapy: A guide to symptoms, evaluation and treatment* (2nd ed.). Los Angeles, CA: Sage Publications. Curran, L. A. (2013). *101 trauma-informed interventions: Activities, exercises and assignments to move the client and therapy forward*. Eau Claire, WI: PESI Publishing & Media Herman, J. (1992). *Trauma and recovery.* Basic Books: New York. Levers, L. L. (2012). *Trauma counseling: Theories and interventions.* Springer: New York

to be able to understand and define trauma" and "leave understanding that that word means something, and that as a profession, we associate it with a very specific set of, I don't want to say rules, but of definitions." He went on the state that when students finished the course "they would have the information to know there's a different way I need to interact, and I need to be in the relationship." His hope was to choose content and methods that created a course focused on fostering fundamental change in the counselor:

> So, it's not an issue of looking at what's wrong with our clients and how our clients, how individuals that have experienced trauma are different than all our other clients. That's not key to me. For me, it's how do we change who we are as helpers in this relationship to provide the best possible experience to our clients? And so, for me, that's how I choose this information, is how do I give you that bird's eye view of what trauma is, how it impacts, and how it plays in the relationship, and then how to take care of yourself.

Teaching and learning activities. Jimmy described his teaching as constructivist. Jimmy explained so my constructivist is at my

> core of who I am. I do believe that ‘we’ know more than ‘me’. So, when we invite everyone together in the same space, I view my role more as a facilitator than as a disseminator of content.

The theme of *counselor educator as the facilitator* will be discussed later in this section and was at the core of the teaching and learning activities in Jimmy’s course. He described this role as the facilitator as shifting the responsibility of learning out of his hands and onto the hands of the learner. He stated:

> I do have pretty high expectations when learners join me in that space. So, coming prepared to engage in what we’re doing is paramount. Which usually involves having read content ready to discuss, not just to regurgitate what was shared and be willing to engage with the material to create new in the group spaces.

Jimmy placed his teaching philosophy into his syllabus “because it’s almost like a counseling informed consent,” he wanted students to be “informed that they understand that they have to take a large part of the responsibility of their learning in my spaces.” For this course, Jimmy mentioned the initial challenge of trying to translate the teaching skills he learned in a face-to-face format into an online asynchronous learning environment. He stated, “it did take some time for me to figure out how do I create, there's this online learning spaces where individuals can still engage with content, and it's not just the dissemination and pouring out of information.” He stated that in the online format it is important for him to create a learning space that discourages passive engagement and that “the responsibility is placed squarely on the learners’ shoulders.”

One of the ways Jimmy integrated his constructivist teaching philosophy into the teaching and learning activities for this course was focusing on tasks that facilitated connection.

These included viral synchronous and asynchronous conversations, assignments that were intended to be shared at the students' internship sites and encouraging students to present at conferences. The push for students to take the information and "create new" was integral to the course. Jimmy stated, "teaching is my favorite part of what we do" and he has learned to create a virtual learning environment where videos help his learners feel connected to him. The videos "point toward things to focus on. So, if you're overwhelmed by the amount of content that you're reading this week, jot these things down in the margin and when you see these, make sure that's what you're paying attention to." He utilized technology to allow "individuals to still see each other and to have conversations with each other, to have conversation with me to simulate as much as possible the in-class conversation that would take place." He went on the say that despite the learning curve, "I've gotten spoiled because these conversations, I believe, are better than our in-class conversations because they're laser focused."

Jimmy wanted his students to share the information they learned in the course with classmates, other counselors at their sites, and at conferences. He felt strongly that trauma courses needed to be grounded in application-focused information where students could directly utilize the content that was being taught. Furthermore, many of the assignments that will be discussed in-depth later in the case involved creating tangible products that could be presented at staff in-services, community agencies, conferences, or be an easy reference for students while working with clients.

Jimmy justified these teaching goals by stating:

> everyone should be a trauma-informed clinician, because approaching everyone as though trauma exists does not hurt anyone. But approaching individuals with a lack of

> trauma knowledge is harmful. So, I'd much rather approach it in a trauma-informed approach and then find out that that's not there.

Additionally, he warned of the danger of teaching too much theory and not moving into application when teaching about trauma.

> So, when we're talking about trauma and we're talking about what can occur if we do not go into practice very quickly. Then what we have is a lot of educated clinicians on what could happen with no clinician's understanding what to do next. And so that's what we have. We have, that's great. That trauma in practice impacts the brain this way. I'm going to start doing things differently, but I don't know what to do. What are we supposed to do?

These teaching goals were met through many different teaching and learning activities including recorded lectures, case study, and synchronous and asynchronous video communication.

Additionally, the weekly online modules Jimmy created were structured in a “Read, Watch, Review, Homework” format to meet the weekly teaching objectives. Jimmy stated,

> No matter what course you open up in the trauma program, that's the format that it's going to be to help adult learners. And also, whether or not they realize or not, none of them do. But it's also to simulate the effectiveness of predictability in trauma treatment. So it's watch, review, homework. Each one of those has a folder if there's articles, if there's something to upload. So the inside matches exactly what the outside has. To help reduce anxiety. And so they're not trying to figure out where things go. They know exactly what's expected of them and they know exactly how I'm going to present information every week.

The next sections will explore the primary teaching and learning activities that are embedded in these weekly modules and attend to the primary goal of each of these activities.

Recorded lectures. Jimmy stated that the he utilized recorded lectures sparingly because he did not believe they were the most effective teaching method for applied information. He explained that he utilized them for specific

> lectures because the concepts were more abstract. So if a concept is more concrete based then what I'm able to do is provide students with the information to read then give them additional resources and homework that helps them interact with the material.

Jimmy stated that lectures were reserved for topics where he was "having a hard time coming up with a homework assignment that would be able to merge these abstract topics." An example was the Week 4 trauma-informed care foundation lesson. This lesson was a combination of the foundational information presented in Weeks 1-3 on trauma, development, ethics, and assessment. He stated:

> So that is one where we really are getting into the foundational, and those core pieces that so far we have built upon things that you already know. I'm giving you some content information. We're talking about understanding what trauma is and not using it euphemistically, but understanding that it does have a standardized definition.

In this lesson he stated that he wanted students

> to hear from me what we believe in this program is the core of trauma care, and then the rest of the course does build upon taking this information and putting some concrete application to it through the text that they're reading.

While the lectures were reserved for a few of the lessons, case study was an integral part of the course design that permeated almost every lesson of the semester.

Case study. Jimmy had students create their own case studies during the second week of class. He stated

> so instead of me providing cases continually for this course, there is a case study that they develop using the information that's covered. And so the very early phases are creating a case study that has a background showing that a trauma occurred in childhood.

This learning activity "requires the student to put themselves in the positions of, okay well this is all the information that was provided. How do I put it into application?" After the case studies were created, students turned them in to be assessed for accuracy and thoroughness. Jimmy ensured there was a level of depth and complexity appropriate to complete the rest of the assignments that utilized the case study for application purposes. Jimmy stated, "and then we use that case study to then move into assessment and ethics. That's what they do their mock assessment on." Additionally, students utilized the case study for the intervention homework which will be discussed in the assessment and feedback section of the case.

The purpose of the case study was to allow Jimmy to gauge depth and understanding of the foundational information on trauma across the lifespan presented in the first week of class. Additionally, it provided an opportunity for students to take responsibility for their learning and choose a type of trauma and population that they were interested in working with for the remainder of the semester. They brought the foundational information to life and articulated what trauma looked like for "a client across the lifespan." This teaching and learning activity aligned with Jimmy's constructivist perspective of learning, by prompting students to create their own client to work with for the semester, instead of the instructor crafting the case studies. In addition to the case study, Jimmy also invited students to participate in synchronous and asynchronous video communication throughout the semester.

Synchronous and asynchronous video communication. Students engaged in synchronous video community to discuss the Herman (1992) text. Jimmy explained, "So we use the blackboard collaboration function to be able to record their conversations and group wherever they are." Jimmy explained the choice in text and the structure of the groups,

> The Herman text is the one that's used, because it's a foundational text, a trauma and recovery text and is important. And so that is usually broken into four sections, and they read incremental sections on that and the groups are three or four people. And so those four people set up a time to discuss those pieces.

When the course was first created, these groups were required to meet weekly to simulate the group discussions that would take place in a face-to-face classroom environment. Jimmy stated,

> I was simulating as much as possible in-person classroom environment and then getting the feedback from that, which was, that was my least favorite part of what was going on. I'm trying to schedule time for, four people to meet outside of class.

As previously mentioned, connection and fostering a space where students can co-create the learning was an important aspect of Jimmy's teaching philosophy, so figuring out a way to allow students to connect without over burdening them was one of the challenges to synchronous communication. He responded by decreasing the number of times students had to meet and being intentional about the pacing of these learning activities with the other required assignments.

> So, four weeks is pretty much the max I understand that I can do. I try to do it toward the middle. So it looks like two, three, four, and five. So they have a couple weeks under their belt to get acclimated with the platform and the system and then it's going to be over before they're larger assignments are due at the end.

This responsiveness to student needs allowed Jimmy to keep this learning activity because he stated, “I want this in there because I want them to be discussing this information with each other.” He recognized that because this course is an elective, these students were taking a course that their peers were not, and he wanted to encourage them to have conversations with each other to foster a connection with others who are interested in the same information. Additionally, by recording the conversations, Jimmy was able to “hear and monitor the depth of knowledge” and “hear how they’re responding to the Herman text,” in addition to creating an environment where students were co-constructing meaning with their peers.

Jimmy also used Flipgrid for asynchronous video communication. Flipgrid is a platform that allows the instructor to post a list of questions and students to answer the questions over video. There are classrooms set up to allow the instructor and/or other students to view and respond directly to students’ video. Jimmy stated:

> So it's a way for us to have one on one contact at the beginning of the semester to let them know that I can see what you're saying. I hear what you're saying. I'm listening to what's going on. You're not gonna see my face a whole lot but know that I'm here and I'm with you in context. I did move the format to where the Flipgrid is in some small groups. And so instead of doing the traditional discussion boards and that it's now done kind of as a video discussion panel where you would post your topic and then the two or three group members would then respond to your topic. And so there, it does have this like I said, it has a conversational nature to it, but it doesn't require that they're all in the same space and all at the same time.

By utilizing this online platform, Jimmy was able to capture the relational and constructivist learning environment, without trying to re-create a face-to-face classroom in an online format. It

allowed students to converse in a way that does not overburden students who were expecting an asynchronous class that allowed them to self-pace around their schedules.

Assessment and feedback. There were three graded components of this course: weekly homework assignments, small group discussion boards, and a white paper.

Homework assignments. Jimmy assigned homework for seven of the eight weeks of the course. The homework assignments created opportunities for the students to explore content, apply and integrate various topics in the class, and create material that they could use at their clinical sites or in the future. For the first week students were asked to create a short presentation explaining what trauma-informed care was.

> That's an application of knowledge information as well as, are they able to glean the important pieces, right. So if I, you have a 10 slide maximum, I'm not asking you to give me a 45 page or 45 slide presentation that had all of that. Can you glean and do you understand the important aspects of trauma so you can repeat it?

For the second week, students created the case study that was introduced earlier. This assignment allowed students to take the developmental and foundational information presented in the first week and create a character to work with for the remainder of the semester. Jimmy assessed case studies to determine if they were "able to be used, that's practice on administering assessment to a client" in week three. Students practiced the *Difficulties in Emotional Regulation Scale* (DERS) with their case studies. Week 4 switched gears slightly to ensure that students were pacing themselves for the semester-long white paper assignment. This week, students completed an annotated bibliography that Jimmy described as the "don't wait until the end of the eight weeks to do your paper" assignment. He stressed that this assignment was difficult for students because

it is much different and feels less applied than the other assignments in the course. By supporting students early on with this mid-way assignment, Jimmy was able to monitor progress.

Week 5 began the intervention weeks where students were required to choose two psychoeducation resources for their case study client and create a short script that involved their clients escalating during the session and what they would do as clinicians to attend to the clients' needs. Additionally, they utilized a worksheet to guide them through some of the core interventions such as Socratic questioning and supporting the "client in developing a coherent narrative while in therapy." In Week 6, interventions continued with another worksheet to support students in exploring emotional processing. Jimmy stated, "I found worksheets are helpful because it focuses the, it's like fill this out as opposed to here's all this information, but here's what I need you to do and write it in there". This worksheet specifically guided the students in how to help a client "anchor in trauma."

> So how do we increase stress and a situation so we can move into that therapeutic working range? So, after rapport has been built and, you're finding that a client is avoiding of discussing certain items, how can you help create an environment where you're moving up into the therapeutic working level? And then same thing, which is now that your sessions on its way over, how do you decrease and go back to anchoring in the present? So, they use that article, and then they go through those activities and show me that they at least have a cognitive understanding of what those pieces are.

For Week 7 there was no homework "because they're working on their white papers" and in Week 8 they have a self-care assessment. Jimmy described this assignment as two-fold:

> One, it's to work on the vicarious trauma. And we know the highest part of the... Bloom's taxonomy is to create. So, we're asking them to create information but also to provide

> them information on how to create a well-organized presentation as well. So if that's something that has never been given to them, what is a format that they could use to do a well-outlined presentation.

Students were required to create presentations that attended to how vicarious trauma impacted mental health counselors, included a reflection on their strengths and areas of growth measured by taking a wellness self-assessment, and created a self-care plan that could be implemented immediately.

Small group discussions. The second graded assignment which was discussed at length in the previous section was the small group discussion focused on the Herman (1997) text. Jimmy assessed these recorded conversations between peers for depth of knowledge, nothing that this also allowed Jimmy to support connection between students.

White paper. The white paper was the final graded assignment, and the one that students tended to have the most trouble with. Jimmy stated that because this course is a mixture of master's level students and post-master's certificate-seekers, there was a wide range of responses when students were asked to complete an assignment that they perceived to be less applied than the others. Jimmy explained:

> The white paper is designed to help them start to merge what they're learning about trauma-informed care with often times marginalized client populations. And so they, early on, what they do is they research, and they pick a treatment modality that they believe to be effective with a client population. And then they spend the rest of the semester working its way down.

This is a relatively short paper, approximately five pages, and Jimmy provided a suggested outline including headings. Additionally, Jimmy prompted students during the first week of class

to begin thinking about their topic and have an annotated bibliography due mid-way through the semester to ensure they were on track. Although students felt that this assignment was not as applied, Jimmy stated, “I have had students who have submitted this paper for as conference presentations, and it's been accepted” and he viewed this assignment as an advocacy activity. This assignment attends to the “advocacy side of trauma, which is not just providing services directly, but how do we inform and educate the community that these things exist and we need to be doing things differently.”

Some of the common topics for this paper included “LGBTQ folks...African American youth...and women” which Jimmy stated were large topics areas that he helped students narrow down over the course of the semester. Jimmy explained that if students are “working in the schools, they’re seeing a disproportionate amount of young men of color receiving suspension or expulsion or detention.” When students explored this population in the white paper through a trauma-informed lens they were able to have conversations like

> it's not because they're bad kids, right? Which is what the message that they've received their entire lives is that these kids are bad, but there actually could be an impact of trauma on the brain, and they want to explore that more.

The primary teaching and learning activities and assignments described in this section created the *Concepts in Trauma-Informed Counseling* course that Jimmy taught. Each of these learning activities and assessment methods aligned with Jimmy’s constructivist teaching philosophy and his hope to foster student engagement with content in a virtual learning environment that shifted the responsibility n to the students. Throughout the analysis of the interviews and course artifacts, themes were identified that provided an additional layer of

understanding to how Jimmy choose the content for his course and which methods he utilized to teach it. Those themes are described in the following section.

Interpretation of Jimmy's Course Design

This section is my understanding based on the above-presented case information of how Jimmy chose which trauma content to address in his class and which teaching methods he utilized to create significant learning experiences. I found 4 themes and 2 major impacts on course design in the interviews and course documents concerning how Jimmy choose the content for the course and the way that he taught the material. The four themes were: (a) *trauma-informed counselors as advocates that demonstrate the ability to utilize the course information outside of the classroom*, (b) *counselor educators as facilitators to engage students and shift the responsibility to the learner*, (c) *past experience*, (d) *application-focused pedagogy*. Additionally, there were two major structural and situational factors that impacted course content and course development. The three factors were: (a) *format of the course* and (b) *utilizing Bloom's Taxonomy to conceptualize course design*. These two factors will be explored in more depth after the themes.

Trauma-informed counselors as advocates. Jimmy's belief that "everyone should be a trauma-informed clinician" was integrated into many aspects of the course design. This belief was not just that trauma-informed clinicians are better prepared, but that clinicians who were not trauma-informed could do harm. This potential for harm created the framework of advocacy Jimmy utilized to create a course that reached the students in and outside of the class. He designed the self-care and trauma-informed care assignments so that students could carry that information out of the classroom into the community. For example, he designed the self-care

assignment so that students could provide a presentation to an agency "on the importance of self-care when working with individuals who have experienced trauma and why." He stated:

> I know not every person is going to come through and receive this information, but I do believe everyone needs to hear this information. So, how can I better support the individuals who are able to come in and receive this information to share these key aspects.

Additionally, he used the white paper to help students begin to understand trauma and how it impacts individuals who hold marginalized identities.

> And so the vicarious trauma and those pieces and then the marginalized population is really designed to help jumpstart or spark that, 'okay, well. When I'm thinking about trauma I need to make sure I'm not just thinking about white folk', right. Like that, that's what's going on. That this is, what's occurring. That I need to understand intersectionality as it relates to trauma and that I need to be intentional and selective in what I do and not just throw a wide net and say this wide net was made for everyone, understanding that everyone is a very certain population that has been norm referenced on.

As mentioned earlier, Jimmy conceptualized the white paper as an opportunity for students to learn about the "advocacy side of trauma, which is not just providing services direct, but how we inform and educate the community that these things exist."

When asked about the most significant learning experience in his course, Jimmy stated, "I did have a student who took that white paper and use it to do a presentation at the [state] Counseling Association." He went on the say, "that was one of those times that I can see that thing that I want, which is to 'take and make other' actually worked. She did take and make

other." This ability for students to take the information from the classroom and present it in a meaningful way to advocate for others was a central theme in Jimmy's instructional choices.

Counselor educators as facilitators. The way that Jimmy conceptualized his role as a CE also impacted the content that he chose and how he taught it. Jimmy viewed his goal as a CE the same way he viewed his goal as a clinician which "is to be able to provide them with information that spans a wide variety of interventions." He provided these opportunities by creating a learning environment where students took responsibility for their learning and engaged with the content in a variety of ways. As previously mentioned, Jimmy wanted students to "take a large part of the responsibility for their learning" in the classroom which stemmed from his constructivist teaching theory. He was straightforward in admitting that he viewed his role as more of a "facilitator than as a disseminator of content," and he reserved methods of instruction that were purely intended to disseminate (e.g., lecture) for only a few of the more abstract lessons.

Included in this theme of *counselor educators as facilitators*, was Jimmy's emphasis on facilitating connection between himself and his students. He utilized virtual platforms to create a space where students were able to connect with him and each other at various points throughout the semester. When asked if there was a teaching method, he wished he could use that he does not currently he stated, "I would love in some way shape or form to be able to have that in-person type of piece." He went on to say that he recognized that students opted into an asynchronous learning format to be able to have access wherever they are, and he ended by stating that is just something "I need to own." Jimmy facilitated connection through intentional course design in many ways:

1. Creating an introduction assignment on Flipgrid which allowed students to have asynchronous video communication with him and their peers.
2. Incorporating synchronous small group meetings to discuss the Herman (1997) text.
3. Encouraging students to submit articles or videos that he could post on discussion boards which "allowed a space for students to be able to read and respond" to topics their peers introduced.
4. Implementing assignments that required them to create presentations and written documents that were ready to be shared with other professionals in the field.

Furthermore, the theme *past experience* indicated the influence that clinical and personal experiences had for Jimmy on the content that he taught and the methods that he used.

Past experience. There were two types of past experiences that impacted course design: personal experience and professional experience as a clinician. Jimmy's views on mindfulness, trauma across the lifespan, and the role of a trauma therapist all stemmed from past personal and professional experiences.

Prior to becoming a CE, Jimmy was a clinician who worked primarily with children and adolescents who had experienced traumatic events. What he saw work with clients impacted the ways he chose and emphasized material. Jimmy stated from his clinical experience "I'm not a huge fan of mindfulness for trauma therapy, though. Sometimes you calm the mind too much and you're present in the moment and it elevates anxiety." So instead of emphasizing mindfulness interventions, the intervention modules focused on grounding, psychoeducation, emotional-based interventions, and cognitive based interventions. Additionally, when Jimmy was asked which content areas, he placed the least emphasis on he stated, "You know, you forced me

to be introspective on this as well. I do not emphasize revisiting trauma narratives. I don't emphasize that, but it is touched on." He went on to say

> Whereas my own personal view of trauma work is that I don't believe that we have to go back in and relive and rehash trauma. I don't believe that that's a necessary foundation to what needs to happen. I don't think the trauma reprocessing is always effective. I do believe that sometimes it actually creates issues and then individuals don't come back, and we're part of creating issues.

Even though he did not personally utilize revisiting the trauma narrative in this work, he still believed in his role as the facilitator that he needed to present the information to this.

> But in terms of going back and rehashing a trauma narrative, the TF-CBT training is one of these weeks. I think it's when I cover throughout the lifespan and they understand that this is something that could be done for children. But I want them to have the experience, so they do the training. They do training, but it's not something I go back and revisit, because again, my specialty is working with children and adolescence, and I do not believe that having a child go back through and revisiting a trauma narrative, pointing out thinking errors is an effective way to address trauma. I just don't.

As part of his view that the instructor is the facilitator, Jimmy provided information to students which allowed them to evaluate the information on their own terms, but his preference impacted the depth in which he presented the information. In addition to intervention content, Jimmy's clinical background impacted the way he instructed the course.

The application-focused assignments were influenced by information Jimmy wished he had known when he was a clinician. During the interview, he recalled the first time he had to make a report to the Department of Social Services and how lost he felt throughout that process.

In response to that experience, Jimmy explained the assignment he created so that his students did not have the same experience he did:

> the homework for that week is you creating a cheat sheet that you can have in your office drawer with the information that you need on it before you make the call. So that you have that information filled out.

This application-focused assignment is directly informed by his own experience as a clinician, including what would have made his job more efficient if he had known.

In contrast to mindfulness and narrative reprocessing, the emphasis in this course is "how trauma impacts the lifespan" which is rooted in Jimmy's clinical experience working with children and adolescents. He stated:

> it is very key for me for individuals to know that some of the things that we may be experiencing as clinicians working with clients, or school counselors, or school psychologists working, or walking in the hallways, that some of the behaviors and some of the experiences that our clients are coming to us with are indicative for a trauma history.

Just as key definitions of trauma-informed care were introduced within the first week, so were developmental implications. It was also an integral part of the case studies students created in the course where Jimmy instructed students to "write a client sketch of an adult client who experienced unprocessed trauma as a child."

In addition to his professional experience, Jimmy's personal experiences outside of his role as a professional counselor impacted the way that he conceptualizes trauma and competency in trauma counseling. One of Jimmy's family members experienced a traumatic event, and he had seen tremendous growth after they began seeing a trauma-informed counselor. He described

the growth by saying, “And that occurred through their relationship and through some psycho-education, not through picking at the wound, which is sometimes what I see with the revisiting the trauma narrative.” He stated that their “mental health has improved dramatically over the past year and a half with some psycho-education and with the support of family and just the kind of natural healing that can occur in a resilient environment” which further supports his emphasis in the course in basic counseling skills, a trauma-informed perspective, and less emphasis on reprocessing of the trauma narrative.

Application-focused pedagogy. The three themes previously addressed, *trauma-informed counselors as advocates, counselor educators as facilitators*, and *past experiences* all converge into this final theme, which is application-focused pedagogy. *Trauma informed counselors as advocates* described what Jimmy was looking for from his students, *counselor educator as facilitator* described what Jimmy was looking for in himself, *past experiences* described what past contextual experiences influenced Jimmy’s current understanding of trauma education, and this final these *application-based pedagogy* describes what the learning environment actually looked like in Jimmy’s trauma course.

Jimmy’s strong beliefs about counselor and CE roles created a learning environment where almost all information presented was intended to be immediately applied. While describing the assessment lesson Jimmy stated:

> This is designed for working individuals and I want them to have resources that may fit their population. And so, even giving them the information that there are specialized assessments for individuals in these population is what we’re looking for there with assessment.

For the assessment and the intervention lesson, students utilized their case studies to complete assessments and choose interventions appropriate for their clients. In the intervention lesson Jimmy described, he also had students

> go through interventions and start to pick out what interventions fit with their own theoretical model and where they would use them in treatment. Do they use these in rapport building? Do they use these when working on trauma processing? Do they use these in looking at present symptomatology? So that's what's being used there. They go through and they annotate the table of contents to make it easier for them when they're working with a client to be able to say, "Okay, so-and-so's coming in. I know this is where we are in the process. Here's something that I would like to try".

Due to this application focus, theory is not an emphasis in this course. He also mentioned that the audience impacted his emphasis on application. The audience will be discussed in more depth later in the case, but specifically in reference to the emphasis on application Jimmy explained that

> there's nothing that's used overtly. And again, reason being is that as this is a post-master's certificate, individuals are looking for more boots-on-the-ground, what can I do after I finish class this week, what am I going to be able to do in session on Monday morning? And whereas theory is something that is underpinned throughout this entire piece. It's not something that's overtly used.

Jimmy described feeling an urgency or immediacy to help students understand how to apply the information that was presented in his classroom.

> So any sort of assignment that I do, any sort of group conversation, any sort of texts that I provide, does need to have immediate application. So, theory is fantastic, but practice needs to be right behind that and need to be present every week.

When asked what makes trauma education different from other aspects of counselor education, Jimmy stated, “Especially this trauma work needs to have a practice application, every single lesson.” In the course goals section of this case, one of the aspects that was addressed was Jimmy’s fear of having “educated clinicians” that did not understand how to apply what they had learned in the classroom. This aligns with his worry that individuals who are not trauma-informed may cause harm to clients.

Jimmy admitted that for the master’s students this move away from theory and to application is challenging.

> Students, want to be able to master content so they can master theory relatively quickly and relatively easily by regurgitating theory or for those who are a little more in depth, being able to incorporate theory into their worldview. But when we talk about practice, that's where they're the most insecure… students are most insecure about understanding.

He went on to say:

> When we ask someone to become self-aware, or we ask someone to know how to incorporate information, they have all of those tools at their disposal, and those are things that they're just adding onto. Where as the practice is creating brand new. For most of our students, it's creating brand new ways of being, and they're like this is hard. It is hard. I don't know what to tell you. It is hard but it's worth it and its work, worth doing.

Although the application aspect of the course was challenging for students with less experience with clients, Jimmy strongly believed that the application emphasis was necessary. His

intentionality in course design ensured that students had him and their peers as support through this journey even within an asynchronous virtual format.

These next two areas *format of the course* and *utilization of Bloom's taxonomy* were discussed during the interviews but did not necessarily continue as themes. They are included in the case because these areas had a significant impact on course design, shaping what Jimmy taught and how he taught it. These impacts also link back to contextual factors mentioned at the beginning of the case: course, program, and instructor.

Format of the course. The online teaching format, the fact that the course is a part of a certificate program, and the length of the course had major impacts on the methods utilized to teach in the course. Jimmy stated "it is completely taught online, asynchronous, so it can be a graduate certificate. We offer differential tuition for this course; anyone anywhere can take this class for in-state tuition." Additionally, the course is 8-weeks long and worth three graduate credits. When describing the course, he stated,

> So when you go through, and you look at this information remember the focus is on how do we put this information into practice immediately and whereas some of our 16- weeks in-person courses, we have the luxury and understand that this is almost like a process, right?

The online format and that the course is open to individuals outside of the master's program impacted the need for immediate application, and the need to reduce the "fluff" in the course. "And so that's a little different than an in-person class where you may not have practice every week, and you can wax poetic about things that we like to think about that works." He went on to say

> The audience for this certificate is individuals who have completed a master's degree and are coming back for a certificate in trauma-informed counseling. So they want to further their knowledge on how to be an effective practitioner.

Although more than half of the students enrolled in the course were master's students, Jimmy still felt the need to attend to the needs of the advanced-standing professionals who were also enrolled in the course which impacted the course design and focus. Jimmy spoke to the need to support learners in understanding their roles in this online environment, especially since some of the students in this course were adult learners seeking the trauma certificate. He stated,

> there's these pieces as well an almost a reeducation of the learner about what it means to be responsible for your own learning. So, there's a difference between having to log on, physically engaged with material as opposed to come in and passively sit in the class.

One of the most significant distinctions Jimmy saw between the post-master's and master's students in his course was the level of satisfaction with application and theory-based assignments. He stated, "I've noticed too that my students don't always understand the importance of practice. And so it comes off as busy work." He went on the say with the assignment aimed at helping students prepare to make a department of social service report,

> and repeatedly... what I do, is I get feedback that says, this is busy work only from my students. There are individuals who are in practice already I think that's when I get the feedback that says, 'my God, why haven't I thought about this before?

This distinction between the needs of the learners in the course is something Jimmy was aware of and tried to manage through explicit instructions, justification for assignments, and consistency.

Bloom's taxonomy. Jimmy referenced Bloom's taxonomy several times during the interview, but never explicitly mentioned how this taxonomy impacted the ways in which he

chose content or his teaching methods. He referenced it when speaking about students creating self-care projects stating that the assignment attended to the "highest part of Bloom's taxonomy, to create" and that when he was assessing their presentations "it's looking at Bloom's taxonomy, they're creating." Additionally, when he spoke about the case study assignment, he stated "they create of their own case study which is designed to do a little more kind of Bloom's type of work." There was not any explicit conversation about the intentional use of this taxonomy to guide course design, but the frequency of Jimmy's references to it led me to include it in this case report as a tentative influence on how Jimmy choose the course content and his teaching methods.

Individual Case Limitations

There are two limitations for this Case, Jimmy taught all the courses in the certificate, and this course was open to students outside of the master's program. For this present inquiry, I was attempting to examine a single course, but throughout the interviews Jimmy admitted to confusing content and learning activities he utilized in this course with those he uses in the other courses. At points he would provide examples of learning activities that he used in other courses, and he stated that he viewed the content in the trauma certificate as holistic which made it difficult of him to reflect on this course in isolation. Additionally, this inquiry is aimed at understanding teaching trauma content to master's-level counselors. Although the majority if students in this course were master level counselors in training, the post-master's students impacted Jimmy's choice in content and how it was taught.

Individual Case Conclusion

This case study aimed to better understand how Jimmy chose the content in this trauma course and the methods he utilized to facilitate significant learning experiences in the classroom.

Jimmy covered a broad range of content including foundational information about trauma-informed care, developmental theories, interventions, vicarious trauma, and self-care. The methods utilized to teach in this course included recorded lecture, case study, and virtual communication through synchronous and asynchronous video.

Many factors impacted how Jimmy choose the content and the methods used to teach it including his view of counselors as advocates, his understanding of the role of CEs as facilitators, his past experiences, and the emphasis he placed on application-focused pedagogy. Additionally, the structural implications of the course format and his pedagogical meta-theory also impacted the design of the course. Jimmy had a strong belief in counselors' obligation to be trauma-informed, and he demonstrated a palpable love for the profession. This drive to educate in a way that created trauma-informed counselors prepared to act was central to how he chose content and methods he utilized to facilitate significant learning experiences.

Case Three: Alex

This case study aimed to understand how Alex choose the content in her trauma course, *Trauma & Crisis Intervention: A Survey of Theory, Response Models, and Techniques,* and how she used that content to create significant learning experiences for master's level counseling students. As detailed in Chapter Three, I utilized four primary forms of data to create this case report: an open-ended questionnaire about the instructor, course, and community; the course syllabus; one 52-minute interview focused on course content, and a second 62-minute interview focused on course teaching methods. The first section of this case report includes contextual information collected from that questionnaire. Next, I analyzed Alex's syllabus examining the structure and content included in the document. This case ends with my interpretation of how Alex chose content and utilized methods in her trauma course.

Instructor and Course Context

The participant described the information I present in this section in the instructor in course context questionnaire and in the initial interview. Some aspects of it may appear non-linear, the reader should approach this information as a conversation providing context for the Findings presented after this section. The aim of this section is to add background information to aid the reader understanding the interpretations presented late in this chapter within the context of the Case. The following section includes pertinent information about the instructor of the course, Alex, and her educational and clinical background. Additionally, I expand on the counseling program in which Alex taught and the community in which the University was located. The section ends with an overview of the course including the texts that were used, content covered, instruction methods.

Instructor. Alex was a 41-year old cisgender woman who identified as Caucasian or White. At the time of the inquiry, she had been a professional counselor and CE for fifteen years. Additionally, she was the associate director of her university counseling center and coordinator of the campus emergency crisis stabilization services. Due to her position at the counseling center she stated, “I know the most about the college kids.” When she was completing her doctorate, she was enrolled in this crisis and trauma course which was taught by the instructor who originally created it. She stated that she was mentored by the pervious instructor for approximately 15 years. Additionally, she had certifications and specialized training in trauma and crisis and had responded to numerous natural and human-inflicted disasters. Alex considered trauma and crisis to be her primary specialty areas. She stated:

> I've gone through all of the FEMA online trainings. I've done ... I started EMDR, but it was cost prohibitive for me to continue that. So, a lot of mine is more trainings that I'll go

> to CE trainings on; I have a 40-hour training on threat assessment, for example, through the Gavin de Becker group.... Our county crisis center, I've done a 60-hour training with them on crisis response and then proceeded to become a trainer within their field.

Although she had many specific trainings, she also felt that her time as a clinician was extremely valuable in informing how she understood crisis and trauma. She expressed worry for clinicians who only had the certifications and did not combine that with consistent clinical work.

> I think certifications are helpful, and I worry that lots of folks are getting certifications without, again, the practitioner piece behind that. Which is something that I'm seeing in my own field, where somebody will come up with a certified trauma therapist training or certification that they're working to gain some hours towards, but ... so a lot of mine are time in the field.

At the time of the interview, she was employed as a clinical associate professor at the student counseling center and an affiliate faculty member of the counselor education department. She had taught the course six times at her current institution. When asked about her identity as a CE, she expressed that she considered herself a professional counselor who teaches counseling courses, and not necessarily a CE.

Program. The counseling program in which Alex was an affiliate faculty member in had approximately 150 mental health, school counseling, and marriage and family counseling students. The students took the trauma course during their second semester. At the time of the inquiry the course was an elective, but the program was in the process of making it a requirement for all counseling students. This course has always been taught face-to-face but was going to be moved to an online format. Alex expressed worry in shifting the course from face-to-face to a virtual format. She stated that the experiential nature of the course, specifically the discussion

and reflective components, would be challenging to replicate in a virtual format. This sentiment will be expanded on when Alex's discussion-based teaching methods are introduced.

The last time she taught the course was in Fall 2017. Alex was unsure how many times the course had been offered, but it had been in existence since the late 1990s. She began teaching it when the original instructor, her mentor, retired.

Community. The community in which this course was taught had approximately 130,000 people and was described by Alex as urban; however, the surrounding towns were rural. Alex reported that the types of traumatic events commonly seen in this community were homelessness, racial violence, and sexual assault. Additionally, the populations Alex viewed as most impacted by trauma were individuals in the LGBTQ community, ethnic minorities, and individuals experiencing housing instability. Alex identified many traumatic experiences that had impacted the community at large, including hurricanes, a serial killer, serial sexual assault, and youth death by suicide. Due to this wide variety of communities impacted, Alex focused on providing a range of examples for students. When asked how she integrated the specific communities that were impacted into the course she stated:

> We're looking at the what-ifs. What if this person were from an oppressed population or an oppressed group or minority group or an elderly group? What would you be doing the same or different? What other factors would you consider? With a child, maybe you consider the language that you're using, or the parental consent, or the socioeconomic status, or any learning disabilities that may be present.

In addition to content, she targeted teaching and learning activities that incorporated an emphasis on understanding the community.

> You know, we have our student newspaper, so we would bring that in weekly and say, "Okay, what's the crisis of the week?" And maybe it's that the football team lost, or maybe it's the actual crisis of the week, but that crisis is self-defined; how could people be impacted by whatever it is that they're seeing, whether that's large scale or on a micro-scale?

Furthermore, she reported many resources available in the community stating that they were a "resource-rich community" but she went on to state that "surrounding towns are less fortunate" and the metropolitan city in which she worked assisted other towns in the county when necessary.

Course overview. *Trauma & Crisis Intervention: A Survey of Theory, Response Models, and Techniques* covered a broad range of topics and was focused on theory and application. Alex stated that the course content had gone through some changes due to student feedback which will discussed in depth-in the interpretation section. Ultimately, a co-instructor was added to teach the trauma content in the course in Fall 2016 and Fall 2017. Of the three cases examined for this inquiry, this course had the most crisis content because it was originally a primarily crisis course.

Alex reported there were a maximum number of 20 students enrolled in the course, and the course typically filled. It was restricted to master's counseling students and taught once per year. There was no prerequisite for the course, but the syllabus stated that "first practicum experience is highly recommended" prior to taking the course. The primary instructional methods for the course were lecture and experiential activities. Additionally, the content in the course was introduced "through didactic, experiential, research, and multimedia learning approach." I will address instructional methods in-depth later in the case.

Alex detailed the structure and procedural elements of the course in a nine-page syllabus. The syllabus included the required university and program information such as the learning objectives, applicable professional standards, accommodations, and a statement concerning religious holidays. In the syllabus, Alex described the instructional goal as "to introduce current theory and practice models related to trauma and crisis intervention." Broadly the course content included, "definitions of key constructs… theories associated with conceptualizing trauma and crisis… nature and types of trauma and crisis… intervention models… psychosocial factors associated with trauma response … affective, behavioral, and neurological sequelae associated with trauma." Additionally, "skills and techniques in crisis intervention," "trends in post-trauma therapy," counselor distress, and several specialty topics were covered.

The syllabus listed the 2009 CACREP standards as the applicable professional standards addressed in this course; the course was an elective and not part of the CACREP core curriculum at the time Alex taught the course. Unique in this syllabus was a statement concerning the expectation to participate in small groups. This statement clearly stated that "the ability to work in small groups is an integral aspect of the course," it went on to mention "shared responsibility" and expectation of cooperation. This statement is especially important because the oral presentation project which will be explained in detail later in the case was completed in a group format.

The course was a full fall semester with a day off for a university holiday, two days reserved for group presentations, and the final class which focused on group processing of the experience. This was 16-weeks which allowed for a wide variety of content to be addressed. When asked to describe the course Alex stated:

> The most recent version of the course that I taught used the first half of the semester to look into crisis intervention theories and putting it into practice, and then the second half of the course was really more of trauma-informed therapy, and that shift came after some feedback from the students who wanted ... It was very heavily just crisis intervention-focused and group crisis intervention-focused, and feedback from the students over the few terms was that they were looking for more trauma-informed therapy.

Student feedback was a primary theme that impacted course content and process and will be discussed later in the case.

The course began with an orientation to expectations and moved into foundational knowledge on the biological basis of crisis and trauma. Alex stated, "We start out with that biological piece, neurobiological piece. We move into how that then manifests later in a post-traumatic stress related way." The content in both the crisis and trauma sections began with foundational knowledge on intervention and assessment and led into special topics for the respective areas. The biological basis for behavior was integrated throughout the course and wellness activities were incorporated into every lesson.

In the first week of class, Alex introduced concepts focused on the neurological and biological basis of crisis and trauma response. This included content areas such as the "organization of the central nervous system," "effects of extreme stress," and "categories of memory." Then, she introduced PTSD prior to moving into crisis-specific content. Alex stated that typically PTSD is introduced later in the semester, but for this semester a guest speaker was lecturing and was only able to attend class that day. The crisis content covered the next four weeks and included various interventions, assessments, and specialty areas in crisis such as group crisis intervention, lethality assessments, and disaster response.

Students explored conceptualization models such as the “National Organization of Victim Assistance...Red Cross...Psychological First Aid... Mental Health First Aid... and the NOVA Model.” Alex stated that “A lot of them have overarching and overlapping pieces, so we'll look at the different models and see what seems to be the theme that's going on.” Additionally, when she introduced the crisis models and interventions, she noted to students that “… anybody trained can do some of those crisis intervention models, which is different than crisis counseling. So we talk too about the difference between intervention versus counseling.” Included in these weeks was also an entire lesson dedicated to grief and loss as trauma which included death notifications. Alex expanded on this content by stating, “we'll talk about complicated grief and complicated grief reactions and how we as crisis interventionists can help in that immediate moment of complicated grief.”

When asked about the interventions that were addressed in the course, Alex explained that many of them were embedded in the student’s basic counseling skills and connected to the models that were being discussed.

> A lot of them are just humanistic interventions where we're doing ... a lot of it is feeling identification. If you think through the Psychological First Aid model, just building connection, making sure that there's safety and security. It really goes back to the models, and the models become the intervention, where we're thinking through safety and security, whether that is physical or emotional safety. We're thinking through ventilation and validation; how do we help them do that? How do we help them predict and prepare? That's a big intervention in the crisis and trauma world where, if it's a one-time contact, how do I help people think ahead to, maybe tomorrow you might feel this way or experience this if you hear a siren again ... or maybe on Mother's Day, maybe you'll

> notice that ... whatever the preparation for that is. That's a big intervention that we talk a lot about, the predicting and preparing.

Then, the class shifted into trauma content which covered introductions to trauma therapy, specific types of traumatic experiences such as interpersonal trauma, and developmental trauma; the course ended with “spiritual dimensions of trauma.” Alex addressed trauma-specific interventions such as EMDR and Internal Family Systems (IFS) in addition to information on how to choose and evaluate treatment modalities. In terms of interventions, Alex introduced “grounding...trauma-informed yoga...kindling cues...and cognitive behavioral therapy.” She encouraged students to consider these types of questions when they were working with individuals on an ongoing basis in trauma therapy,

> ... how do I help make them feel safe and secure? How do I help them feel validated about their experience, and how do I help them prepare for, when you leave my office, what might trigger you? What are you going to do if you're triggered? How can you keep yourself safe?

Although crisis and trauma were taught in separate sections of the course, Alex expressed that she hoped the content built throughout the semester and was integrated. She provided an example

> ...now that you gave this death notification to somebody, which is another piece that we do in the class is just how to do a death notification and how to cope with that immediate reaction, and then the second half of the semester is, "Now what do you do?" You're seeing this person as a client, perhaps on an ongoing basis, and they're having complicated grief reactions, so trying to tie the first half of the semester to the second half.

Ethics associated with crisis and trauma counseling were also addressed, in addition to assessments such as mental status exam. The semester ended with group presentations and a whole group processing of the experience in the course. Alex also integrated the philosophy that client response to crisis and trauma was a normal reaction. This emphasis connected to the focus on the biological basis for crisis and trauma and was the justification for the content being woven throughout the course. Alex noted, "…we place a lot of emphasis on, again, understanding the body's reaction. It's a big part, and again, that happens at both sections." She continued:

> A lot of the course, too, is also actually about just normalizing crisis response, because I think there is so much pathology that gets tapped on to somebody that may be experiences a normal crisis reaction to an abnormal event, so that is really my approach, just generally speaking, is more humanistic.

Alex utilized her experience as a clinician to emphasize understanding crisis and trauma in context. She utilized the topic of self-harm as an example

> In each classroom, I'm trying to help them think through both scales. So for example, when we talk about harm to self, maybe we're talking about it from the individual's perspective of, "I want to self-harm," "I have self-harmed," or "I plan to self-harm". So we're looking at that.

She went on to say,

> So with all the content pieces, we're trying to make it, "If it looked like this for you, or if it looks like this for you," so if you were working at a high school and there was a club of students who were self-harming, then what ... Would a group crisis intervention be appropriate in that context, or would it not be appropriate? If you did decide to do group

> crisis intervention, how would you do it? Because we know there's concerns about copycat contagion effect, and so trying to help them think through that.

Alex justified this content focus due to her own personal experience as a clinician. She stressed to students that context impacts the role of the helper, so it was important for them to understand the various elements such as time, resources, population, and access that may impact what interventions are utilized to support clients. She stated,

> You know, I think because I've previously assisted with hurricanes, with fires, fires in California, hurricanes in various states; I helped with the Fort Hood shooting; I helped with the Family Assistance Center after the attacks on September 11th, so to have bigger scale crises, but I went into those different ones at different times. Hurricane Katrina, I went in to it a week after, versus another hurricane that I worked in that I went into the day that they were letting folks come in. And it looked very different, so trying to help them think through ... just because I know these crisis intervention skills or these post-trauma therapy skills, which part of them do I need to access depending upon when I'm going in?

Alex acknowledged that talking about crisis and trauma for three hours a week can be quite heavy for students. She attended to the intensity of the content by building in wellness activities which will be discussed further in the teaching and learning activities section of the case. There is a detailed chart of what was taught, and the methods utilized to teach it in Table 4.5 and all required readings in Table 4.6.

Table 4.5: Topic Areas Alex taught, and the instructional method utilized during the module for each week based on information provided in the syllabus

Topic Areas Taught	Instruction Methods Utilized During Each Module (required materials)
Class 1: Introduction including orientation and review of class culture. Annotated bibliography, and group topic assignments, QPR suicide prevention training.	
Class 2: Understanding people in crisis - An overview of the cognitive, affective, behavioral, and neural sequelae associated with trauma. This includes the hierarchy of elements in crisis, individual responses to a crisis, the neuropsychology of trauma, the organization of the central nervous system, memory, the HPA axis, integration model, problem-solving model, effects of stress, neurons, cognitive processing, and processing of traumatic stimuli.	The concepts in this lesson were taught by the use of van der Kolk (2014) Chapter 1- Lessons from Vietnam Veterans and Chapter 4- Running for Your Life: The Anatomy of Survival
Class 3: Post-traumatic Stress Disorder	The concepts in this lesson were taught by the use of van der Kolk (2014) Chapter 2- Revolutions in Understanding Mind and Brain; and Chapter 3 - Looking into the Brain: The Neuroscience Revolution.
Class 4: Crisis Intervention Models including psychological first aid, NOVA Crisis Response Model, Stages of Impact Model, Basic ID model, Multimodal dimensions, Dixon model, FIRST model, SAFE-R model, Green's Crisis Intervention Model, and Deep-SFA model of Crisis intervention. Additionally, Maslow's Hierarchy of Needs, definitions of crisis, historical developments in crisis intervention, Caplan's paradigm, and BASIC- ID will be introduced.	The concepts in this lesson were taught by the use of Greenstone & Leviton (2011) Chapter 1- Approach to Crisis Intervention; Chapter 2- Procedures for Effective Crisis Intervention; and Chapter 3- Communicating Effectively with Those in Crisis. Additionally, case studies are utilized.
Class 5: Assessment including suicide	The concepts in this lesson were taught

Table 4.5. Continued.

Topic Areas Taught	Instruction Methods Utilized During Each Module (required materials)
assessment and intervention, lethality scale, and survivors of suicide. Additionally, the typology, assessment, and interventions for behaviors to harm and homicidal assessment and intervention are covered. Furthermore, the mental status exam is introduced.	by the use of Greenstone & Leviton (2011) Chapter 5- Special Issues for the Intervener and an online training on involuntary commitment.
Class 6: Greif and loss as trauma from a multidimensional perspective including transgenerational trauma and death notifications. Additionally, complicated mourning and post-death relationships are covered.	The concepts in this lesson were taught by the use of Greenstone & Leviton (2011) Chapter 10- Greif, Loss, and Change.
Class 7: Group crisis intervention which introduced disaster crisis and the function and types of individual, group, and community interventions. The American Red Cross disaster recovery model and emotional impact of the disaster, advanced preparation for disaster model, Teaching Recovery Techniques intervention model, and response incident intervention were discussed. Additionally, the topics of the scope of disasters and incident intervention for higher education were introduced.	The concepts in this lesson were taught by the use of Greenstone & Leviton (2011) Chapter 4- Team Intervention. Additionally, the annotated bibliography was due this week
Class 8: Introduction to trauma therapy including trauma in the body and the role it has in the resolution of trauma response, and the goals of trauma therapy. Furthermore, the Polyvagal theory is introduced in addition to the need for self-care for the trauma therapist.	The concepts in this lesson were taught by the use of van der Kolk (2014) Chapter 5- Body-Brain Connections; Chapter 6- Losing Your Body, Losing Your Self.
Class 9: Victimization and violence including sexual and interpersonal trauma, and repeated victimization. Additionally, the systemic sources of trauma including sexism and discrimination are addressed. Furthermore, the role of the therapeutic relationship in healing interpersonal trauma	The concepts in this lesson were taught by the use of van der Kolk (2014) Chapter 7- Getting on the Same Wavelength: Attachment and Attunement; Chapter 8- Trapped in Relationships: The Cost of Abuse and Neglect.

Table 4.5. Continued.

Topic Areas Taught	Instruction Methods Utilized During Each Module (required materials)
is explored.	
Class 10: Developmental trauma and trauma in children. Additionally, the role of attachment and crisis in a school setting are introduced.	The concepts in this lesson were taught by the use of van der Kolk (2014) Chapter 9- What's Love Got to Do with It; and Chapter 10- Developmental Trauma: The Hidden Epidemic. Greenstone & Leviton (2011). Chapter 7- Reactions of Children in Crisis. Additionally, a guest lecturer is utilized during this lesson.
Class 11: Spiritual dimensions of trauma including primal wounds and moral injury. Additionally, the elements of trauma recovery including post-traumatic growth.	The concepts in this lesson were taught by the use of van der Kolk (2014) Chapter 13- Healing from Trauma: Owning Your Self; Chapter 14- Language: Miracle and Tyranny; and Chapter 20- Finding Your Voice: Communal Rhythms and Theater. Additionally, a guest lecturer is utilized during this lesson.
Class 12: Models of trauma therapy including eye movement desensitization and reprocessing (EMDR), Internal Family Systems (IFS), and other therapies for trauma survivors. Additionally, how to select and evaluate trauma therapies is covered.	The concepts in this lesson were taught by the use of van der Kolk (2014) Chapter 15- Letting Go of the Past: EMDR; Chapter 16- Learning to Inhabit your Body: Yoga; and Chapter 17- Putting the Pieces Together: Self-Leadership. Additionally, a guest lecturer is utilized during this lesson.
Class 13: Student chosen topics	Group presentations
Class 14: Student chosen topics	Group presentations
Class 15: No new content	Group processing of course experience

Table 4.6: Alex's Required Readings

Type	Required Course Reading
Books	Greenstone, J.L. & Leviton, S.C. (2011). *Elements of crisis intervention: Crises and how to respond to them* (3rd ed). Belmont, CA: Brooks/Cole Publishing. van der Kolk (2014). *The body keeps the score.* Penguin Books: New York.

Individual Case Findings

In this section I describe the individual Case Findings. I first introduce Alex's course goals which is the overarching aim of the course. I then detail the teaching and learning activities in the course. These activities include all in-class teaching methods that use in her course. The next section describes assessment and feedback methods which include all course assignments that were graded. I organized these descriptive Findings based on a review of course artifacts such as syllabi and assignment descriptions in addition to the interviews with the course instructor. These Findings do not reflect thematic analysis but are reported in an attempt to stay as true to the participant's self-report of course design in interview and course documents.

Course goals. Alex had three primary course goals for her students; (a) to understand the biological basis for trauma and crisis response, (b) to be able to apply this material in whatever setting they were working in, and (c) to expose students to material that they would not be exposed to in other courses.

Alex stated, "So I really hope they walk away with a lot of brain knowledge on how the brain impacts crises and the person's ability to respond to crisis in the moment, as well as post-crises, so that post-trauma growth perspective." She went on to say that her emphasis on the biological basis of behavior is one aspect that set this course apart from the other counseling courses. When she spoke about the biological basis for behavior she stated, "I think that's one

thing that, in my opinion, a lot of courses don't offer." She justified this emphasis for her student's due to this prior knowledge, "But our students in our program didn't have any awareness of brain response and physiological responses to a person in crisis immediately pre-, during, and post. So, I'm hoping they walk away with that."

Additionally, Alex had an understanding that many of her students would be going directly into clinical work and needed to know how to apply the information with clients.

> I'm hoping they walk away with the ability to put it into practice, because a lot of our students, I would probably say 95% of them, are going to be practitioners when they're done, so a lot of them are not going into a doctorate program, are not going into teaching or research. They're going into practice, so if they don't walk away with an ability to put those concepts into action, then for me, I think that would be a big fail of my course for that.

She stated that "trying to move from what we know to what do we need to do?" is a primary focus in the course which could be seen through the theme *application focused pedagogy* which will be presented later in the case. Regardless of the material, Alex focused on moving from conceptualization to application fairly quickly because she believed that he helped students understand the material better.

The final goal for the course was to expose students to content that they would not be exposed to in other courses. At the time of the inquiry, this course was the only one that exposed students to lethality assessments, self-harm, and homicidality. Alex stated:

> None of our courses also address how to do a thorough lethality assessment, for example, just something basic like that. So we do ... There's a whole section about lethality

> assessment and self-harm, how they're different. Some homicidality assessment and put those pieces in practice as well.

Additionally, Alex trained students in a crisis identification and intervention method during the first week of class. She had them practice delivery notices of death which will be expanded on later in this case. Finally, she leaned into process conversations that encouraged students to explore how their understanding and experience with crisis and trauma impacts the way they work with clients. All of these teaching and learning activities aligned with her primary goals which are stated above.

Teaching and learning activities. Alex described her teaching style as similar to the way she approached counseling with an experiential humanistic perspective. She stated, "I'm person-centered in general. I'm kind of Jungian in how I approach therapy, and I think that translates into my teaching style, because I'm also very experiential in my teaching style." She went on to say that specifically for this course she aimed to understand the lived experience of her students while they are exploring the content. The impact her *clinical experience* had on course content and methods was a primary theme for this case and will be discussed in-depth in the interpretation section. After aiming to understand student experience Alex stated she began to bring

> ...in some of the experiences that the literature may say, or my own experiences. But really those come from kind of the expert role. But because it's experiential, we have a lot of conversations. It's really more of a seminar style class, so there's a lot of ... it's less didactic and more conversational and experiential.

Due to the intensity of the content in this class, she also viewed herself as offering both therapeutic and supervisory support in addition to her role as the instructor. She viewed this as a

parallel process, which helped students understand that, “If you're a counselor in the making and this happens to you with a client, how do you want to attend to it in that time, as well?” She conceptualized her role as “tending to them in the moment” so that they can learn how to do it for themselves later while they are with clients. Additionally, she worked to create a learning environment where students had the autonomy to attend to each other or excuse themselves if necessary.

Alex facilitated this learning environment by offering students choice and autonomy. She stated, “I don't like to make things too structured, so I'm not a big rubric fan, which some people like and some people hate.” The course was process driven with an emphasis on “trying to link back everything to the neurobiological pieces.” Alex provided an example of a vignette of a client who had been sexually assaulted. She would prompt students, so you are working with

> Somebody who has been sexually assaulted, or maybe a victim of childhood sexual assault or incest or molestation, think about how that trauma reaction may show up in immediate moments, and then the second half of the course, again, how do you work with somebody on an ongoing basis who may be experiencing those trauma reactions?

Due to Alex’s identity as an educator and as a clinician, she was able to bring many of her own experiences into the classroom to provide examples for students. She found that her deep well of clinical experience was an asset, and student feedback seemed to indicate that her students believed it to be also. Additionally, Alex believed the developmental level of students had a large impact on the teaching and learning activities. Student take this course later in the program which allowed them to have many of their foundational courses completed and to have begun some work with clients. Alex went on the explain:

> I think it's just different because there's a developmental quality. We've got a different developmental component that they've got at this stage, I think. They're working in the field more, again in a practicum-based way. Yeah, I think there's just more of a sophistication for conceptualization, and hopefully at this point, by the time that they are in this class, they've done some of the personal pieces of how does this impact me? I think at the beginning, developmentally, it's still like, I need to get the A. I need to say the right thing. Can I say this? Is this right? And I suppose at this point, everything is right, it's just kind of how you say it, what do you do next? So, that worry feels a little bit less, the worry of am I going to say the wrong thing feels a little bit less.

From this explanation, student development included an increased understanding of client issues through clinical experience, self-awareness, and a shift from the extrinsic motivation of grades to the intrinsic motivation of "young professionals."

Alex utilized many teaching and learning activities including PowerPoint, role play, required reading, video, discussion, experiential exercises, outside modules and training, guest speakers, vignettes or case studies, and self-care activities. The class periods were three hours long and were structured with the PowerPoint as a touchstone and integrated experiential activities such as role play. She explained "I do have a PowerPoint, and a lot of times that's more to guide me in what I'm wanting to make sure that I hit upon… Every class, there's something experiential that we're doing."

Role play. Alex stated that she utilized role play to help students practice the phrasing they would use with clients and to simulate a client experience. She stated that, "some role plays will take an hour, and we'll pause it halfway through and say, where's everybody at? What's standing out? What are we missing? What are we doing a great job on?" Additionally, she

utilized a specific feedback model to guide self-reflection. She explained, “I like to use one where the client gives feedback first, and then the audience gives feedback as if they were the client. And so, they really try to put themselves in the shoes.” She used this feedback model because she wanted students to understand:

> Just because it works for one client doesn't mean it would work for another. So, when you said this, I felt, as a client, I felt that you really understood me, that really connected with me. But maybe somebody else said, when you said this to me as a client, I felt really judged. And so, then we'll talk about, is that different?

She recalled utilizing a role play for lethality assessment, suicidality assessment, and mental status exam, but she stated that she does some sort of demonstration in almost every class. When structuring the role plays, she stated, “And sometimes I'll bring in doc students to be the role player, the client. Sometimes I'll be the client. I oftentimes don't ask them to be the client.” She explained that in this class they are “really trying to elicit a particular thing in the role play” so she preferred “somebody with a little more sophisticated role play” skillset to ensure students were actually able to benefit from the learning activity.

Required reading. Much of the information on crisis response was guided by required reading in the Greenstone and Leviton (2011) text; the information on the biological basis of trauma response was guided by the van Der Kolk (2014) text. These texts were utilized to introduce foundational knowledge, but the instructor did not emphasize them in either interview. This aligns with the instructor’s attention to application-based teaching and learning activities and drive to create a discussion-focused classroom that went beyond didactic reiteration of foundational knowledge.

Video. Alex used video as a teaching activity for disaster response and its impact on first responders to facilitate conversation about interventions and to provide a visual representation of client presentation for the mental status examination. She provided this example for her use of video in a disaster lesson.

> I show a 90-minute video on, it's called, there was a series called Third Watch years ago, and they do a really nice video about a month post-September 11th, the first responders, and it's really nicely done. Kind of starts at the beginning of when they first got the fire alarm bell, all the way to when they were on-scene, and now a month post that. And that's a really powerful video.

Additionally, she stated that she used videos to help students conceptualize interventions and strategies they could use with clients. She provided this example for that specific learning goal,

> I show a video called “FAU Student Goes Crazy in Class” and it's a student at a school in Florida, who kind of had a breakdown in class, and students were filming it, and it kind of went viral. But we talk about what would you do if she came to your office? What would you do if one of the classmates came to your office? What would you do if the professor came to your office? To try to look at it from a different kind of lens.

Similar to the student video she stated that she showed a video to help students conceptualize how they would work with a family.

> I'll also show, sometimes, it's called the Bridge. It was a documentary that came out in 2005 about suicide. And so, working with families, because our program also has a family subsection. And so, this family came to you, and they're having much different reactions. So, a lot of it is thinking through, how would you respond to this clinically?

Overall, Alex wanted students to consider, “What do you think you might want to attend to, just based on the little part that you know right now, from the video?” She stated that the mental status videos have a different learning goal because they are utilized to provide a visual for students. She explained, “the mental status exam one would be different, because that one's more just illustrating, when I say labile affect, there's a little 90-second clip on somebody with labile affect to demonstrate that. So, that one is more what that's for.” With each of the videos and the role plays, Alex ended with a group discussion on what the activity meant to students and how it connected to course content.

Discussion. Alex incorporated discussion into every class period. She stated that, “We're doing the constant conversational reflections and the personalization.” The theme of *counselor self-awareness* and *student processing* will be explored later in the case. Every teaching and learning activity that Alex implemented in the classroom had a discussion-based reflective component where students processed how the activity impacted them, what feelings it brought up, how it may impact students in the classroom differently, and how that translates to the counseling process. Alex reiterated that “counselor as person” is a central part of the learning process for her, and that goal was often achieved through in-class discussions. Her emphasis on student-led classroom discussions was one of the aspects that made her wary of online trauma course. She stated, “I am so experiential and discussion-based, I feel like there's a piece of that that even if you're doing experiential things and discussion-based things online, I feel like it may be different.” She went on the say,

> We have so many rich discussions that will get lost if it moves to ... in my opinion ... an online version. Because there's so many things like, "Oh, I hadn't thought about that”. Or, "Gosh, when you said that, it just pushed this button of mine that I didn't even know

> existed, and it makes me think of this traumatic experience". I just worry that that will get lost.

The emphasis on classroom discussion as a teaching and learning activities aligned with Alex's teaching philosophy which focused on the "collaborative wisdom of the group". In addition to the unstructured reflective discussion, every class period ended with a reflection assignment. Alex explained,

> I ask them to do a one-minute written reflection every class. And so, I literally set a timer, and I just ask them, what's on your head or your heart right now? And so, they can say, I'm really tired and I'm hungry, and that's fine in their one-minute reflection. Or maybe they say, it actually made me think about my friend who was suicidal, or whatever. It's an opportunity for one-minute reflection at the end of class.

These reflections were aimed to help students process the information in class and practice attending to themselves on a consistent basis.

Experiential activities. Alex explained that every class period included an experiential activity. She stated that sometimes she will "start the class out with those to really set the tone" and other times they are interspersed throughout the lesson. She provided the example of the activity from the death notifications lesson.

> I even just have them kind of line up and practice the spiel they want to say about delivering the death notification. So, it's not even a huge role play, but it's, "I have some difficult news to share with you. I've learned that your child has passed away in a car accident". Or whatever. We talk about the phrasing, and then they just say the phrase.

In other lessons the activities were more involved, she provided the example of the mass disaster response class activity.

> ...it's kind of a mass disaster, where they get the big case study, and they quickly have to pull together a team and determine what their role is on the team, and how do they respond to that. Which that one's kind of a fun one, because they're in different rooms and groups, and I pop in and inject another piece of information after they kind of have a plan developed. Then I'll say, "Oh, actually, we just learned this, and now you have to ... Now you just learned this". So, the information is constantly changing, which is consistent with more mass disaster.

For the sexual assault and death lessons, she facilitated activities to help students build empathy. Within this lesson,

> I'm essentially asking them "who's the person that they're closest to, what's the place that they feel the safest, what's the activity that they enjoy doing the most?" So, they talk about why this person is their favorite person, and then I say, okay, imagine that that person's not in your life anymore. "They've either assaulted you; they didn't believe that you were assaulted, they blamed you for your assault. What's that feel like now?"

Additionally, she provided the example from the lesson on death:

> It's an activity where you have everybody stand in a circle, and they're all holding hands, and they close their eyes, and I say I'm going to ask you to imagine in your head a number, an age that you think you will die at. So, if you think you'll die at 35, 105, 75, pick a number, and keep your eyes closed. And so, everybody's holding hands, and I say, I start counting up. And when I get to your number, I want you to let go of the hands of the people next to you and then take a step back. And so, that activity is really, really powerful. Some people are dropping their hands, maybe their parent passed away at 45, and so now they think, there's a personal mortality associated with it. Maybe I'm the last

> person still in the circle, but I don't know it because my eyes are closed, but gosh, this person to my left is gone, this person to my right is gone.

Just like the in-class discussions, experiential activities are an integral aspect of this course. Alex explained that regardless of the activity her goal was to

> create a space where it's safe to feel tearful, or to be tearful, to then figure out, okay, how can I use that, be aware of that, but then connect and do some of the work through the trauma with the clients?

The course ended with a two-part closing experiential activity. Students were asked to bring in an object, and their peers guessed without knowing who's it was and what the object meant to the other person. The final activity asked students to write a wish and a hope for each other. Alex placed these two activities on the last day of class to help support community building and feelings of resilience after a semester of emotionally challenging content. She stated, "When we look at the factors of resilience, connection is a big piece of resilience, community-building." She hoped these activities helped students feel connected to each other, and the feedback she had received from former students was that this activity was very meaningful to them.

The experiential activities in this course had behavioral and affective components. Alex utilized activities to facilitate the application of theoretical concepts and to increase counselor self-awareness by reflecting on the "here and now" experience of students while they were engaging in the experiential activities. The themes of *application* and *counselor self-awareness* will be addressed in-depth later in the case as primarily themes that impacted course design. In addition to experiential activities, Alex integrated outside modules and training.

Outside modules or training. Alex had students complete the Question, Persuade, and Refer (QPR) training during the first-class period. She explained her justification for

implementing this training on the first day of class. "Yeah, because another one of the pieces of feedback that I got from doing it over the years was that they were starting their practicums and had never had a conversation about how to even just listen for signs of suicide, even just basic, what's the point, kind of statements." Alex explain that her goal was to provide students with "even just some basic nuts and bolts for doing their practicum." She went on to say, "it's negligent if they're in the practicum and they've never had a conversation about how to assist, even just hear the first signs of suicide. That is not good."

When asked about other modules or trainings included in the course, she stated that students were required to complete various disasters and crisis certifications in previous versions of the course. She stated, "I ended up taking that out because it was, I think it was helpful, but most of the students that I work with are not going to be responding to a national tragedy." Alex removed the assignment based on student feedback but continued to provide the information in case students were interested in accessing that information outside of class. The theme of *student feedback* impacting course design will be explored later in this case.

Guest speakers. Alex typically invited three guest speakers to speak in this course. The first was a labor and delivery nurse who also was a sexual assault nurse examiner, the other was an expert and advocate on peer support, and the third was the director of the local crisis intervention services agency. Alex described the first guest speaker,

> We have a nurse who comes in who is a sexual assault recovery nurse, so SA nurses is what we call them here. And also just labor and delivery in a hospital where there's a lot of infant deaths or mothers addicted to substances.

The learning goal is for students to understand the guest speaker's specialty area and setting, and "talking about that process for her patients as well as her own process." The second guest speaker offered a unique perspective on the client experience. Alex explained,

> he identifies as a person in mental health recovery who was really injured by the system, the mental health system, through hospitalization, and still actively hears voices, and still lives a very productive life. And so, really kind of comes and talks about his experience being a patient, being what he thought was hurt within the system, and now the work that he's done to kind of recover from that.

This guest speaker helped to bring in the human element to crisis and trauma-specific services. With this guest, Alex aimed to facilitate a dialogue on the harm that counselors can do when they do not consider how crisis services may cause additional distress for clients. The final guest speaker was invited to speak about the services that were offered through their agency. Alex explained that "they do crisis counseling, individual, ongoing counseling, as well as on-site crisis response. And they run a phone line, as well, the national suicide prevention hotline." This speaker helped introduce students to the continuum of care in their community.

Vignette or case studies. Alex utilized case studies with prompts to help students work through more complex issues. One of the prompts she liked to use was called two-two-two. She explained with one of the disaster case studies, "so if they were coming into that disaster two hours after it had happened, two days, two weeks, two months after it had happened, what would what they're going to do ... how would that look differently?" Alex stated that she used vignettes as a starting point, but that was followed by application and self-reflection to solidify the skill associated with what comes after conceptualization. She provided the example with the sexual assault lesson,

> They'll read through that; they'll talk about it in groups. But it's one thing to say, I would want to know about their sexual history, if that was relevant to sexual assault or something. But then, how do you actually ask that to somebody? And so that part of ... I'll ask them, "How do you "... Because again, the conceptualization of the vignette. "I can conceptualize that I would ask them these sort of things". But then, when you roll it off your tongue, does it make you feel nervous? Does the person feel judged? What was the client's reaction to how you framed that?

Alex's identity as a clinician impacted the information that was discussed in the case studies. Alex stated, "We also, when we talk through, my lens is less involuntary hospitalization, and more hospital diversion. So, we do talk through the case studies of where is your threshold for hospitalization? That's kind of in the harm to self-care." The theme *instructor clinical experience* as an influence on course content and design will be explored later in the case.

Self-care activities. The final in-class teaching and learning activity that Alex described were student-led self-care activities. Alex stated,

> We end every class with a wellness activity, and how that looks is, the students volunteer for different weeks, and the wellness activity could be something simple like leading us through a stretching activity or coloring a card or watching a funny video. The students get to pick what the wellness activity is.

Instead of offering points for this activity Alex explained, "I think that the wellness activity is just kind of more of an expectation" for the class. The justification for this activity was the realization that the course content could impact student wellbeing. She stated, "Even just the class can be heavy, because our class is a three-hour class where we're talking about sexual assault for three hours. So not only could that be personally triggering, but it's just heavy in

general." Class ended each week with these self-care activities followed by the one-minute reflections.

Assessment and feedback. Alex stated that learning would be assessed through "preparation for and participation in classroom, role-play activities, written assignments, and group workshop presentation." There were five graded components in the course: participation, annotated bibliography, interview response paper, oral presentations project, and the final exam.

Participation. Class participation was a pivotal part of students' final grade, accounting for the 30% of the course grade. Participation included preparation for the class which was clearly stated in the syllabus. Furthermore, Alex stated, "attendance during class periods is necessary for an optimal learning experience for oneself and peers." As explained in detail above, the foundation of this course was experiential activities and full-group discussion. Due to this teaching and learning activity emphasis, it aligns that the largest portion of student grades would stem from their participation in class. Additionally, this is congruent with Alex's teaching philosophy which emphasized the importance of experience and collaboration in student learning. Alex described her expectations for participation:

> ...obviously my ideal participation is you verbally engaging, but I also realize that's not everybody's style of participation. Some people are more absorbers than they are speakers. And so, I understand that participation may not show up in you actively engaging and participating in this dialogue, but just being attentive is part of that.

She went on to say that the learning goal with class participation is for students to demonstrate self-awareness and engagement which she felt were essential characteristics for practicing clinicians. The next graded aspect of the course was the annotated bibliography.

Annotated bibliography. For this assignment, Alex allowed students to choose their own topic from the list she provided in the syllabus or something that they are interested in that is related to the course. In this assignment she wanted students to demonstrate that they could find relevant literature for a topic of interest and present it in a concise manner. She had stipulations such as how many of the resources had to come from referred journals or restrictions on how old the articles could be. In addition to learning how to find and organize literature, she added:

> there's some critical thinking in there, too... when they synthesize the article, the literature, that we also ask them to write a paragraph on their reaction, because again, that counselor piece. Do they think it's valid? Do they think it's easy to digest? Do they think it's a little bit skewed, because maybe they find out that it was sponsored by a big pharma[ceudical] company? So, trying to do some critical thinking in that. Do they recommend the article to people? Why or why not? That's another piece after they have read it and written the synthesis of it, putting in that paragraph about that piece.

Interview response paper. Alex explained that for this assignment students facilitated an interview with a counseling professional.

> I ask them to interview somebody in the field, and I don't give them a list of questions that they need to ask them, but just some general pieces of what's it like to work in this field? What are some stressors that you experience? How do you take care of yourself? What are some of the common themes that maybe you've come across in your work with clients, with yourself, with colleagues?

She provided a list of potential agencies for students to contact in the syllabus and also stated that in her 15 years on the college campus she has cultivated many relationships with the “crisis people in town and on campus.” These relationships allowed her to connect students to specific

people if they had an interest area that was not represented on the list provided. Alex also welcomed students to find other practices if they chose to, and she spoke of the feelings that came up for students with this assignment. She stated that even though students like this assignment, "I think they're intimidated by it, because a lot of times they're contacting the person, they're going to their location, trouble finding parking or the building, or maybe it's somebody in a hospital setting that's really hard to find."

She used this assignment as an opportunity to process what it may be like for clients who are seeking services from these agencies. The goal of this assignment is twofold, she explained "so, trying to parallel not only the information that they learn from the person with their interview, but also their own experience in the process."

Project oral presentation. The last three days of class were dedicated to students presenting their oral projects. Alex described this assignment:

> The oral project is that I ask them to find a topic that they are interested on that we haven't covered in class, and they can do it solo, they can do it with two or three or four people, and just do their own research and give us the presentation.

She encouraged students to choose topics that they were interested in and provided the example of "prenatal trauma" as a topic area that a student chose. She stated that she used to solicit feedback from students on what topics they did not cover in class that they were interested in. She found that specialty areas of trauma, such as prenatal trauma, were of interest to some students, but were too "small of a sliver" to cover in the course. She stated that child and adolescent crisis and trauma was another popular topic for this assignment.

> …we will talk about children, how might this look differently, this lethality assessment, with a child, or how might grief and loss look differently with a child, but we don't really

> dig into childhood or adolescence...

This assignment encouraged students to pursue topics that aligned with their interest areas, work collaboratively with their classmates, organize information into a cohesive and concise presentation, and practice their presentation skills. These presentations were not only open to their classmates, but an "announcement and invitation for attendance" was provided to the counseling department and university counseling center.

Final exam. The final assignment for the course was the take-home exam. Alex provided three detailed case studies, and students chose one to use for the exam. She explained:

> I used to give them a more traditional exam, multiple choice, fill in the blank, a couple little short answers. What does QPR stand for? What are the components of the lethality assessment? But it always just felt like rote memory. So now, what I do is, I give them, they can pick from one of three case studies, and then they do a paper on that, which then is asking them to integrate the pieces that we've learned.

She provided the example of one of the case studies which involved a mother whose child died in a car accident while the mother was driving. In the case, the mother was checking her cell phone and was responsible for the car accident. Students are asked to "put all the pieces together" and describe how they would work with this client two days, two weeks, and two months after. Alex adds additional complexity to the case by providing background information such as the mother's history of childhood sexual abuse and her complicated presenting issue which included suicidal thoughts. Students had approximately a week to work on the paper which targeted the integration and application of all course information. Alex also asked foundational knowledge questions such as "So, what are you paying attention to in the mental

status exam? What do you imagine are some of the neurobiological components that are impacting right now?" to assess for specific content retention.

The primary teaching and learning activities and assignments described in this section created the *Trauma and Crisis Intervention: A Survey of Theory, Response Models, and Techniques* course that Alex taught. Alex's collaborative and person-centered teaching philosophy aligned with the teaching activities and assessment methods described above. Collectively they exemplified her hope to create a learning environment where students felt safe being vulnerable and exploring their own reactions to the content. Throughout the analysis of the interviews and course syllabus, themes were identified that provided an additional layer of understanding to how Alex choose the content for her course and which methods she utilized to teach it. Those themes are described in the following section.

Interpretation of Alex's Course Design

This section is my understanding based on the above-presented case information of how Alex chose which trauma content to address in her class and which teaching methods she utilized to create significant learning experiences. I found 4 themes, one of which had three subthemes, and two major impacts on course design in the interviews and course documents. The four themes were: (a) *instructor clinical experience*, (b) *application-based pedagogy*, (c) *counselor self-awareness*, and (d) *student influence on course content and process*. The last theme, *student influence on course content and process* had three subthemes: (a) *student feedback*, (b) *student processing*, and (c) *student choice*. Alex's themes are integrated in some ways which created a consistency across her worldview, teaching and learning activities, and assessment and feedback. Her experiences as a clinician informed and justified her push for application-based pedagogy. Those application based instructional methods created a learning environment where students

were constantly asked to reflect and increase the depth of their self-awareness. As a result of this student-centered learning environment, student feedback, processing, and choice had a very large impact on how the course was taught and the content that was covered. Although each of these themes will be explored separately, it is important to remember that they feed into each other to create the course as a whole. Additionally, there were two major structural and situational factors that impacted course content and course development. The two factors were: (a) *format of the course* and (b) *co-instructor*. These two factors will be explored in more depth after the themes.

Instructor clinical experience. Alex's job as the administrator of the counseling center and numerous experiences responding to "larger scale disasters" impacted many aspects of the course design. From a structural perspective, Alex believed that trauma and crisis could have been two separate courses stating "my opinion is that that could actually be another class" when asked about the integration of trauma content into the crisis course. With the integration of trauma content, the course turned into a two-part series with crisis content presented in the first half and trauma in the second half by another instructor whose clinical experience was in trauma therapy.

This addition of the co-instructor aligned with Alex's belief that instruction should be informed by the educator's clinical experience. She stated that her ability to utilize clinical examples is an asset to the course. She explained, "I respond to larger scale disasters, so I think for my classes, they're always thankful for that, because a lot of their instructors are not practitioners at all."

Alex's background as a clinician impacted the content in the course in many key ways. Two of the primary content areas in the course were the biological basis for crisis and trauma response, and lethality and homicidality. As previously mentioned, Alex's justification for an

emphasis in these areas was a lack of attention to this content in other courses. She was able to identify this gap because her clinical expertise is in these areas. When asked about how she choose the content to put into the class she stated “a lot of it was just through my own clinical work of what I was seeing” additionally she stated, “my own experiences of what I kept seeing of when folks were getting stuck in the trauma, what was helping and what was happening.” In combination with her own clinical experience, *student feedback*, examined later, was also an integral piece that she combined with her own clinical experience to decide which trauma content to teach.

In addition to the primary content areas, Alex’s clinical experience impacted the course focus on diversion from hospitalization, influence of time since the crisis event on counselor role, and models and conceptualizations of focus. When asked about hospitalized diversion Alex stated that

> if somebody is having a normal trauma reaction and we put them in a psychiatric hospital, there can actually be compounding impacts. So that is something that we talk about too in the class, because I think our students don't hear that.

Alex stated that her perspective was informed by the center that she worked at which functioned from a “hospital diversion mind frame.” When asked about the models and theories that are introduced in the course Alex reported, “I hit on all of them, but then I talk about the ones that I like the most, of course.” Additionally, when asked about areas that are emphasized the least, she reported that cognitive behavioral therapy was one of the areas that received the least course time. She justified this pedagogy decision by stating

> We touch on the CBT pieces, but just to be honest, we're biased on that being a long term solution for effective trauma therapy, which I am also aware that the literature very much

> supports it, but I have concerns about where that literature comes from and who's funding it and some other pieces of that. So, we do talk about it as a piece that we come from a more humanistic lens.

Alex's clinical experience also impacted teaching methods. As previously stated, Alex described her teaching philosophy as "Jungian in how I approach therapy, and I think that translates into my teaching style, because I'm also very experiential in my teaching style." Additionally, she described herself as very collaborative and relationship focused. Her background as a clinical also allowed her to be attuned to students and attend to their needs in the classroom in a therapeutic way. She explained, "something maybe has been triggered in the class, because it's done in an experiential way, where something's come up and we try to attend to it in almost a therapeutic way, and also a supervision way." Furthermore, the emphasis on *counselor self-awareness* which will be explored in depth later in the section was informed by her clinical experience. She stated, "I think if I can be aware of my own reaction, then that's going to help me be more helpful therapeutically."

The final aspect that was impacted by Alex's clinical experience was her connections to the community and the guests she invited into the class. The importance that Alex placed on diversion from hospitalization may have impacted her choice to invite the peer support guest speaker. If Alex was aiming to integrate the client perspective into course content, she could have chosen a wide variety of speakers, but she chose to invite a guest speaker "who was really injured by the system, the mental health system, through hospitalization." This content aligns with her perspective on hospital diversion. She also noted that her clinical experience allowed her to connect students to a wide variety of professionals in the community for the interview

assignment. The next theme that was identified from the course documents and interviews was the *application based-pedagogy*.

Application based-pedagogy. Alex stated that her goal for this course is that "they walk away with the ability to put it into practice." As previously stated, she justified this statement because most of her students would be going into clinical practice after graduation. Even when she spoke about foundational knowledge such as a biological basis of behavior, she referenced students utilizing that information beyond conceptualization to support client intervention. She stated that students "will often talk about going into using that as a psychoeducational component when they're going in to talk to people about even just the fight/flight/freeze idea and how their body responds." She believed that students needed to apply the information because conceptualization "doesn't hold as much weight, oftentimes," she stated that this was why many of the activities in the course were experiential. She wanted to "move from what we know to, what do we need to do?" as soon as possible so that students had a variety of opportunities to apply the material in class. The need for application also impacted the content the Alex removed from the course. She stated that she removed the FEMA Standards assignment, she explained "I feel like that, again, when folks were looking at, how do I make this applicable, the FEMA pieces felt too technical." Additionally, when she was asked what content she placed the least emphasis on she stated "We didn't highlight a lot of ... We would talk about the research, but then we would talk more about what that looks like in practice."

In addition to course content, the emphasis on application-based pedagogy permeated through all the teaching and learning activities and assessment and feedback. Explained earlier, the class was experience driven with shorter opportunities for application (e.g., practicing death notifications) and larger scale disaster simulations. The two primary aims of application-based

pedagogy were to allow students ample opportunity to practice the skills presented in the class while providing an opportunity to increase *self-awareness*.

Counselor self-awareness. Alex focused much of class process questions and assignment prompts on increasing counselor self-awareness, creating "constant conversational reflection and personalization." With the intensity of the course she was able to utilize her clinical skills to help support students, but she stated that intensity also provided an opportunity for them to learn how to take care of themselves and each other. She explained

> Sometimes it happens in class, and their classmates will attend to them, or I often invite people, if you need to step out of class, please feel free to step out. If you don't come back, I'll probably come looking for you, because I expect that people will ... Well, I shouldn't say expect, but I hope that it is, because I do think for me, the counselor as a person is a part of this class also. And so, it's really like, you're a person dealing with people in pain, and so how do you attend to yourself, also?

Throughout the class she expected students to reflect on their own experiences and then expand on that to contemplate how their clients may experience the same phenomena. She prompted with questions like, "Think about a time when you experienced a stressful event, a trauma, and what did you notice in your body? What was helpful to you?" She used these questions to try to build empathy and self-awareness.

She built self-reflection into the feedback model that was utilized to process class role plays. In the feedback model, the client and the audience provided feedback first which Alex stated was an attempt to get them to "really try to put themselves in the shoes. Which the idea for that is, just because it works for one client doesn't mean it would work for another." In addition to in class activities, when introducing interventions Alex pushed students to reflect on what they

are going to do if they are triggered and how they are going to keep themselves safe when working with clients in crisis or with histories of trauma. Alex really believed in the philosophy of "you as practitioner and you as a person."

From a method perspective, Alex integrated counselor self-awareness into every class through the one-minute reflections, the process section of the interview project where students reflected on how their experience accessing the professional may parallel that of a client, and many of the activities such as the mortality activity and sexual assault reflection introduced earlier. Alex stated that after every experiential activity the first question she asked students was "how did that impact you?" which set the counselor-as-a-person tone throughout the semester. The final theme that will be discussed concerning how Alex choose the content for her course and the methods she utilized to facilitate significant learning is *student influence on course content and process*.

Student influence on course content and process. Alex's Jungian and humanistic teaching philosophy created an environment that was experiential in nature and focused on collaboration through group process. Due to this emphasis, student involvement in the class was central to the methods utilized in this course. Within this theme, three sub themes were discovered: *student feedback*, *student processing*, and *student choice*. Each of these will be discussed below.

Student feedback. Student feedback was the primary reason Alex initially added trauma content to the crisis course. Alex noted:

> You'll notice the title of the course is still a survey class, so I think students were also not ... I shouldn't say they weren't happy, but they wanted more than survey stuff; they wanted more in-depth trauma-informed care theories and practice.

Although the course was still taught in a survey style, by adding a co-instructor who could provide depth to the trauma content like Alex could add to crisis content, students were given a more in-depth experience of both topic areas. Alex noted several times during our interviews the positive student feedback about her ability to integrate her clinical experience into the classroom. One example she provided was, “I'll get feedback on, that it's nice to have somebody who's still practicing and has been practicing, to be able to integrate that piece outside of a textbook or a research article.”

Additionally, the trauma content Alex chose to integrate into the class was partially grounded in the feedback she received from students. When asked how she choose what trauma content to integrate into the course she reported responding to what students “were seeing at their practicum and internship sites” and her own clinical experience. She also utilized student feedback to determine what content to remove from the class. She provided the example of the FEMA standards, “The feedback from the students was that those particular pieces were not as helpful as the global trauma-informed care perspective.”

As noted previously, Alex chose to have students complete QPR due to feedback she received from them about the relevance for their practicum. She stated that students often provide feedback on how meaningful specific assignments are for them, and she welcomed this feedback to help her shape future courses. She provided the example of the death notifications activity she stated, “And that's always one, that particular activity, they'll say at the end of the semester was so powerful, because they had to roll the words off their tongue.” Furthermore, when she changed the final exam from multiple choice to a more applied format, she received affirming feedback from students. She stated, “And that one, again, has been, they've said that that has been more, just felt more purposeful than the basic ones.” In addition, to using student

feedback throughout the course, Alex relied heavily on oral and written activities that prompted students to think critically about the course content through individual, small group, and whole group processing.

Student processing. Alex stated that she believed in the "value in the collective wisdom of the group" while she was teaching her classes. As the instructor she was aiming to take the perspective of her students by asking them to "help me understand your experiences with this, whatever this is, whether this is death, loss, grief, trauma." As a result of this style of teaching she described the class as "less didactic and more conversational and experiential." As previously mentioned, during group processing sometimes she would attend to students, students would attend to each other, or students would utilize coping strategies such as leaving the room for a short time to help mitigate any distress from the course content or process. The foundation of the push for the group to process each of the activities was a sense of community that Alex was attempting to build in the classroom. Alex stated, "I think if you can build a strong relationship, then you can do a lot of good therapy work." So much of what they were doing in the class was focused on "really how, do you start building a good relationship?" At the time of the inquiry the class was typically capped at 15-20 students to help build this sense of community and maintain a small learning environment where students could know each other and learn to trust. When asked to explain her expectations for in-class participation Alex explained,

> It really means more of that, just being thoughtful, because for me, if there's a therapist-focused piece, I'm wanting to know that you're looking at yourself in this process, so if you can demonstrate some of that, whether it's verbally or in the written piece.

Although much of the processing in class was conducted orally, the annotated bibliography assignment also had a processing component where students were asked to think critically about the content exploring the validity of the article, how easy it was to digest, their perspective on the funding source for the research, and if they would recommend the article to their colleagues. The final aspect of the overarching theme of *student influence on course content and process* was student choice.

Student choice. Alex offered students choices in every course assignment in the course and even in some of the in-class assignments. For the annotated bibliography students were able to choose from her list of suggestions or propose their own topic area. In addition to the open topic area, Alex did not provide a template or suggested format for this assignment. Students were able to annotate articles in a format that made sense to them as long as they attended to the critical thinking questions and the criteria in the syllabus. Similar to the annotated bibliography assignment, students were able to interview any professional of their choosing for the interview project. Alex provided a list of local agencies in the syllabus and made herself available to provide connections if students had a particular interest area, but students were prompted to call the agency and set up the interview on their own. Much like the annotated bibliography, Alex did not provide any specific interview questions for this assignment which allowed students to explore topics that interested them most.

For the oral presentation students were able to choose format and content by choosing their topic areas and if they wished to complete the assignment independently or in a self-selected group. Alex explained, “I ask them to find a topic that they are interested on that we haven't covered in class.” When asked if they tend to do this assignment independently or in groups she stated, “They tend to do it in groups. And sometimes I actually have to cap the group,

six is too many." The limiting of group size is the only aspect of this assignment that Alex manages, the remainder is completely dependent on group interest. The final assignment that incorporates choice is the final exam. Alex explained, "I give them a really long case study that they can pick." She provided some guidance on topic areas that they needed to respond to, but by providing three separate scenarios Alex shifted some of the choice onto students. The last piece of the course that involved student choice was the wellness activities that were presented at the end of each class. This allowed for a different type of wellness activity to be provided each week for the students to mitigate the heavy course material.

These next two areas *format of the course* and *co-instructor* were discussed throughout the interviews but did not necessary constitute themes. They are included in the case because these areas had significant impact on course design, shaping what Alex taught and how she taught it.

Format of the course. The face-to-face format of the course heavily impacted the course design. Alex was able to utilize in-class time to process material, integrate experiential activities, and attend to here and now experiences of students. Most of the process elements of this course (e.g., death activity, disaster simulation, empathy activity) would have been difficult to recreate in an asynchronous virtual format. Alex relied heavily on the activities and the whole group processing after the activities where students reflected on their experiences and heard about their peers' experiences. As previously mentioned, Alex had a lot of trepidation about teaching this course in an online format because of the loss of the experiential and processing components that were so deeply ingrained in this course and in her teaching style.

Co-Instructor. The other factor that impacted the teaching of this course was the co-instructor format. The function of the co-instructor has been previously discussed, but due to the

impact that it had on course process and content, it bears repeating. The co-instructor was not available for the interviews, and Alex was the instructor who taught the crisis content in the course. The first time the two instructors taught together, Alex and the co-instructor were both in the class during each class period. Alex explained:

> So, the first year that we did it, I went to both halves of the semester. I taught the first half, and then the other person taught the second half, although I was still there. And then this last year when we taught it for the second time as a co-instructor model, I was present for the first half and taught it, and then I wasn't present for the second half of the semester.

Alex noted this decision was related to workload and confirmed that "the colleague who taught that other piece, yeah, she kept the same materials." There were no explicit conversations about how the co-instructor model impacted the course besides Alex stating that students appreciated having instructors who were respective experts in their content area and practicing clinicians. She explained several times that her being a crisis professional and the co-instructor having certifications in trauma yoga and somatic experiencing as aspects of their specialty in trauma enhanced their ability to teach a course focused on application.

Individual Case Limitations

There is one primary limitation for this case, the inability to speak to the co-instructor of the course. For this present inquiry, Alex was able to provide depth and context for much of the crisis content in the course, but she had to reference her co-instructors' course documents to confirm the content that was taught during those class periods. Although Alex sat in on the course while it was taught the first time, the last time she taught the course was in Fall 2017, and she did not sit in the entire course at that time. Thus, the last time she experienced her co-

instructor's sections of the class live was fall 2016. I specifically asked Alex how comfortable she felt stating that the information that she provided was consistent with what was taught in the class, but I may have missed valuable information regarding additional elements that were improvised or added and not reflected in Alex's course documents.

Individual Case Conclusion

This case study aimed to better understand how Alex chose the content in this trauma course and the methods she utilized to facilitate significant learning experiences in the classroom. Alex's course covered a broad range of content including the biological basis for trauma and crisis response, trauma and crisis specific interviews and models, wellness, and contextual factors that influence a counselor's role in supporting clients that have been impacted by crisis and traumatic experiences. The methods utilized to teach in this course included lecture, role play, required readings, videos, reflection, guest speakers, case studies, and various in-class experiential activities.

Many factors impacted how Alex choose the content and the methods used to teach including her *clinical background*, *application-based pedagogy*, the wish to increase *counselor self-awareness*, and *student influences on course content and process*. Additionally, the structural implications of the course format and the use of a co-instructor impact the course design. Alex's strong belief that counselors must be aware of their own reactions and understand client's reactions within the context of the biological basis of behavior were integrated into every aspect of this course. This focus to educate in a way that elicited an experience for students that they could reflect on as a community was central to how she chose content and methods to utilize to facilitate significant learning experiences.

Multicase Report

The primary reason for completing a single-case study report was to highlight the unique situational factors that contribute to the Case Findings. The primary reason for completing a multicase report is to identify similarities across cases (Stake, 2006). Due to this incongruence, one of the prominent challenges for the researcher is to create a multicase report that preserves the uniqueness of each case while drawing similarities for the reader. Stake explained that readers, "want the benefit of the team's understanding of the aggregate. Given the binding concept—a theme, issue, phenomenon, or functional relationship that strings the cases together—the researchers have an obligation to provide interpretation across the cases" (Stake, 2006, location 1122). This next section details the Findings of the cross-case analysis. I will describe the teaching and learning activities and the assessment and feedback methods across the three Cases. Additionally, I will provide the multicase Assertions. This multicase report is my understanding of how each of these single Cases contributed to a better understanding of the whole.

As introduced in Chapter Three, the binding concept of the Cases is the Quintain, the shared quality that links the cases together. For this inquiry, the Quintain was *trauma courses intended for master's level graduate students in counselor education*. The overall aim of the inquiry was to understand how the Quintain manifested within different contexts and to identify similarities across contexts. Alex, Jimmy, and Jade each taught a master's level trauma course with unique situational factors that were explored in-depth in the individual Case reports. This report will "take evidence from the case studies to show how uniformity or disparity characterizes the Quintain" (Stake, 2006, location 1150). This report has two sections aligning with the research questions: a comparison of the methods utilized to create significant learning

experiences and how they align with Fink's Taxonomy of Significant Learning (Fink, 2013) and a comparison of Case Findings specific to how instructors choose which content to address in their respective trauma courses.

While reading the multicase report, I urge the reader to keep in mind that "often the Quintain will appear increasingly less a coordinated system and more a loose confederation, or less a simple pattern and more a mosaic" (Stake, 2006, location 1148). I will begin with participant demographics (Table 4.7), present an analysis of teaching methods, and finish with analysis of how the course content was chosen and the multicase Assertions.

The participant demographics were presented in depth in each of the cases. Table 4.7 provides a brief overview of some of the participant demographic information. One of the multicase findings was the impact of instructor identity including clinical background on the choice of course content and method. Thus, the demographics presented below are those most closely pertaining to each instructor's identity.

Table 4.7: Multicase Participant Demographics

	Age	**Gender Identity**	**Racial or Ethnic Identity**	**Professional Counselor**	**Counselor Educator**	**Clinical Background**
Jade	36	Cisgender Woman	Caucasian/ White	9 years	3 years	Training sites focused on trauma/grief/ loss; private practice specializing in this area
Jimmy	38	Cisgender Male	Caucasian/ White	11 years	4 years	Focus with children and documented cases of abuse
Alex	41	Cisgender Woman	Caucasian/ White	15 years	15 years	Current practicing Clinician in a college

Teaching and Learning Activities

This section examines the teaching and learning activities used by Jade, Jimmy, and Alex. There were three teaching methods that were utilized by all three instructors: (a) case study, (b) discussion, (c) lecture. Additionally, Alex and Jade both utilized role-play, guest speakers, mindfulness and/or self-care activities, outside modules and/or training, and media such as video or podcast. Table 4.8 details which types of teaching and learning activities each of the instructors utilized. Jade, Jimmy, and Alex explained learning goals for each of the teaching methods they used. To better understand the Quintain, I coded these learning goals and their explanations utilizing Fink's Significant Learning Taxonomy (2013) which included the domains *foundational knowledge, application, integration, human dimension, caring,* and *learning how to learn*. A detailed description of each of these domains was included in Chapter Three in the theoretical frame section. In this case report, these domains of significant learning (Fink, 2013) will be referred to as the Quintain Themes. They are the theoretical frame I have chosen to better understand the teaching and learning activities and assessment and feedback methods in trauma courses. Many of the teaching and learning activities utilized by the instructors incorporated multiple Themes of significant learning (Fink, 2013).

Each of the instructors included teaching and learning activities in their course that attended to the Themes of *foundational knowledge*, *application, integration,* and *human dimension*. Furthermore, Alex and Jade both included activities that attended to the *caring* Theme, and Alex and Jimmy both included an activity that attended to *learning how to learn*. Table 4.9 represents the individual frequencies for each unique learning method. Comparisons of frequency between cases should be interpreted tentatively due to instructor use of a method once

Table 4.8: Multicase Types of Teaching Methods Utilized

Case	Case Study	Discussion	Role Play	Guest Speaker	Lecture	Mindfulness / Self- Care	Outside Modules	Media (video)	Experiential Activity
Alex	X	X	X	X	X	X	X	X	X
Jimmy	X	X			X				
Jade	X	X	X	X	X	X	X	X	

or repeatedly. For example, although it appears that Jade incorporated *foundational knowledge* more often in her teaching and learning activities, it would be more accurate to conclude that Jade used more unique learning methods that incorporate *foundational knowledge*. Thus, this chart counts each method once regardless of if she used it in one lesson or every week. Jimmy's one teaching and learning method that focused on *foundational knowledge* was lecture, and he used this method multiple times throughout the semester. Although it was a single method, as indicated in Table 4.9, it does not indicate that Jimmy offered less *foundational knowledge* in his course than Jade or Alex. The conclusions that can be drawn from this chart are that in general Alex and Jade had more unique teaching and learning methods than Jimmy, a finding that may have been due to the format of the course (e.g., hybrid or face-to-face, 16-week or 8-week).

The majority of the teaching and learning activities between the three Cases were focused on *application* of course material. Additionally, *integration* and *human dimension* Themes were represented the same number of times between the three cases. *Integration* was the only Theme where Jimmy had two teaching and learning activities represented, making it a potentially more prominent Theme than *human dimension* although they were represented at the same frequency. *Foundational Knowledge* was the third highest Theme that was represented in all three Cases. Table 4.9 details the types and frequency of significant learning Themes in the teaching and learning activities for the three Cases examined in this inquiry, one "x" indicates single teaching and learning activity (i.e., case study).

Jimmy, Alex, and Jade utilized many different types of teaching and learning activities coded as *foundational knowledge* which included virtual and face-to-face lectures, guest speakers, outside resources, and media. All three instructors utilized lecture to introduce foundational ideas and information to their students regardless of whether they did it virtually or face-to-face. Jade and

Jimmy stated that they utilized lectures to ensure students understood complex content, and Alex utilized PowerPoint with lecture to help pace the course and create a firm foundation so that material could be applied later in class.

Learning activities coded as *application* included case study, role play, mindfulness, discussion, guest speakers, experiential activities, outside modules and training, and self-care. Jade, Jimmy, and Alex utilized case study as a primary method for students to apply course content in a variety of ways. Jade and Alex used case study to present examples from clinical practice and prompt critical thinking. Additionally, Jimmy had students create a case study that they continued to use throughout the semester to demonstrate skills and think critically through the course material.

All three instructors also used case studies to attend to the *integration* Theme of the Quintain. Students were asked to connect ideas and learning experiences to better understand how various course concepts such as development, intervention, assessment, and foundational information about trauma impacted different cases. Other teaching and learning activities utilized to stimulate *integration* were discussion, media, video communication, experiential activities, guest speakers, and discussion.

The final Theme that was shared between the three instructors was the *human dimension*. Unlike the first three domains, the instructors did not use the same type of activity to attend to this Theme. Jade and Alex both utilized discussion and media; Jimmy utilized synchronous and asynchronous video communication. All three instructors aimed to facilitate activities that allowed students to better understand themselves and others through dialogue with other students or exposure to novel human experiences through media. Table 4.10 details the teaching methods utilized to target areas of significant learning for the three Cases examined in this inquiry. In the

table, each of the teaching and learning activities has the Case that it was coded in next to it in parenthesis.

Assessment and Feedback

This section examines assessment and feedback methods used by Jade, Jimmy, and Alex. All three instructors used papers and projects/presentations. Additionally, Alex and Jade assessed participation or attendance in the class, and Jimmy and Jade assessed discussions and an annotated bibliography. Jimmy utilized many different assessment methods in the course that were folded into weekly homework assignments. For analysis, those 7 assignments were collapsed into categories: project/presentation, homework/worksheets, annotated bibliography, and self-assessments. Table 4.11 details which types of teaching and learning activities each of the instructors utilized.

As explained above, Jade, Jimmy, and Alex expanded on the learning goals for each of the assessment and feedback methods used in their course. I used the same coding method with the assessment and feedback methods as I did with teaching and learning activities to better understand the Quintain. Many of the assessment and feedback methods aimed to assess multiple Themes of significant learning, and thus a single assessment method may be included in multiple Themes of significant learning (Fink, 2013).

Jade, Jimmy, and Alex used many different types of assessment and feedback methods in their respective courses. All three instructors assessed for all Themes of significant learning throughout their course. Table 4.12 details the type and frequency of significant learning in each Case assessment and feedback method. One “x” indicates a single assessment method such as the integration project assigned by Jade.

Table 4.9: Multicase Types and Frequency of Significant Learning Themes in the Unique Teaching and Learning Activities

Case	Foundational Knowledge	Application	Integration	Human Dimension	Caring	Learning How to Learn
Alex	xxx	xxxxx	xxxxx	xxxxx	xxx	x
Jimmy	x	x	xx	x		x
Jade	xxxx	xxxxx	xxx	xxx	x	
Total Activities	8	11	9	9	4	2

Note. x = one activity (i.e., case study)

Table 4.10: The Teaching Methods Utilized to Target Areas of the Significant Learning Taxonomy

The Domain of Significant Learning Theme	The teaching and learning activity and associated Case
Foundational Knowledge	• Live or Recorded Lecture (P1/P2/P3) • Video/Media (P1/P3) • Guest Speakers (P1/P3) • Outside resources (P1)
Application	• Case Study (P1/P2/P3) • Roleplay (P1/P3) • Mindfulness/Self-care Activities (P1/P3) • Discussion- Online and/or face to face (P1) • Guest Speakers (P1) • Experiential activities (P3) • Outside- Modules and/or training (P3)
Integration	• Case Studies (P1/P2/P3) • Discussion- Online and/or face to face (P1/P3) • Media/Video (P1/P3) • Synchronous and asynchronous video communication (P2) • Experiential activities (P3) • Guest Speakers (P3)
Human Dimension	• Mindfulness (P1) • Discussion- Online and/or face to face (P1/P3) • Media/Video (P1/P3) • Synchronous and asynchronous video communication (P2) • Guest Speakers (P3) • Role play (P3) • Experiential activities (P3)
Caring	• Mindfulness/Self-care Activities (P1/P3) • Discussion (P3) • Experiential activities (P3)
Learning How to Learn	• Case study (P2) • Self-care Activities (P3)

Note. P1= Jade, P2=Jimmy, P3=Alex

Table 4.11: Multicase Types of Assessment and Feedback Methods

Case	Participation / Attendance	Discussion	Journals	Paper	Project/ Presentation	Homework / Worksheets	Annotated Bibliography	Self-Assessments
Alex	x			x	x		x	
Jimmy		x		x	x	x	x	x
Jade	x	x	x	x	x			

The assessment and feedback methods coded as *foundational knowledge* included all assignments that aimed to assess students' understanding and retention of foundational ideas and information in the course. These methods included online discussion sets, homework assignments, small group discussions, annotated bibliography assignments, oral presentations, and the final exam. Jimmy and Alex both utilized an annotated bibliography assignment to assess for *foundational knowledge*. There were no other methods in this Theme category that overlapped between instructors.

Jimmy, Jade, and Alex assessed students' ability to *apply* information in a variety of ways. They utilized participation, online discussion, projects, homework assignments, and the annotated bibliography. Jade and Alex shared two types of assignments aimed at assessing students' ability to apply information: a course paper and a project. Jade's film reaction paper and Alex's final exam paper both asked students to think critically about the content and apply the skills they had learned in class to a particular case. Additionally, both instructors utilized projects: the integration project in Jade's course and the oral presentation project in Alex's course. Both of these assignments assessed students' ability to apply skills they learned in class to a particular subject and create a presentation that was cohesive and concise to demonstrate their ability to apply the information.

All three instructors assessed students' ability to *integrate* content through a written assignment. Jade used the film reaction paper, Jimmy used the white paper, and Alex used the final exam. Each of these assignments instructed students to connect ideas, learning experiences, and realms of life to the course content to demonstrate their ability to integrate various concepts such as foundational information about trauma and trauma recovery, biological information such as stress response and basic neurobiology, and developmental theory.

There were no common assessment methods for the Theme *human dimension*. The instructors used reflective journals, participation and discussion sets, homework assignments, small group discussion, papers, and projects to assess students' ability to learn about others and themselves. This was often done by exposing them to populations or situations that were different from themselves and asking them to reflect on that experience.

Like the *human dimension*, there were no assignments all three instructors utilized to assess the *caring* Theme. Jade, Jimmy, and Alex used class participation, reflective journals, and homework assignments aimed at helping students understand their values, interests, and skills. Both Jade and Alex used class participation to assess students' ability to be mindful of their own reactions, self-regulate, and demonstrate self-awareness.

Assertions

Jade, Jimmy, and Alex had eleven individual Case Findings between the three of them that described how each instructor choose the trauma content and methods in their courses (Table 4.14). The following section will aim to understand similarities between case Findings and how those relate to the Quintain. Case Findings endorsed with evidence from all three Cases will be called Assertions. Case Findings that are endorsed with evidence by two of the three cases will

Table 4.12: Multicase Types and Frequency of Significant Learning Domains in the Assessment and Feedback

Case	Foundational Knowledge	Application	Integration	Human Dimension	Caring	Learning How to Learn
Alex	xxx	xxx	x	xxx	x	xxxx
Jimmy	xx	x	xxx	x	x	xxx
Jade	x	xxxx	xx	xx	xx	xx
Total Activities	6	8	6	6	4	9

Note. x = one assignment (i.e., integration project)

be called Tentative Assertions. Findings that seem to be unique to a single case will not be discussed in this section.

The individual Case Findings were combined into three Assertions: Instructor Role, Instructor Identity, Teaching Methods to Elicit Fundamental Change in the Learner, and one Tentative Assertion: Teaching Methods to Develop Student Skill Acquisition. Table 4.15 includes the case Findings and the evidence used to support the Assertions and Tentative Assertions. The situational and unique factors of the Individual Cases will not be discussed, as the aim is to better understand the commonality between Cases. More specifically, these Assertions aim to explore the first research question: How do CEs choose which trauma content to address in master's level trauma theory and practice courses? Although it was not one of the research questions, these Assertions also provide insight into how the CEs choose course methods.

Instructor role. The way the three CEs conceptualized their role as instructors impacted how they chose the content and methods for their respective courses. Jade believed that an aspect of the instructor role was to be responsive to student development level and pace the course in a way that allowed assignments to build off of each other. Additionally, Jimmy stated that CEs should view themselves as facilitators of content and connection. Furthermore, he believed that CEs' primary role was to provide information on a variety of topics and allow students to direct their learning experience. Finally, Alex viewed CEs' role as collaborative, with a focus on creating classroom

environments that facilitated student feedback, choice, and processing of their experience with the content. Overall, this Assertion provides evidence to support that how CEs understand their role in the classroom impacts the course content and teaching methods utilized.

Table 4.13: Multicase The Assessment and Feedback Activities used to Target Areas of the Significant Learning Taxonomy

Dimension of Learning	Evidence From Individual Cases
Foundational Knowledge	• Annotated bibliography, students were asked to acquire relevant information and ideas about a topic of their choice (P3/P2) • Online participation and discussion sets demonstrate they understand the information presented in the lectures (P1) • Homework assignment(s) focused on demonstrating the retention of foundational ideas and concepts (P2) • Small group discussions on course required reading to assess the depth of understanding of foundational topics (P2) • Oral presentation, learn about ideas and information about the topic area (P3) • Final exam, demonstrate they know foundational ideas and information from the course such as mental status exam and neurobiological concepts (P3)
Application	• Film reaction paper and final exam paper, critical thinking skills to take information from the movie, analyze it, and apply skills learned in the course. Think critically about the case being presented and apply skills they learned in class to the case (P1/P3) • Integration project and oral presentation project, managing a project and applying the skills they learned in class to a particular subject of their choice, creating a presentation that is cohesive and concise (P1/P3) • In-class attendance and participation, self-care and mindfulness activities interspersed throughout the course material (P1) • Online participation and discussion sets apply information to critical thinking exercises (P1) • Homework assignment(s)focused on creating a case study, presentation, demonstrating the use of an assessment, demonstrating the use of an intervention (P2) • Annotated bibliography, students were asked to think critically and present the information in a concise manner (P3)
Integration	• Film reaction paper, white paper, and final exam were used to integrate information from the film/case study/topic of their choice and the course (P1/P2/P3) • Reflective journals, merge course learning; demonstrate they have learned different information and ideas and connected them to different realms of life (P1) • Homework assignment(s) focused on integrating various foundational topics/ideas/learning experiences such as trauma across the life span, a trauma in specific populations or settings (P2)

Table 4.13. Continued.

Dimension of Learning	Evidence From Individual Cases
	• Small group discussions to encourage students to integrate information and "create meaning" (P2)
Human Dimension	• Reflective journals, increase self-awareness (P1) • Online participation and discussion sets reflect on how the content is presented and their own experiences (P1) • Homework assignment(s) focused on learning about how vicarious trauma impacts mental health professionals (P2) • Small group discussions to learn about the self and classmates' reactions to course content (P2) • Participation, attendance in class is necessary for an "optimal learning environment for oneself and peers" (P3) • Interview response paper, learn about how other mental health professionals take care of themselves (P3) • Oral presentation project, work collaboratively with other classmates (P3)
Caring	• In-class attendance and participation, being mindful of our own reactions in this course/, learning how to tolerate the material and sit with it, demonstrate self-awareness (P1/P3) • Reflective journals to self-evaluate values, interests, and feelings (P1) • Homework assignment(s) focused on reflecting on strengths and weaknesses and creating a personalized self-care plan (P2)
Learning How to Learn	• Film reaction paper, white paper, interview paper and final exam, utilize outside sources/material in the paper to better explain information in the movie, choose a population and intervention for paper, seek out clinician in the community to conduct an interview with (P1/P2/P3) • Integration project and oral presentation project, create a training module or prevention project grounded in research on a topic of their choice by using outside sources and pursue a topic of their choosing that aligns with their interest area (P1/P3) • Annotated bibliography, students had the ability to choose their topic area demonstrating they are self-directed learners and are able to independently inquire about a subject (P2/P3) • Homework assignment(s) which allowed students to choose the population, intervention, assessment, or setting they wanted to focus on and encouraged self-directed research on a topic area (P2)

Note. P1= Jade, P2=Jimmy, P3=Alex

Table 4.14: The Individual Case Themes

Case	Individual Case Themes
Jade	• Embracing and capitalizing on instructor expertise and limitations • Awareness of contextual factors and current events • Responsiveness to student developmental level
Jimmy	• Application-based pedagogy • Instructor past experiences • Counselor educators as facilitators • Trauma-informed counselors as advocates
Alex	• Instructor clinical experience • Student influence on course content and process • Counselor self-awareness • Application-focused pedagogy

Instructor identity. Jimmy, Jade, and Alex all spoke to the importance of their past clinical and personal experiences in addition to their specialty areas, theoretical orientation, and personal dispositions as an impact on course design. Jade's orientation toward Feminist Theory impacted her humility and transparency in the classroom. Additionally, it framed the way she approached teaching from a non-expert perspective. Alex's clinical background impacted the way she conceptualized trauma and crisis as two separate content areas, her utilization of clinical examples in class, and her attunement to student needs. For both Jimmy and Alex, their clinical backgrounds impacted the emphasis they placed on specific content, the depth with which they addressed specific topic areas, and the use of experiential or application-based assignments and methods in their courses.

Furthermore, Alex and Jade both mentioned mentorship as a large influence on how they inherited their respective courses, choose which content to incorporate, and facilitated classroom activities. Both instructors utilized content and methods from their mentor's version of the course

as the foundation for the current iteration of the course. Alex and Jade both had the opportunity to work with the individual who taught the course prior to them either as a teaching assistant or as a student in their course and then a colleague. These relationships shaped the content in the course and allowed Jade and Alex to share many philosophical ideas of their mentors. For example, Jade credited her Feminist and contextual understanding of trauma response to her mentor. This Assertion provides evidence that the identity of CEs as it relates to past clinical and personal experiences that impact which content they emphasize and how they do so.

Teaching methods to elicit fundamental change in the learner. The final Assertion endorsed by the evidence in the Case Findings for Jimmy, Alex, and Jade focused on a fundamental change in the worldview or disposition of the learner. Jimmy hoped that through the course material and teaching methods his students would have an understanding of their identity as advocates. Alex hoped that through class processing, reflective assignments, activities, and continual conversations, students would gain a deeper understanding of themselves and how "counselor as a person" impacts the therapeutic process. Jade structured course assignments and assessment methods to help students gain a better understanding of trauma, trauma response, and diagnosis in context. She hoped that students would gain a more nuanced understanding of how pathology and treatment are impacted by various factors. This Assertion provides evidence that each of these instructors hoped for a deeper learning goal than skill or knowledge acquisition. Through intentional teaching and learning activities, and assessment and feedback methods, each of the three Cases provided Findings to support that the instructors choose content and methods to elicit some sort of fundamental change in the learner.

Teaching methods to develop student skill acquisition. Jimmy and Alex both provided Case Findings that aligned with course content and methods to increase student skill acquisition

or application of course material. Jimmy and Alex both strongly believed in the need to move from conceptualizing to action quickly. Additionally, they both emphasized their worry about counseling students who had foundational knowledge without knowing how to put it into practice. Both instructors removed content from their courses that did not align with an application focus and pushed students to practice with case study, role play, and homework assignments. This Assertion was not endorsed with evidence from Jade and is presented in this inquiry as tentative.

Summary

I reported in this chapter the Findings of the cross-case analysis for the individual Case studies of Jade, Jimmy, and Alex. The first half examined the teaching methods utilized in each of their courses and the Quintain Theme aligned with the specific teaching and learning activities and assessment and feedback methods. The second half of the multicase analysis examined the individual Case Findings and combined them into three Assertions and one Tentative Assertion to draw multicase inferences about the Quitain. The next chapter will introduce implications and recommendations from these individual and milticase Findings and Assertions.

Table 4.15: Assertions and Evidence from Individual Case Findings

Assertion	Case Finding, Evidence to Support it, and the Case it Originated from

Instructor Role	• **Responsive to student developmental level (P1)**
	  ○ Tailor teaching style to the developmental needs of students
	  ○ Pace course so that assignment build off of each other
	  ○ Attended to the individual and holistic developmental needs of the class
	• **Counselor educators as facilitators (P2)**
	  ○ Provide information that spans a wide variety of content
	  ○ Students responsible for learning
	  ○ Role as a facilitator instead of disseminator of content
	  ○ Facilitate connect between instructor and students
	• **Student influences on course content and process (P3)**
	  ○ Collaborative, experiential, student involvement
	  ○ Create an environment where student feedback impacts course content
	  ○ Value collaborative group processing
	  ○ Student choice in assessments

Instructor Identity	• **Embracing and capitalizing on instructor expertise and limitations (P1)**
	  ○ Humility and transparency rooted in theoretical orientation
	  ○ The instructor not an expert in every topic area
	  ○ Encourage students to share their experience
	• **Instructor past experiences (P2)**
	  ○ Clinical and personal experience impact course content emphasis
	  ○ Clinical experience impacts the depth in which content is presented
	  ○ Clinical experience impacts the application teaching methods
	• **Instructor clinical experience (P3)**
	  ○ Trauma and crisis should be two separate courses
	  ○ Instruction should be informed by the educator's clinical experience
	  ○ Utilize clinical examples
	  ○ Content emphasis based on the expertise of the instructor

Table 4.15. Continued

Assertion	Case Finding, Evidence to Support it, and the Case it Originated from

Teaching Methods to Elicit Fundamental Change in the Learner	• **Awareness of contextual factors and current events (P1)**
	  ○ Guest speakers from the community to increase student awareness
	  ○ Integration of current events to highlight the prevalence and impact of trauma-related topics
	  ○ Understanding trauma, trauma response, and diagnosis in the context
	  ○ Geographic context and its impact on access to resources
	• **Trauma-informed counselors as advocates (P2)**
	  ○ Assignments designed to reach the community
	  ○ Increased understanding of how trauma impacts marginalized populations
	  ○ A motivation to inform and educate the community
	  ○ "Take and make other"
	• **Counselor self-awareness (P3)**
	  ○ Processing questions and assignment prompts to increase self-awareness
	  ○ "Constant conversation and personalization"
	  ○ The intensity of the course offers an opportunity to learn how to take care of yourself and others
	  ○ Reflect on experiences in the course and expand on how clients may experience the same phenomenon

***Teaching Methods to Develop Student Skill Acquisition**	• **Application-focused pedagogy (P2)**
	  ○ Fear of educated clinicians that do not know how to apply content
	  ○ All course information intended to be immediately applied
	  ○ Theory not emphasized
	  ○ The urgency to move to application
	• **Application-based pedagogy (P3)**
	  ○ Walk away with the ability to put it into practice
	  ○ Need to be able to apply all course information

Table 4.15. Continued

Assertion	Case Finding, Evidence to Support it, and the Case it Originated from
	○ Move from "what we know, to what do we do" ○ ○ Less emphasis on research and theoretical concepts and more on what those pieces look like in practice

Note. * = Tentative Assertion

CHAPTER FIVE: DISCUSSION AND IMPLICATIONS

The purpose of this inquiry was to understand how CEs design and facilitate significant learning experiences regarding trauma theory and practice. Two research questions guided the study: (a) *How do counselor educators choose which trauma content to address in master's level trauma theory and practices courses?* and (b) *Which teaching methods do counselor educators utilize to facilitate significant learning in master's level trauma theory and practice courses*? I used multiple case study (Merriam, 1998; Stake, 2006) to provide an in-depth understanding of three individual Cases, and I conducted a cross-case analysis to better understand Assertions across Cases. In this chapter, I review individual and multicase Findings in context of existing literature, address limitations, and suggest implications for CEs. I conclude the chapter with recommendations for further research.

Discussion

A discussion of this inquiry begins with brief considerations of the context for each of the individual cases. Jade taught a 6-week trauma course that was offered as an elective over the summer in a hybrid format. The hybrid format impacted the content that was taught and the teaching methods in the course. Jade believed that the format allowed her to form relationships with her students while also providing distance for them to work through challenging material at their own pace. Other contextual considerations that impacted Jade were her relationship with her mentor, the movement toward CACREP accreditation in her program, and a depth of community resources.

Jimmy taught an 8-week elective trauma course in an asynchronous online format. The online format impacted the content that was taught and the teaching methods in the course. Jimmy attempted to facilitate a sense of connection through multiple synchronous and

asynchronous video methods in the course to foster a sense of community in this online format. In addition to course format, other contextual considerations that impacted Jimmy were that this course was embedded in a larger trauma certificate that he coordinated, and the class was open to both master students and "students at large" who were non-degree seeking students.

Jade taught a 16-week elective trauma and crisis course in a face-to-face format. Additionally, Jade worked with a co-instructor for the course to split the teaching and course preparation. The face-to-face format and the use of a co-instructor had significant implications on the content that was taught and the teaching process. Other contextual considerations included that Jade worked full time in the on-campus counseling clinic in addition to being affiliate faculty in the counselor education department. These contextual factors in addition to the in-depth contextual factors introduced at the beginning of each individual Case are important to consider when interpreting Findings.

In the following sections I will discuss the Findings from this current study in relation to the content introduced in Chapter Two on trauma content and teaching methods. Additionally, I will discuss instructor identity and background in relation to how instructors choose content and methods by introducing additional literature since this was an unanticipated Findings and thus not covered in the literature review. Then, I will discuss the unique Findings of this inquiry and how they fit into the current body of literature on trauma education in counselor education. This section will end with a discussion of the limitations for this study prior to moving into implications for CEs and future research.

Trauma Content

I thematically categorized the competencies examined in the literature review (AMHCA, 2016; APA, 2015; CSWE, 2008; Multiple Connections, 2008; NCTSN Core Curriculum on

Childhood Trauma Task Force, 2012; SAMHSA, 2014; VA/DoD, 2010/2017) into 7 themes: *biological impact of trauma, awareness of self and practitioner characteristics, evidence-based practice, cultural factors, impact on systems, strengths-based collaborative protective factors,* and *assessment and diagnosis.* Jade, Jimmy, and Alex each included content at varying degrees that aligned with the themes of *biological impact of trauma*, *awareness of self and practitioner characteristics,* and *evidence-based practice*. *Cultural factors* were included in competencies for counseling (AMHCA, 2016), psychology (APA, 2015), and social work (CSWE, 2008); both Jade and Jimmy had teaching and learning activities and assessment and feedback methods that aligned with this theme. *Impacts on systems* such as mental health and community were a large emphasis for Jade and Alex, but the *impact on system* with regards to family unit was a larger impact for Jimmy with his emphasis on developmental trauma and clinical specialty with adolescents. None of the Cases specifically mentioned the integration of content that attended to *strengths-based collaborative protective factors.* This finding does not align with the educational and practice standards examined in the literature which placed an emphasis on the importance of this content area. Additionally, Jimmy was the only instructor who intentionally created teaching and learning activities focused on *assessment and diagnosis,* to help students practice delivering an assessment to their case study.

Alex and Jade both relied on student feedback through summative and formative evaluations, class conversations, and an awareness of group dynamics to shape course content. Alex inherited the course from an instructor who based the content primarily on crisis theory and practice. Although this was Alex's specialty area, she was responsive to student feedback and incorporated more trauma content which eventually lead to incorporating a co-instructor to meet the needs of the students. Jade incorporated content such as suicide assessment even though it

was addressed in other classes, because she knew that the specific group, she was teaching would benefit from more practice in this area.

This finding provides evidence for the importance of formal and informal means of assessing student learning throughout the course alongside flexibility in course design to attend to needs of the students as individuals and as a group. These align with recommendations by Ambrose et al. (2010) that master instructors are guided by "timely and frequent feedback on what aspects of our courses are and are not working" (p. 221). Consistent with need to integrate feedback as part of strong teaching, the type of ongoing evaluation Jade and Alex incorporated into their courses shifted the teaching process to one that focused more on on-going development, or a "progressive refinement" (p. 222), of the course to meet the needs of students. These Findings are also consistent with Veach and Shiling's (2018) recommendation to be responsive to the needs of students depending on the specific demands of their caseloads. Although their work focused on students in a trauma-specific clinical setting, the underlying premise of being responsive to student needs is consist with their findings.

Jade, Jimmy, and Alex all covered the topics including types of trauma, symptom recognition, practitioner distress (e.g., compassion fatigue, self-care), and interventions. These topics were consistent with previous findings (Lokeman, 2011) that these are some of the most frequently covered content areas in trauma courses. Jimmy also exposed students to different types of assessments, and Jimmy and Jade mentioned exposing students to content covering legal and ethical considerations. Lokeman (2011) mentioned both assessment and ethics as frequently covered content topics in trauma education.

All three cases placed varying emphasis on TF-CBT as a trauma specific intervention. Regarding content covering trauma interventions, Lokeman (2011) stated that TF-CBT,

cognitive-behavioral intervention for trauma in schools (CBITS), and multimodal trauma treat program (MMTT) were the interventions most often taught to school counselors. Lokeman's population for her study was exclusively school counselors (2011), but each of the three instructors had both school and mental health counselors in their respective courses.

Finally, all three instructors addressed content pertaining to practitioner distress at varying degrees throughout the course. Jade had her students complete reflective journals and asked her guest speakers to expand on their experience working with clients and the impact it had on them. Jimmy had students complete a self-care presentation at the end of the semester. Alex utilized class discussion to encourage student self-reflection and awareness of their own reactions in addition to the 1-minute reflections at the end of class. The need to teach counselors-in-training about self-care, vicarious trauma, and the impact of working with individuals who have experienced traumatic events was consistent with multiple recommendations in the existing literature (Lokeman, 2011; Sommer, 2008; Veach & Shilling, 2008). In all, Findings aligned with the literature that integrating content that increases student self-awareness, reflection, and foundational knowledge about the symptoms of vicarious trauma is an integral aspect of trauma training. In addition to the content areas that aligned with the literature, Alex included content on lethality assessments and homicidality which were not covered in the existing literature as common topics in trauma courses.

Teaching Methods

Three methods of teaching were utilized across the three Cases: lecture, discussion, and case study. Lecture was used sparingly by each of the instructors for a specific purpose such as integrating abstract ideas, explaining complicated topic areas, or delivering a large amount of knowledge to provide a common understanding of foundational topic areas. This "intentionally

chosen teaching method, decided upon from among options because it best achieves the learning goals" (p. 60) aligns with McAuliffe's (2011) recommendations for reasons to lecture in counselor education courses. Furthermore, McAuliffe (2011) mentioned several advantages to lecturing such as connecting multiple sources of information and providing a "common frame of reference" (p. 61) that aligned with the Findings. For each of the Cases, instructors often coupled lecture with more experiential activities which also aligned with McAuliffe's (2011) recommendations on the use of lecture in counselor education courses.

Jade, Jimmy and Alex included class discussion to expose students to multiple perspectives, develop communication skills, process course content, and shift the responsibility of learning on to the student. The aim for the integration of discussion into each of these Cases aligned with many of the benefits corroborated by McAuliffe (2011). These benefits included "creating a community of learners," "generating activity," "offering clarification," and "enhancing relativism" (McAuliffe, 2011, p. 63).

The use of case study and lecture allowed all instructors to use both didactic (lecture) and experiential (case study) methods to enhance student learning. Kitzrow (2002) stated that teaching in trauma courses must be both didactic and experiential to facilitate an in-depth understanding of both knowledge and skills. Although Kitzrow's (2002) study was restricted to teaching specifically about sexual assault, there was consistency with Kitzrow's recommendation of the use of didactic and experiential teaching methods in the findings for all three cases.

Jimmy utilized case study in his course in a similar fashion that Green et al. (2016) described in their article, which allowed students to continue to engage with the same case over the course of the semester while they practice interventions, assessments, and other techniques. Much like Kitzrow (2002) and the Findings from this inquiry, Green et al. (2016) reiterated the

need for both interactive and didactic approaches in crisis, trauma, and disaster preparation training. Jimmy and Alex both heavily relied on teaching methods which encouraged students to apply the material in their classrooms which was consistent with the recommendations of Kitzow (2002), Moate and Cox (2015), and Green et al. (2016). Jade relied heavily on theory and conceptualization in her course, stating that application of the material was a more advanced skill not appropriate for an entry level course.

Jade and Alex both emphasized being responsive to student needs in the classroom and creating learning environments that were attentive to challenging and potentially distressing course content. Jade also provided resources in her syllabus on personal counseling which is consistent with Kitzrow's (2002) recommendation of offering resources to students who may be impacted by the content in the course. In the general counselor education and higher education teaching literature, numerous scholars have recommended creating a classroom environment that was attuned to the needs of the students and a safe space, which included providing resources for students who may need them while taking the class (Ambrose et al., 2010; Hill, 2014; Kitzrow, 2002; McAuliffe, 2011; Morrissette & Gadbois, 2006).

All three instructors had students create presentations, with both Jimmy and Alex having students create presentations specifically on vicarious trauma and self-care. Each instructor also had students pick a topic of their choice and create a presentation for their classmates. Sommer (2008) examined the use of student presentations on specific topics as a method of instruction for trauma content and stated that it was the ethical responsibility of CE to teach students how to identify and manage the symptoms of vicarious trauma. She recommended that students utilize presentations to introduce topics about self-care, vicarious trauma, and crisis response. As stated above, these recommendations were consistent with the Findings in each Case. Sommer's (2008)

final recommendation was the use of reflective reading to stimulate conversation. This final recommendation was not consistent with the Findings for Jade or Alex, but Jimmy did have students engage in synchronous video communication to reflect and discuss one of the assigned textbooks.

How Instructors Choose Content and Methods

Across Cases, the content was heavily influenced by the identity of the instructor and the feedback or/and developmental level of students. Jimmy's perspective on course content concerning interventions, the role of the counselor in supporting individuals who have been impacted by traumatic experiences, and his emphasis on trauma across the lifespan all stemmed from his personal and professional experiences and expertise. Jade's conceptualization of trauma as a systemic and contextually embedded phenomenon aligned with her philosophical foundation in Feminist Theory. This awareness of contextual factors encouraged her to integrate a wide variety of content that exposed students to the evolution of the understanding of trauma in mental health. Alex's identity as a clinician with a specialty in disaster and crisis impacted the emphasis on disaster, crisis, and lethality assessment content in the course.

These Findings provided evidence of the importance of CEs reflecting on their understanding of trauma and how that influences the content they teach in their courses. This Finding was novel in the trauma education literature but was mentioned by Ambrose et al. (2010) as a strategy to help engage students in the general teaching literature. Ambrose et al. (2010) stated that instructors should "identify and reward what you value" (p. 84) and "show your own passion and enthusiasm for the discipline" (p. 85). Through these two strategies instructors can be transparent about what they view as important and link that back to their excitement for the content area. Ambrose et al. (2010) reported these two strategies as a way for instructors to

generate excitement in students and motivate them to want to understand more about the topic for themselves. None of the reviewed literature on teaching about trauma in counselor education, psychology, or social work acknowledged or examined the identity of the instructor as a factor in selecting course material.

The personhood that Alex brought into the classroom with her clinical examples was reported as a positive influence in the class. Consistent with how each of the instructors utilized their expertise and preferences to impact course design, Ambrose et al. (2010) mentioned the need to ensure that instructors align their values with course goals and assessment measures. Additionally, Hill (2014) found that students identified instructors demonstrating their expertise and ability to apply content to real-world examples as essential for effective instructors. In addition to Findings consistent with the literature, this inquiry produced several unique Findings.

Unique Findings

As previously mentioned, the primary Findings in this inquiry focused on the impact of instructor conceptualization of identity and their role. Neither of these two influences were mentioned in the counselor education, psychology, or social work trauma literature as an influence on course design. Furthermore, the theoretical frame for this inquiry, Fink's *Model of Significant Learning* (2013), was oriented more toward the course than the personhood of the instructor, although instructor factors were mentioned a few times throughout his text.

Scholars did not mention instructor identity in the trauma literature, but in the general teaching literature Hill (2014) mentioned teacher competencies, teachers' relationships with students, and teachers' attitudes as three of the main areas that students believed contributed to effective teaching. Facets of these broad categories included some aspects of instructor identity such as "understands and knows himself," "lets their personality show," "acting as a servant to

the learner, not a dictator," and "has relevant practice experience, shares experiences" (pp. 61-62). Additionally, Ambrose et al., (2010) stated that instructors' core beliefs about teaching, core values, and examining expert blind spots or self-awareness were important aspects of master instructors. As CEs, we are consistency imploring students to reflect on how their identities, experiences, values, and beliefs influence how they engage in counseling, a theme that emerges as a foundational ethical responsibility (ACA, 2014). It seems that there is a gap in the trauma literature, and this study's Findings add empirical data to support the impact of instructor identities, experiences, values, and beliefs on trauma education course design.

Additionally, the instructors' hope to elicit fundamental change in the learner was tied to their values and beliefs. Fink (2016) stated that "for learning to occur, there has to be come kind of change in the learner" (p. 26) which aligned with this Finding. Because each instructor's conceptualization of fundamental change in the learner was grounded in their own belief system, there was limited consensus across instructors.

Jade valued the contextual conceptualization of trauma, hoping her students would understand culture-bound aspects of trauma response and intervention. Jimmy valued advocacy, so he hoped his student would grow into trauma-informed advocates. Alex valued the ability of students to be able to immediately assist clients in imminent danger of harming themselves or others, so she emphasized this content in the hope that her students walked away with these skills. Each of these instructors utilized a combination of their past personal and professional experiences as they conceptualized their role in guiding students toward a goal that was rooted in their own values and beliefs about trauma response and recovery.

This Finding is consistent with the previously mentioned general literature from Ambrose et al., (2011) on instructors identifying and emphasizing their core values as an effective teaching

practice. Furthermore, instructors must keep in mind that this is only an effective practice if their beliefs align with the course goals and assessment methods in addition to the external standards of best practice in the field. This unique Finding in trauma education leads to the discussion of the importance of CEs reflecting on differences between teaching from instructor preference, expertise, and experience. It appears from these Findings, that a combination of these three influences without the constant validation that the content being taught aligns with field established best practices, could lead to teaching content that may not reflect the most recent, accurate, and impartial literature. This is especially relevant for courses that do not have broadly accepted educational teaching standards and entry-level competencies.

I believe that these Findings came to light because of the multifaceted and in-depth nature of case study research design. This design allowed me to take different angles in this inquiry and to boil down the phenomena to its foundation. Additionally, each of the instructors in these Cases had an in-depth understanding of trauma as a specialty area. It seems natural that in a content area with no broadly accepted educational standards or training competencies, an instructor would draw from their own expertise/experience/preference to inform course design.

Certainly, one's personhood as instructor impacts class process (Ambrose et al., 2011). Some instructors prefer lecture and others PowerPoint, some enjoy classroom activities while others prefer service learning. The novel finding is that instructor identity and experience impact both class process and course content in trauma education. Although these findings were present in general information reported by Ambrose et al., (2011), they had not been validated until this current study through empirical means specifically in trauma education in counselor education.

The emphasis that instructors placed on certain topic areas or the exclusion of others for these three Cases was largely impacted by instructor identities, experiences, values, and beliefs;

across interviews and in written case documents, instructors made no mention of trauma counseling competencies or standards beyond mention of general, core curricular CACREP standards. The dearth in the literature on this impact may stem from the vulnerability that comes from admitting that the choices we make as educators may not be as evidence-based as we believe. Additionally, it is important to note that CACREP did not add teaching as a core area in doctoral level counselor education and supervision preparation until 2016 (CACREP, 2016). Jimmy and Alex both graduated prior to these being added to the standards, but Jade graduated most recently and may have received training directly in teaching in her doctoral program. This context was not specifically mentioned by any of the instructors. The following sections will address the limitations of this study, implications for teaching, and recommendations for future research.

Limitations

The limitations of the individual Cases were included in the Case reports presented earlier due to each case having its own limitations created by the unique context. Below I include the limitations for case study methodology, and multiple case study as they pertain to the inquiry as a whole. Case study design is intended to provide an in-depth exploration of an issue, person, place, or process (Stake, 2006). In general, limitations of single case study design include generalizability, reliability, validity, and researcher subjectivity (Merriam, 1998). By using a multiple case study design, I attended to some of the limitations of a single case study design.

Inherent in all qualitative research is the protentional for the researcher's bias to impact the work. I detailed in Chapter 3 my subjectivity statement, and measures that were put in place to ensure trustworthiness throughout the study. With a sample size of three for this study, generalizability remains limited (Stake, 2006). In case study research the more in-depth the

analysis, the more contextually bound the results are to the phenomenon. In the case of the current inquiry, Findings were contextually bound to the individual Cases, and Assertions were contextually bound to the three collective Cases. In Case selection, I aimed for a balance between a variety of Cases that were representative of the sample but still remained similar enough to create Assertions. The representation of an online, face-to-face, and hybrid course allowed for the Assertions to capture the variability of course delivery in counselor education. I utilized the screening survey which included the submission of the course syllabi to ensure that each course was majority trauma content regardless of teaching format. The diversity of cases did not make it difficult to create Assertions, even with the number of differences in course design and content. Even though there was a diversity of delivery methods, there was not a diversity of ethnicities or races represented in this study, with all three participants identifying as White or Caucasian. With instructor identity being such a prominent theme, the lack of diversity in race and ethnicity may significant impact generalizability. Inclusion of additional cases may have led to greater generalizability and greater nuance to the Assertions.

Additionally, I recruited from a professional network which may have caused instructors to only talk about and submit artifacts that represent their courses in a positive light. I also only recruited participants who considered trauma and/or crisis a clinical specialty area, which was not one of the recruitment parameters. This limitation may have led to results that were not representative of general education of trauma content in counselor education. Finally, the results of the survey and artifacts were self-report, and I did not specifically ask about graduate level training in course design or teaching. I relied on instructors to disclose and submit content for analysis; this left no way of knowing if they were omitting content or representing material in ways that were not reflective of the actual course. Without incorporating observation or a

measure of outcome for student performance, I was unable to assess the emphasis or impact of the methods on student understanding of the content or skill acquisition.

Implications

Although the Findings from the individual Cases and the cross-case Assertions are not generalizable, multiple case study provides for opportunities for practical and tentative extrapolations (Stake, 1995). The methods these three instructors used to choose course content and teaching methods highlight some decision-making processes and influences that may be useful for other educators to take into consideration. As such, the next two sections will offer implications for CEs and researchers based on findings from the individual cases and assertions from the cross-case analysis.

Counselor Educators

Across cases, participants illustrated how their identity, experiences, values, and beliefs impacted the content they choose and the teaching methods they utilized in trauma courses. Each of the instructors acknowledged that they chose the content or the methods because of a personal or professional preference. CEs may reflect on "why" when they are choosing course content and teaching methods. Such an exploration may help instructors ensure that their course design ties together course goals, teaching and learning activities, and assessment and feedback to create integrated course design to facilitate significant learning experiences (Fink, 2013). Additionally, there is a need for instructors to continually reflect on their own identities and how they are impacting the learning environment. This includes the content instructors choose for students to learn and the methods instructors use to facilitate this learning. Finally, instructors need to ensure that course content is reflective of best practices in the topic area and provide a wide

variety of content that expands beyond their personal preferences to include literature-based best practices.

There is a very high likelihood that professional counselors will provide services to individuals who have experienced traumatic events (Cunningham, 2004; Kilpatrick et al., 2004). CEs are responsible for teaching course content that is evidence-informed. Because the majority of research on trauma response and treatment is generated outside of the counseling profession, CEs should work to align multidisciplinary sources and tentatively present to students in ways that align with our developmental and wellness-oriented profession. This may help them to integrate their experiences, values, and identities with the current state of literature within and beyond our profession.

When examining the teaching and learning activities, none of the instructors in this inquiry reported in-class activities that aligned with the *learning how to learn* theme. These are in-class activities that stimulate students to "become a better student, inquire about a subject, and become self-directed learners" (Fink, 2013, p. 34). Using class time to allow students to work in small groups to research topics, submit questions about the content for that week and allow their peers to answer them, or workshop interventions would align with the domain of Fink's learning taxonomy (2013). Fink stated that the values of this domain is that, "this kind of learning enables students to continue learning in the future and to do so with greater effectiveness" (p. 36). This type of learning is especially important for a topic such a trauma education that is evolving quickly and requires careful evaluation of each passing fad for its validity. Each of these Cases included assessment and feedback opportunities for students to research their own topics of interest and practice compiling that information in a clear and concise way to present to their

peers. It pushed students to integrate, synthesize, and think critically about the research they were finding.

All three instructors have been teaching trauma courses for at least three years and consider trauma and/or crisis to be a specialty area. None of them mentioned the AMHCA teaching standards (2016) as an influence on their course design. Although it is tentative to generalize this to other instructors teaching trauma courses, it appears that instructors may not be aware that there are counseling specific educational standards available. Having instructors ground their content in the same set of teaching standards may decrease variability in content across sections while still maintaining instructor academic freedom. Additionally, from an instructor perspective it is important for CEs to incorporate both their own experience, expertise, and preferences while also being aware of the professional resources available to them in their content area. This has implications both for instructors and for professional organizations that provide standards and resources related to these areas.

Furthermore, this study adds to the growing body of literature (Avery, 2017; Layne et al., 2014; Mattar, 2010; Paige, 2015; Turkus, 2013; Watkins Van Asselt, Soli, & Berry, 2016) calling for trauma competencies in counselor education. Specifically, competencies for preparation of master's-level counselors and for counseling practice. This study's findings support the tentative notion that without broadly accepted training standards and competencies to guide course design, instructors may rely on their past experiences, personal preferences, and professional expertise, all factors which vary widely across instructors. Additionally, this study provides an emerging sense of common topic areas to include in trauma courses which adds to the literature produced by Lokeman (2011) which was specific to school counselors and the methods for doing so. These topics include types of trauma, interventions, and responses to

traumatic experiences. Instructors may use findings from this study, alongside additional resources cited here, as a starting point to further explore effective course design in trauma courses for CEs.

Future Research

This multiple case study provided an initial inquiry into the experiences of three CEs teaching trauma courses for master's level CIT. The context-bound nature of this inquiry offers many avenues for future research to further understand the current findings. Because this study focused on three CEs, additional case studies of the same course delivery method to compare findings across face-to-face, hybrid, and asynchronous courses could better tie case findings to delivery method. Additionally, I did not conduct a case study for a synchronous online trauma course which might yield unique findings due to that teaching method.

This current study only explored instructor perceptions and did not focus on actual outcomes for students. To date, few researchers have explored effectiveness of different teaching methods in trauma courses for counselor education, beyond the study conducted by Green et at. (2016). Furthermore, the study conducted by Green et at. (2016) measured the self-efficacy of the counselor, not the actual ability of the counselors to utilize to skills with clients. Outcome research of teaching methods as they relate to actual student preparedness in client interactions is necessary to gain a better understanding of student's abilities to utilize the content they learn in class effectively with clients. There has been an increase in published empirical research in the general CE teaching literature (Barrio Minton, C. A., Wachter Morris, C. A., & S. L. Bruner, 2018; Barrio Minton, C. A., Wachter Morris, C. A., & Yaites, L. D., 2014). This indicates that there is room for deeper understanding from conceptual and theoretical manuscripts to "direct

measures of learning outcomes" (p. 234) in trauma literature to align with the trends in general teaching and learning research in CE.

Finally, further quantitative and qualitative studies examining the instructor experience, expertise, and preferences as they relate to course design could yield a clearer understanding of how those three factors interact and impact course content and teaching methods. Further research could explore how existing literature and competencies guide course design decisions to gain a better understanding of how instructors use these competencies to guide course design. Examining use of competencies in both courses that have clear teaching standards and practice competencies (e.g., counseling skills or ethics) and those that do not (e.g.., trauma or human sexuality) may help CEs better understand how these external parameters impact course design.

Conclusion

In this chapter, I described contextual factors influencing the individual and cross case Findings, compared the Findings to the current literature on the topic, and discussed the Findings in relation to the two research questions. Then, I provided a brief overview of the study limitations. I described implications for the practice of counselor education. Finally, I provided several suggestions for future research on the topics of trauma education in professional counseling programs.

Overall, this study was the first to provide an in-depth examination of course content and teaching methods utilized in trauma courses for masters-level counseling students. This study supports existing literature recommending exposing students to types of trauma, trauma interventions, and practitioner distress while attending to the needs of students who may experience distress from the content (Kitzrow, 2002; Lokeman, 2011; Sommer, 2008; Veach & Shilling, 2018). Additionally, it was consistent with the literature that recommended teaching

methods that were both didactic and experiential (Green et al., 2016; Kitzrow, 2002). The study provided unique findings about the impact of instructor identity on course design which raises questions about how influential these instructor characteristics are in a larger representation of the population. The results of this study may increase awareness of the need for CEs to be reflective in their decision-making process as they choose course content and highlights evidence for the need for teaching standards and entry-level professional competencies in trauma education.

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APPENDICES

Appendix A

American Mental Health Counselors Association Trauma Training Standards

Category	Standard
Knowledge	a. Recognize that the type and context of trauma has important implications for its etiology, diagnosis, and treatment (e.g. ongoing sexual abuse in childhood is qualitatively different from war trauma for young adult soldiers). b. Know how trauma--causing events may impact individuals differently in relation to social context, age, gender, and culture/ethnicity. c. Understand the distinctions among relational, acute, chronic, episodic, and developmental traumas, and the implications of these for treatment. d. Understand the impact of various types of trauma (e.g. sexual and physical abuse, war, chronic verbal/emotional abuse, neglect) may have on the central nervous system and how this might impact attachment styles, affect regulation, personality functioning, self--identity, and trauma re--enactment. e. Recognize the long--term consequences of trauma--causing events on communities and cultures. f. Understand resiliency factors for individuals, groups, and communities that diminish the risk of trauma-related disorders. g. Understand the application of established counseling theories to trauma treatment. h. Recognize differential strategies and approaches necessary to work with children and adolescents in trauma treatment.
Skills	a. Demonstrate the ability to assess and differentiate the clinical impact of various trauma--causing events. b. Demonstrate the ability to use established counseling theories, and evidence--based trauma resolution practices, to promote the integration of brain functioning and help resolve cognitive, emotional, sensory, and behavioral symptoms related to trauma--causing events for socially and culturally diverse clients across the lifespan. c. Demonstrate the ability to facilitate client resilience and to resolve long--term alterations in attributions and expectancies. d. Demonstrate sensitivity to individual and psychosocial factors that

	interact with trauma--causing events in counseling and treatment planning. e. Demonstrate the ability to recognize that the impact of his/her trauma may impact counseling trauma survivors. f. Use differentially appropriate strategies and approaches in assessing and working with children and adolescents in trauma treatment. g. Use differentially appropriate counseling and other treatment interventions in the treatment of developmental and chronic traumas.

Note. AMHCA training standards can be found at http://connections.amhca.org/HigherLogic/System/DownloadDocumentFile.ashx?DocumentFileKey=e6b635b0-654c-be8d-e18c-dbf75de23b8f

Appendix B

American Psychological Association Guidelines on Trauma Competencies for Education and Training

Cross-Cutting Trauma-Focused Competencies	1. Demonstrate understanding about trauma reactions and tailor trauma interventions and assessments in ways that honor and account for individual, cultural, community, and organizational diversity. This includes demonstrating the ability to identify the professionals' and clients' models of intersecting cultural identities (e.g., gender, age, sexual orientation, disability status, race/ethnicity, SES, military status, occupational identity, rural/ urban, immigration status, religion, national origin, indigenous heritage, and gender identification) as related to trauma and articulate the professionals' own biases, assumptions, and problematic reactions emerging from trauma work and cultural differences. 2. Demonstrate understanding and ability to tailor assessment and interventions to account for developmental lifespan factors at time(s) and duration of trauma as well as time of contact. 3. Demonstrate the ability to understand, assess, and tailor interventions and assessments that address the complexities of trauma-related exposure, including any resultant long- and short-term effects (e.g., comorbidities, housing-related issues, etc.), and person-environment interactions (e.g., running away from home and being assaulted). 4. Demonstrate the ability to appropriately appreciate, assess. and incorporate trauma survivors' strengths, resilience. and potential for growth in all domains. Facilitate shared decision making whenever appropriate. 5. Demonstrate understanding about how trauma impacts a survivor's and organization's sense of safety and trust. Apply the professional demeanor, attitude, and behavior necessary to enhance the survivor's and organization's sense of physical and psychological safety. This includes respecting the autonomy of those exposed to trauma but also protecting survivors as appropriate. 6. Demonstrate the ability to recognize the practitioner's': (1) capacity for self-reflection and tolerance for intense affect and content, (2) ethical responsibility for self-care, and (3) self-awareness of how one's own history, values, and vulnerabilities impact trauma treatment deliveries. 7. Demonstrate ability to critically evaluate and apply up-to-date existing science on research-supported therapies and

	assessment strategies for trauma-related disorders/difficulties. 8. Demonstrate the ability to understand and appreciate the value and purpose of the various professional and paraprofessional responders in trauma work and work collaboratively and cross systems to enhance positive outcomes. 9. Demonstrate the ability to understand the value and purpose of the various professional, paraprofessional and lay responders in trauma work and work collaboratively and across systems to enhance positive outcomes.
Scientific Knowledge	1. Demonstrate the ability to recognize the epidemiology of traumatic exposure and outcomes, specifically: a. Prevalence, incidence, risk and resilience factors, and trajectories. b. Subpopulations (e.g., children, adolescents, young and middle-aged adults, older adults; men, women; veterans, civilians) and settings (e.g., primary care, general or specialized mental health, forensic, juvenile justice). 2. Demonstrate basic knowledge of findings, mechanisms, models, and interactions among social, psychological, neurobiological factors (e.g., relational, developmental, cognitive and affective, economic, genetic/epigenetic, health and health behaviors). 3. Demonstrate understanding of the social, historical, and cultural context in which trauma is experienced and researched. 4. Demonstrate the ability to critically review published literature on trauma and PTSD by employing general knowledge as well as trauma-specific knowledge. 5. Demonstrate the ability to effectively and accurately communicate scientific knowledge about trauma to a broad range of audiences.
Psychological Assessment	1. Demonstrate a willingness to ask about trauma exposure and reactions with all clients, in both trauma- and non-trauma-focused presentations. 2. Demonstrate the ability to conduct comprehensive assessment of trauma exposure and trauma impact based on the most current available evidence base. 3. Demonstrate awareness of, and capacity to appropriately adjust procedures, processes, and interpretations related to, the unique impacts of trauma (e.g., dissociation, avoidance, triggers) as they affect assessment processes and responses. 4. Demonstrate the ability to understand the course and trajectory of trauma responses and tailor assessment

	accordingly. 5. Demonstrate the ability to assess strengths, resilience, and growth both preexisting and post trauma. 6. Demonstrate the awareness of test interpretation issues frequently encountered in trauma-exposed populations (e.g., appropriate use of validity scales, response styles, motivation). 7. Demonstrate the ability to assess the extent to which culture, beliefs, and practices influence the expression and coping with trauma exposure, including barriers to assessing treatment. 8. Demonstrate knowledge about the practical consequences of trauma-related assessment and diagnosis in different contexts (e.g., social services, military, forensic). 9. Demonstrate the ability to tailor the trauma assessment, battery, and interview questions to match characteristics (e.g., culture, age, socioeconomic, family or systems) of client, setting, and trauma experience. 10. Demonstrate knowledge appropriate to scope of practice regarding major trauma-relevant and generic questionnaires/interviews; this can include the psychometrics, strengths, limitations, and appropriateness for specific groups of trauma survivors.
Psychological Intervention	1. Demonstrate knowledge of the current science on research-supported interventions (psychosocial, pharmacological, and somatic) for trauma-related disorders/difficulties. 2. Demonstrate the ability to employ critical thinking collaboratively to tailor and personalize treatment and its pacing with survivors in order to be responsive to trauma survivors' trauma type and comorbidities, as well as personality, culture, values, strengths, resources, preferences, parents/caregivers/families, and communities within the context of the recovery environment. 3. Demonstrate the ability to use the right treatment and monitor the effects. Namely, demonstrate the ability to apply trauma-focused phased treatment and match treatments to evolving needs. Effective trauma treatment is inherently complex; Psychologists should demonstrate the ability to continually assess the interaction of the client and the changing environment for indicators of improvement or worsening. 4. Demonstrate understanding of the components and mechanisms of change, both common and unique, underlying various therapies for trauma-related disorders. 5. Demonstrate the ability to attend to trauma-related material

	non-judgmentally and non-punitively with empathy, respect, and dignity and a belief in recovery and resilience (in contrast to pity, condescension, and resignation). 6. Demonstrate the ability to implement non-avoidant strategies in engagement, retention, and delivery of trauma-focused treatment (i.e., avoid avoidance). 7. Demonstrate the ability to identify opportunities to reduce the deleterious effects of trauma and promote recovery and growth before, during, and following trauma exposure (i.e., prevention and mitigation). 8. Demonstrate understanding about how a comprehensive pharmacological treatment plan can be part of a biopsychosocial approach to trauma response, when warranted. 9. Demonstrate an understanding about the pharmacology of each medication as it relates to therapeutic and adverse effects and how drug actions might be modified by genetics, gender, age, and health behaviors (e.g., diet, smoking, alcohol use) as well as their interactions (e.g., race-based medication interactions). 10. Demonstrate the ability to collaborate with trauma clients' families, social networks, and care systems to promote non-avoidance and positive trauma-related responses. 11. Demonstrate the ability to cultivate and maintain a therapeutic relationship with trauma-impacted individuals and their families that fosters a sense of safety, trust, and openness to addressing trauma-focused material.
Professionalism	1. Demonstrate the ability to sensitively interface with legal and other external systems in ways that safeguard trauma survivors and enhance outcomes (e.g., create and share records that do not create iatrogenic harm when introduced into the system). NOTE: APA (2007) has record keeping guidelines that address these issues and practice should not change according to specific diagnoses or settings. NOTE: It is important that psychologists working with trauma survivors remain cognizant of the context (e.g., legal setting, insurance disputes). 2. Demonstrate enhanced attention to ethical issues that are relevant to trauma survivors and appropriate boundaries in trauma work (e.g., boundary maintenance, role overlap, informed consent, confidentiality). NOTE: APA (2010) has ethical guidelines that cover this area and those should not be overshadowed. 3. Demonstrate skills to hear and work with clients' trauma material and associated distress that minimizes the risk of

	iatrogenic harm. 4. Demonstrate an understanding of how public policy issues affect trauma work within organizations and with individuals. 5. Demonstrate the ability to engage with relevant leaders around trauma issues and promoting systemic, social, and policy changes.
Relational and Systems	1. Demonstrate knowledge of the disorganizing effects of trauma. Given that trauma results in changes at the individual and systems levels, psychologists demonstrate the ability to respond to these deleterious effects appropriately. 2. Demonstrate knowledge about and skills in offering consultation on trauma-informed systems of care and models of care. 3. Demonstrate the ability to engage in interdisciplinary collaboration regarding traumatized individuals, their families, and communities. 4. Demonstrate the ability to educate and communicate trauma-specific knowledge effectively to multiple audiences, including those communities and organizations that are acutely impacted by trauma. 5. Demonstrate understanding that institutions and systems can contribute to primary and secondary (or vicarious) trauma and offer strategies to reduce these barriers as appropriate. 6. Demonstrate an understanding of the importance of using relational healing for relational injury (e.g., trustworthiness) and the capacity to use the relationship effectively. 7. Demonstrate knowledge about the role of organizations in building resilience, prevention, and preparedness (universal precautions). 8. Demonstrate the ability to consistently recognize how cultural, historical, and intergenerational transmission of trauma influences the perception of helpers.

Note. American Psychology Association training standards can be found at https://www.apa.org/ed/resources/trauma-competencies-training.pdf

Appendix C

Advanced Social Work Practice in Trauma

2.1.1—Advanced social work practitioners are knowledgeable about the impact of direct and vicarious exposure to trauma on the practitioners. Working in the area of direct practice with trauma survivors requires the professional to develop and maintain adequate self-care and recognize his or her strengths and challenges. The advanced social work practitioner is also knowledgeable about the impact of traumatic events and provision of services to traumatized populations on organizations and communities. The advanced practitioner works to improve the understanding of trauma on organizational culture and communities.
2.1.2— According to the National Association of Social Workers' Code of Ethics, advanced practitioners adhere to the ethical responsibility to represent themselves as competent only within the boundaries of their education, training, supervised experience, or other relevant professional experience. As such, they stay abreast of current evidence-informed approaches for working with individuals who have suffered trauma. Advanced practitioners also demonstrate knowledge and skill in identifying and setting appropriate interpersonal boundaries in order to promote or enhance physical and emotional safety for clients and client systems. They engage in decision-making that recognizes the fundamental breach to the social contract implicit in client or client systems traumatized by interpersonal violence or human-made disaster. Advanced practitioners know how workers' own trauma-related history, clients' experience of trauma, and organizations' history can influence clinical decision-making.
2.1.3— Advanced practitioners know how to synthesize relevant theories of trauma and relate them to social work practice. They know how to differentiate and communicate about trauma depending on the target audience, understanding that different audiences will need different information in order to appropriately respond to trauma.
2.1.4— Advanced practitioners know that the intersection of race, class, gender, sexual orientation, religion, and national origin results in disproportionate trauma exposure, access to services, and social support resources. Consequently, they approach traumatized clients in a manner that avoids blaming the victim, so they do not contribute to stereotypes and stigmatization. They also understand that the disparities produced by such disproportionate exposure evoke client shame and self-blame and that interventions that emphasize strengths, promotive factors, and wellness help to reduce these trauma-induced consequences.
2.1.5— Advanced practitioners understand that societal exposure to oppression, social and economic injustice, and denial of fundamental human rights represents a traumatic abuse of power that ruptures expectations of trust and security. They know that such profound violations of the social contract exacerbate a traumatized client's sense of helplessness and lack of control. They also understand that the consequences of marginalization affect help-seeking and access to effective services.

2.1.6— Advanced practitioners engage in research-informed practice. They know the range of empirically supported trauma treatments and know the differential selection and application of evidence-informed research across populations. Advanced practitioners know how to collect and include trauma-informed data on how the client is progressing in order to make clinical decisions. Advanced practitioners engage in practice-informed research. The advanced practitioner knows models for developing research questions based on community input and partnership with their own clients.
2.1.7— The advanced social work practitioner brings knowledge of the impact of trauma on the biopsychosocial development of the individual, including specific knowledge of the neurological impact of trauma. The impact of trauma exposure is inherently complex and is mediated by class, gender, race, ethnicity, and culture. Advanced practitioners understand that trauma has an impact on individuals, families, organizations, and communities in specific ways, and are able to use knowledge about resiliency to develop promotive factors facilitating recovery from trauma.
2.1.8— Advanced practitioners understand that social and economic injustice increases exposure to trauma. They know that traumatized individuals are over-represented in populations that suffer homelessness, substance abuse, low educational attainment, joblessness, and chronic poor health. They understand that the use of a trauma-informed perspective toward policy advocacy emphasizes safety, support, and nonpunitive access to resources. They also understand the need for policy practice in organizations to reflect an appreciation of the role of secondary trauma in the workplace.
2.1.9— Advanced practitioners understand that a reciprocal interaction exists between traumatized systems and traumatized individuals that affects a traumatized system's capacity to effectively respond to the needs of traumatized individuals. They know that contextual factors shape perceptions of and responses to trauma exposure and intervention efforts. Consequently, they understand that the use of a trauma-informed practice lens extends the scope of intervention to the social, political, legal, educational, workplace, and family systems contexts in which traumatized individuals operate.
2.1.10(a)–(d)— Advanced practitioners integrate knowledge as well as skills specific to client systems in the midst or aftermath of a traumatic event. Intervention requires the creation of optimal psychological and physical safety for client and worker systems during all treatment phases and in varying contexts. Assessment and diagnosis take into account the specific types of trauma that were experienced, their impact, trauma-specific coping behaviors, risk, and protective factors, and emerging neuroscience developments. Trauma-informed assessment also includes the practitioner's familiarity with the strengths and limitations of standardized trauma assessment tools for individuals, families, and communities. Advanced social work practitioners understand common trauma-based therapeutic obstacles as well as the specific methods used to overcome them, particularly those that are evidence-based, evidence-informed, or evidence- supported. Knowledge about the impact of working with trauma survivors on the worker and on the systems that serve them is critical to trauma-informed practice. During all phases of working with trauma survivors,

the advanced practitioner appreciates how survivors' identities have been shaped by biopsychosocial, cultural, spiritual, and organizational factors. Advanced practitioners know evidence-informed indicators of trauma recovery and evidence-informed indicators of a trauma-informed system and can assess organizational readiness to integrate evidence-based trauma treatment. Client and program evaluation are undertaken collaboratively with clients to maximize client empowerment and minimize the impact of the breach of the social contract experienced by trauma survivors.

Note. The Advanced Social Work Practice in Trauma can be found at https://www.cswe.org/getattachment/Publications-and-multimedia/CSWE-Full-Circle-(1)/Newsletters-Archive/CSWE-Full-Circle-November-2012/Resources-for-Members/TraumabrochurefinalforWeb.pdf.aspx

Appendix D

The National Child Traumatic Stress Network Core Curriculum on Childhood Trauma

1	Trauma experiences are inherently complex
2	Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances
3	Trauma events often generate secondary adversities, life changes, and distressing reminders in children's daily lives
4	Children can exhibit a wide range of reactions to trauma and loss
5	Danger and safety are core concerns in the lives on traumatized children
6	Traumatic experiences affect the family and broader caregiving systems
7	Protective and promotive factors can reduce the adverse impact of trauma
8	Trauma and post trauma adversities can strongly influence development
9	Developmental neurobiology underlies children's reactions to traumatic experiences
10	Culture is closely interwoven with traumatic experiences, response, and recovery
11	Challenges to the social contract, including legal and ethical issue, affect trauma response and recovery
12	Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care

Note. full competencies can be found at: https://www.nctsn.org/sites/default/files/resources//the_12_core_concepts_for_understanding_traumatic_stress_responses_in_children_and_families.pdf

Appendix E

Trauma-informed care in behavioral health services treatment improvement protocol (TIP) competencies for counselors

Trauma Awareness	1. Understands the difference between trauma-informed and trauma-specific services 2. Understands the differences among various kinds of abuse and trauma, including: physical, emotional, and sexual abuse; domestic violence; experiences of war for both combat veterans and survivors of war; natural disasters; and community violence 3. Understands the different effects that various kinds of trauma have on human development and the development of psychological and substance use issues 4. Understands how protective factors, such as strong emotional connections to safe and non-judgmental people and individual resilience, can prevent and ameliorate the negative impact trauma has on both human development and the development of psychological and substance use issues 5. Understands the importance of ensuring the physical and emotional safety of clients 6. Understands the importance of not engaging in behaviors, such as confrontation of substance use or other seemingly unhealthy client behaviors, that might activate trauma symptoms or acute stress reactions 7. Demonstrates knowledge of how trauma affects diverse people throughout their lifespans and with different mental health problems, cognitive and physical disabilities, and substance use issues 8. Demonstrates knowledge of the impact of trauma on diverse cultures with regard to the meanings various cultures attach to trauma and the attitudes they have regarding behavioral health treatment 9. Demonstrates knowledge of the variety of ways clients express stress reactions both behaviorally (e.g., avoidance, aggression, passivity) and psychologically/emotionally (e.g., hyperarousal, avoidance, intrusive memories)
Counseling Skills	1. Expedites client-directed choice and demonstrates a willingness to work within a mutually empowering (as opposed to a hierarchical) power structure in the therapeutic relationship 2. Maintains clarity of roles and boundaries in the therapeutic relationship 3. Demonstrates competence in screening and assessment of trauma history (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with

	specific screening tools 4. Shows competence in screening and assessment of substance use disorders (within the bounds of his or her licensing and scope of practice), including knowledge of and practice with specific screening tools 5. Demonstrates an ability to identify clients' strengths, coping resources, and resilience 6. Facilitates collaborative treatment and recovery planning with an emphasis on personal choice and a focus on clients' goals and knowledge of what has previously worked for them 7. Respects clients' ways of managing stress reactions while supporting and facilitating taking risks to acquire different coping skills that are consistent with clients' values and preferred identity and way of being in the world 8. Demonstrates knowledge and skill in general trauma-informed counseling strategies, including, but not limited to, grounding techniques that manage dissociative experiences, cognitive–behavioral tools that focus on both anxiety reduction and distress tolerance, and stress management and relaxation tools that reduce hyperarousal 9. Identifies signs of STS reactions and takes steps to engage in appropriate self-care activities that lessen the impact of these reactions on clinical work with clients 10. Recognizes when the needs of clients are beyond his or her scope of practice and/or when clients' trauma material activates persistent secondary trauma or countertransference reactions that cannot be resolved in clinical supervision; makes appropriate referrals to other behavioral health professionals

Note. Trauma-informed care in behavioral health services treatment improvement protocol (TIP) competencies for counselors can be found at https://store.samhsa.gov/shin/content/SMA14-4816/SMA14-4816.pdf

Appendix F

Multiplying Connections Cross Systems Training Institute (CSTI)- Core competencies for trauma informed and developmentally appropriate

Knowledge: Core knowledge needed about trauma, trauma informed practice and child development to provide trauma-informed, developmentally sensitive services to young children and their families
K1. Identify/describe key signs, symptoms, impact and manifestations of trauma, disrupted attachment, and childhood adversity in children and in adults
K2. Explain how behaviors, including those that appear to be "problems" or symptoms often reflect trauma- related coping skills individuals need to protect themselves and survive.
K3. Describe the domains and stages of normal childhood development from infancy through adolescence (brain, social, emotional, cognitive, physical) and how they can be affected by trauma, abuse, adversity and stress
K4. Describe local resources for trauma specific treatment and trauma informed services for children and their families
K5. Define trauma informed and trauma specific care, including knowing the key elements of a trauma informed system and being familiar with evidence-based trauma treatment models.
K6. Explain the relationship between trauma, adversity and disrupted attachment in the child/caregiver relationship
K7. Describe the multi-generational nature of trauma and childhood adversity.
K8 Define re-traumatization and identify ways that children and their families can be retraumatized/triggered by the systems and services designed to help them.
Values and Attitudes: Core values and attitudes needed to provide trauma informed, developmentally sensitive services to young children and their families
V1. Believe that providing trauma-informed/developmentally sensitive care is an appropriate and important role for anyone involved in providing services to children and their families
V2. Recognize that involving clients/parents/caregivers as partners in the process of recovery from trauma and childhood adversity maximizes the potential for healing
V3. Examine personal beliefs about and experiences of trauma and childhood adversity and the impact these have on interactions with clients, colleagues, organizations, and systems.

V4. View childhood trauma and adversity as a significant, complex, and often preventable public health problem with broad ranging effects on children and adults but from which, with proper resources and support, people can recover and heal
Communication: Communication skills needed to provide effective trauma informed, developmentally sensitive services to young children and their families
C1. Develop an interpersonal style that is direct, willing to change as a result of interactions, reflective, engaging, honest, trustworthy, culturally competent and eliminates the use of labels that pathologize.
C2. Communicate and collaborate with children, families, professionals and communities to establish supportive relationships for growth and healing.
C3. Accurately perceive, assess, and express emotions and model non-violent ways of communicating those emotions in order to maintain a safe environment for self and others.
Practice: Core skills and abilities needed to practice trauma informed care with young children and their families
P1. Facilitate trauma-informed collaborative relationships with children, parents, caregivers and colleagues which include demonstrating care, respect, cultural competence, developmental sensitivity, employing strengths-based approaches, maximizing safety for all and opportunities for client/caregiver choice and control.
P2. Provide trauma-informed screening and assessment including obtaining appropriate client and family histories to determine exposure to trauma/childhood adversity and risk and protective factors associated with trauma/childhood adversity.
P3. Demonstrate sensitivity to children's parents/caregivers who often have unaddressed trauma issues that can impact their ability to help their children.
P4. Facilitate referrals and access to trauma informed and trauma specific treatment services for children and their families as needed.
P5. Demonstrate ability to teach children and parent/caregivers techniques that help children who have experienced trauma including relaxation calming, soothing, and grounding themselves and/or their children and strategies for implementing CAPPD (being calm, attuned, predictable, present and not escalating)
P6. Create environments that are safe, comfortable, and welcoming for all children, families, and staff
P7. Educate parents/caregivers about risk and protective factors associated with trauma/childhood adversity, healthy child development, and assist them with developing tools/strategies to strengthen development
P8. Assist parents/caregivers of children who have been exposed to trauma and childhood

adversity to recognize and address their own risk for secondary/vicarious trauma and possible unresolved trauma in their own lives.
P9. Educate and support all staff about the need to recognize and address their risk of secondary/vicarious trauma and how they may be negatively affected by exposure to detailed histories of trauma and adversity.
Communities: Competencies in working with communities to reduce risk factors and increase protective factors associated with trauma and childhood adversity
Educate and inform community residents, leaders, groups, and coalitions about trauma and childhood adversity including its causes and effects on individuals, along with available resources for recovery and healing.
Organizations and Systems: Competencies in organizational management and policy/system change needed to create and sustain a trauma informed and developmentally sensitive service systems for young children and their families
O1. Identify and describe effective models of trauma informed care (e.g. Sanctuary model, Community Connections model)
O2. Introduce changes in organizational procedures, structures, protocols and policies to support trauma informed, developmentally sensitive practices and services.
O3. Involve clients, families, communities and other systems/practitioners in the process of becoming a trauma informed organization.
O4. Establish environments that support staff and ensure children's health and safety and are customized to meet each child and family's needs, strengths, capabilities and interests.
O5. Teach/Train professionals at all levels (administration, management, supervisory, direct service, and support) about core elements necessary for trauma-informed practices and organizations
O6. Advocate with local, state and federal policy makers for the development of funding streams and policies that support and foster a trauma-informed service system for children and families.

Note. Multiplying Connections Competencies can be found at http://www.multiplyingconnections.org/sites/default/files/field_attachments/Multiplying%20Connections%20Core%20Competencies%20(rev%205-10)[1].pdf

Appendix G

Veterans Association Clinical Practice Guide

General Clinical Management	
	We recommend engaging patients in shared decision making (SDM), which includes educating patients about effective treatment options. The shared decision making (SDM) process has the goal of considering patient preference in treatment decisions to improve patient-centered care, decision quality, and treatment outcomes. In SDM, the patient and provider together review treatment options and compare the benefits, harms, and risks of each with the goal of selecting the option that best meets the patient's needs.
	For patients with posttraumatic stress disorder (PTSD) who are treated in primary care, we suggest collaborative care interventions that facilitate active engagement in evidence-based treatments. The collaborative care model is an evidence-based approach to integrating physical and behavioral health services that is usually provided within the primary care setting.[8] Many collaborative care models generally involve a stepped-care approach to symptom management, using a predetermined treatment sequence that starts with simple, low-intensity interventions first. The use of collaborative care interventions that employ or facilitate active engagement in evidence-based PTSD treatments in the primary care setting appears to increase patient compliance with treatment, improve patient satisfaction, and potentially reduce premature termination of treatment when delivered in the primary care setting.[9- 15]
Diagnosis and Assessment of PTSD	
	We suggest periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) and the PTSD Checklist (PCL).Identification of individuals with PTSD is essential to ensure that they receive appropriate treatment. Moreover, screening is often considered a key step in the diagnostic process. Screening for PTSD can be performed in primary and specialty care settings, and both VA and DoD mandate screening either in context with combat deployments or in primary care settings. One-time screening is not recommended because PTSD is a disorder with a fluctuating course for many people. VA recommends annual screening for the first five years following separation and then every five years thereafter. DoD recommends routine screening throughout deployment cycles. Both VA and DoD have relied most heavily on the Primary Care PTSD Screen (PC-PTSD) and PTSD Checklist (PCL) for various screening purposes.[17] No screening measure or cut point should be the sole basis for diagnosis.
	For patients with suspected PTSD, we recommend an appropriate diagnostic evaluation that includes determination of DSM criteria, acute risk of harm to self or

	others, functional status, medical history, past treatment history, and relevant family history. A structured diagnostic interview may be considered
	For patients with a diagnosis of PTSD, we suggest using a quantitative self-report measure of PTSD severity, such as the PTSD Checklist for DSM-5 (PCL-5), in the initial treatment planning and to monitor treatment progress.
Prevention of PTSD	
Universal prevention strategies target the general population and are not directed at a specific at-risk group. There are currently no recommended strategies for universal prevention of PTSD. Selective prevention targets individuals who are at higher than average risk for developing PTSD and includes strategies delivered to trauma-exposed individuals who have not yet developed symptoms or meet criteria for ASD or PTSD. Indicated prevention includes strategies to prevent PTSD in individuals with symptoms of ASD or meet criteria for ASD.	
a. Selective Prevention of PTSD	
	For the selective prevention of PTSD, there is insufficient evidence to recommend the use of trauma-focused psychotherapy or pharmacotherapy in the immediate post-trauma period. Interventions among individuals exposed to trauma (e.g., trauma-focused psychotherapy, Critical Incident Stress Debriefing (CISD), the Battlemind debriefing intervention, and a variety of medications) have not been consistently effective in preventing PTSD. While trauma-focused psychotherapy shows promise, evidence is limited to a single-site study.[26] Neither CISD nor Battlemind debriefing were found to reduce PTSD at six months, and CISD was associated with increased incidence and severity of PTSD at 13 months follow-up.[27,28]
b. Indicated prevention of PTSD and Treatment of ASD	
	For the indicated prevention of PTSD in patients with acute stress disorder (ASD), we recommend an individual trauma-focused psychotherapy that includes a primary component of exposure and/or cognitive restructuring. Among the interventions for treatment of ASD, brief trauma-focused psychotherapy has been found to be effective in reducing incidence of PTSD at six and 12 months without significant reported adverse effects.
Treatment of PTSD	
a. Treatment selection	
	We recommend individual, manualized trauma-focused psychotherapy (see Recommendation 11) over other pharmacologic and non- pharmacologic

	interventions for the primary treatment of PTSD. The Work Group's recommendation to use individual trauma-focused psychotherapy over pharmacotherapy reflects the current state of the research into PTSD treatment. Although there are few data that reflect direct head-to-head comparisons of trauma-focused psychotherapy and a first-line medication for treating PTSD, two recent meta-analyses compared the treatment effects of psychotherapies and pharmacotherapies.[36,37] The results of these meta-analyses strongly indicate that trauma-focused psychotherapies impart greater change with regard to core PTSD symptoms than pharmacotherapies, and that these improvements persist for longer time periods. This appears true even when restricting the meta-analyses to studies that utilized "active" treatments such as Present-Centered Therapy (PCT) (as opposed to waitlist or treatment as usual) as control groups for psychotherapy studies.
	When individual trauma-focused psychotherapy is not readily available or not preferred, we recommend pharmacotherapy (see Recommendation 17) or individual non-trauma-focused psychotherapy (see Recommendation 12). With respect to pharmacotherapy and non- trauma-focused psychotherapy, there is insufficient evidence to recommend one over the other. The Work Group recognizes that individual trauma-focused psychotherapies may not be readily available in all settings and that not all patients elect to engage in such treatment. When this is the case, the Work Group recommends offering treatment using pharmacologic agents or identified individual, manualized psychotherapies that are not trauma-focused (i.e., Stress Inoculation Training [SIT], PCT, and Interpersonal Psychotherapy [IPT]). Notably, at the time the recommendations were developed, there were no well- designed, well-controlled studies available to the Work Group that directly compared the treatment effects of non-trauma-focused psychotherapy and pharmacotherapy. There are no empirical data to clearly differentiate pharmacotherapy and non-trauma-focused psychotherapy in cases where trauma-focused psychotherapy is unavailable or undesired. However, results of recent meta-analyses suggest that pharmacotherapy or individual non-trauma-focused psychotherapy can help reduce PTSD symptoms when used as the primary treatment modality.
b. Psychotherapy	
	For patients with PTSD, we recommend individual, manualized trauma- focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure. For this CPG, trauma-focused psychotherapy is defined as therapy that uses cognitive, emotional, or behavioral techniques to facilitate processing a traumatic experience and in which the trauma focus is a central component of the therapeutic process. There are other psychotherapies that meet the definition of trauma-focused treatment for

	which there is currently insufficient evidence to recommend for or against their use.
	We suggest the following individual, manualized non-trauma-focused therapies for patients diagnosed with PTSD: Stress Inoculation Training (SIT), Present-Centered Therapy (PCT), and Interpersonal Psychotherapy (IPT). If trauma-focused psychotherapy is not available or if a patient prefers a treatment that does not require focusing on trauma, the Work Group suggests individual, manualized psychotherapy that is not trauma- focused. SIT, PCT, and IPT are the non-trauma-focused therapies with the most evidence derived from clinical trials that have involved direct comparisons with first-line trauma-focused therapies.
	There is insufficient evidence to recommend for or against psychotherapies that are not specified in other recommendations, such as Dialectical Behavior Therapy (DBT), Skills Training in Affect and Interpersonal Regulation (STAIR), Acceptance and Commitment Therapy (ACT), Seeking Safety, and supportive counseling. A wide variety of manualized protocols, including Dialectical Behavior Therapy,[61] Skills Training In Affect and Interpersonal Regulation, [62] Acceptance and Commitment Therapy,[63] Seeking Safety,[64] hypnosis,[65] brief psychodynamic therapy,[66] and supportive counseling,[48,67,68] have all been used in the treatment of PTSD. However, at this time there are insufficient data to argue for or against the use of these protocols in treating PTSD. Further research is needed in order to make a recommendation for or against their routine use in patients with PTSD.
	There is insufficient evidence to recommend using individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol. The Work Group does not recommend adding or removing components from evidence-based psychotherapy protocols. If modifications to an established protocol (e.g., PE, CPT, EMDR) are clinically necessary, the modifications should be empirically and theoretically guided, and with understanding of the core components of trauma-focused psychotherapies considered most therapeutically active.
	We suggest manualized group therapy over no treatment. There is insufficient evidence to recommend using one type of group therapy over any other. The limited data on the efficacy of group therapy for PTSD indicates that it is not as effective as individual therapy. However, some patients with PTSD may prefer manualized group psychotherapy over other treatment formats. The research has not shown any particular model of manualized trauma- focused or non-trauma-focused group psychotherapy for PTSD to be superior to other active interventions, such as PCT, psychoeducation, or treatment as usual. However, group psychotherapy is better than no treatment in reducing PTSD symptoms.
	There is insufficient evidence to recommend for or against trauma- focused or non-trauma-focused couples' therapy for the primary treatment of PTSD. In some cases, Veterans may prefer PTSD treatment that includes attention focused on their

	intimate relationships. It is not yet known if a couples-based approach is as effective as individual trauma-focused therapy for PTSD. Overall, there is promising but limited evidence in support of trauma-focused couples' therapy for PTSD
f. Combination therapy Although many patients show clinical improvement in response to recommended evidence-based psychotherapies and/or pharmacotherapies, a sizable proportion of patients are partial- or non- responders. Determining what to do for these patients is a clinically important question, yet the limited evidence available is insufficient to guide clinical decision making. Only a few studies have examined the benefits of administering medication and psychotherapy to either augment a single initial modality following inadequate response, or as a combination at the outset of therapy. In the absence of evidence to guide decision making, clinicians treating partial- or non-responders should rely on their clinical judgment, use an SDM approach, and take patient preferences into consideration.	
	In partial- or non-responders to psychotherapy, there is insufficient evidence to recommend for or against augmentation with pharmacotherapy
	In partial- or non-responders to pharmacotherapy, there is insufficient evidence to recommend for or against augmentation with psychotherapy.
	There is insufficient evidence to recommend for or against starting patients with PTSD on combination pharmacotherapy and psychotherapy.
g. Non-pharmacologic biological treatments	
	There is insufficient evidence to recommend for or against the following somatic therapies: repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), hyperbaric oxygen therapy (HBOT), stellate ganglion block (SGB), or vagal nerve stimulation (VNS). There is considerable interest in alternatives to either psychotherapy or pharmacology for the primary treatment of PTSD. However, there is currently insufficient evidence to recommend the majority of somatic therapies, including repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), hyperbaric oxygen therapy (HBOT), stellate ganglion block (SGB), or vagal nerve stimulation (VNS). Based upon a lack of high quality RCTs supporting the efficacy of rTMS, ECT, HBOT, SGB, or VNS, the Work Group is unable to recommend their use for the primary treatment of PTSD.
h. Complementary and integrative treatments	
The Work Group acknowledges the widespread use of complementary and integrative health (CIH) practices as part of the treatment of individuals with PTSD in the DoD and VA healthcare systems. It is important to clarify that we are not recommending against the	

treatments but rather we are saying that, at this time, the research does not support the use of any CIH practice for the primary treatment of PTSD. These practices hold promise as interventions to improve wellness and promote recovery.	
	There is insufficient evidence to recommend acupuncture as a primary treatment for PTSD. Even though the evidence is trending positively for the use of acupuncture, based on the lack of sham control and other study limitations, the Work Group's assessment was that the current available evidence was still insufficient to recommend acupuncture as a primary treatment modality for PTSD. Practitioners should consider factors such as patient preference and treatment availability when determining CIH treatment options.
	There is insufficient evidence to recommend any complementary and integrative health (CIH) practice, such as meditation (including mindfulness), yoga, and mantram meditation, as a primary treatment for PTSD. There were more clinical trials available for meditation than for any other CIH modality. Grading the body of evidence for meditation overall was complicated by the heterogeneity of the types of meditation that had been assessed. Meditation is promising and may provide a safe, self-administered, and inexpensive intervention for PTSD. Unfortunately, the current research clearly does not establish its efficacy. Additional high-quality trials with adequate power, active control conditions, and longer follow-up periods are needed. Evidence suggests that yoga may be effective for PTSD. No major adverse events have been reported in the yoga interventions. However, the Work Group judged the evidence to be insufficient due to study limitations. A number of other CIH modalities were reviewed, but none were found to have sufficient evidence to support any recommendations regarding their use.[76] Although there is much interest in the area of animal-assisted therapy, no studies evaluating the use of interventions with animals, such as equine therapy or canine therapy, met the threshold for inclusion in the review. At this time, there is no evidence to support their use for the primary treatment of PTSD.
i. Technology-based treatment modalities	
	We suggest internet-based cognitive behavioral therapy (iCBT) with feedback provided by a qualified facilitator as an alternative to no treatment. We suggest internet-based cognitive behavioral therapy (iCBT) with feedback provided by a qualified facilitator (e.g., care manager, trained peer, therapist) as an alternative to no treatment for improvement in PTSD symptoms. Although it is not as well supported as other primary treatments for PTSD, iCBT may be suggested for patients who refuse other treatment interventions. iCBT may be useful to increase access to services and reduce stigma in seeking services. Before recommending iCBT to patients, clinicians should review the content to ensure its accuracy and ethical application.

	We recommend using trauma-focused psychotherapies that have demonstrated efficacy using secure video teleconferencing (VTC) modality when PTSD treatment is delivered via VTC. We recommend using trauma-focused psychotherapies that have demonstrated efficacy using secure video teleconferencing (VTC) modality when PTSD treatment is delivered via VTC. Although there are fewer studies examining the delivery of evidence-based treatments through VTC than those delivered in- person, there appears to be similar efficacy. VTC interventions are encouraged when in-person interventions are not feasible, the patient would benefit from more frequent contact than is feasible with face-to-face sessions, or the patient declines in-person treatment. There are some concerns associated with treatment delivery through VTC such as technical support, computer literacy, and human factors in using technology. Potential advantages include increased access and decreased stigma. Providers using technology-assisted interventions should regularly encourage patients to complete the interventions and endeavor to maintain and strengthen the therapeutic relationship (e.g., through telephone contact), build patient rapport, stress practice, and ensure adequacy of safety protocols.

Note. Veterans Administration and Department of Defense Clinical Practice Guidelines can be found at
https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf

Appendix H

Content Analysis of Competencies Codebook

Code	In vivo	Definition	Knowledge/ Desired learning outcome	Analytic Memos
Research	Research, data, analysis, evaluation, scholarship	Practitioners conducting research, systematic collection of data, evaluation of services, and/or	Practitioner is able to conduct research to further knowledge in trauma theory and practice	Research on the phenomenon of trauma, not to be confused with assessment or psychological testing. Not a direct service to client. Split from testing and assessment/diagnosis as services not provided directly to clients.
Testing	Psychological testing, assessment, interpretation, psychometrics	Services provided directly to clients to assess the presence or absence of distress caused by psychological trauma	Practitioners are able to assess for the presence's symptoms caused by exposure to trauma or assess for a history of trauma	Direct services to clients
Prevention	Prevention, preventive services, preparation,	Strategies that practitioners use to increase the likelihood that clients will not be exposed to traumatic events	Practitioners will have knowledge of, employ, or work toward ensuring that clients do not encounter traumatic events or continue to encounter traumatic events	Can be community based or individual. The veteran's administration competencies interpret prevention as the prevention of meeting full criteria for PTSD not the prevention of exposure
Trauma Theory	Theory, counseling theory, therapy, treatment, model	Practitioners utilizing a systematic theoretical foundation to approach treatment, intervention, assessment, and	Practitioners know, understand, can provide care to clients from a therapeutic perspective.	Can include any sort of theoretical foundation mentioned including but not limited to: counseling theory, crisis theory, systems theory, psychological theory, learning theory

		general client care.		
Vicarious Trauma	Vicarious trauma, secondary trauma, compassion fatigue, practitioner exposure to trauma, secondary traumatic stress	The impact that providing services to clients that have experienced	Understanding of the impact that exposure to trauma narratives can have on the practitioner providing services	Distinct from awareness of self, must focus on practitioner distress/stress from exposure to client's traumatic experiences
Adapt/ Communicate Information	Disseminate, present communicate, articulate, translate, adapt, educate, inform, psychoeducation	The ability to take the complex concepts often associated with trauma and present them to a general audience, clients, or other professionals	Practitioners are able to take information that have learned in the classroom, through workshops, through reading and translate it to individuals without a science background	Changed from disseminate information, trying to capture the essence of translating technical scientific information into a format accessible by the general public
Ethical Practice and Professional Boundaries	Ethics, ethical code, American Counseling Association code of ethics, American Psychological Association code of ethics, National Association of Social Workers code of ethics, boundaries, professional boundaries, do no harm, minimize harm, scope of practice	Practitioners taking into considerations their ethics obligations as stipulated by their professional organization.	Practitioners act and reflect on their professional obligations as it pertains to ethics and professional boundaries in the client practitioner relationship.	Board to encompass the written rules and statements that imply working within a "do no harm" framework
Biological Impact	Body, biological, physical, physical health, physiological, somatic, neurobiology, biological	The biological impact that exposure to trauma can have for clients	The practitioner is able to assess, conceptualize, have knowledge of, take into consideration the impact that trauma can have on physical health or body-based	Any mention of the impact that trauma has on client beyond the psychological impact

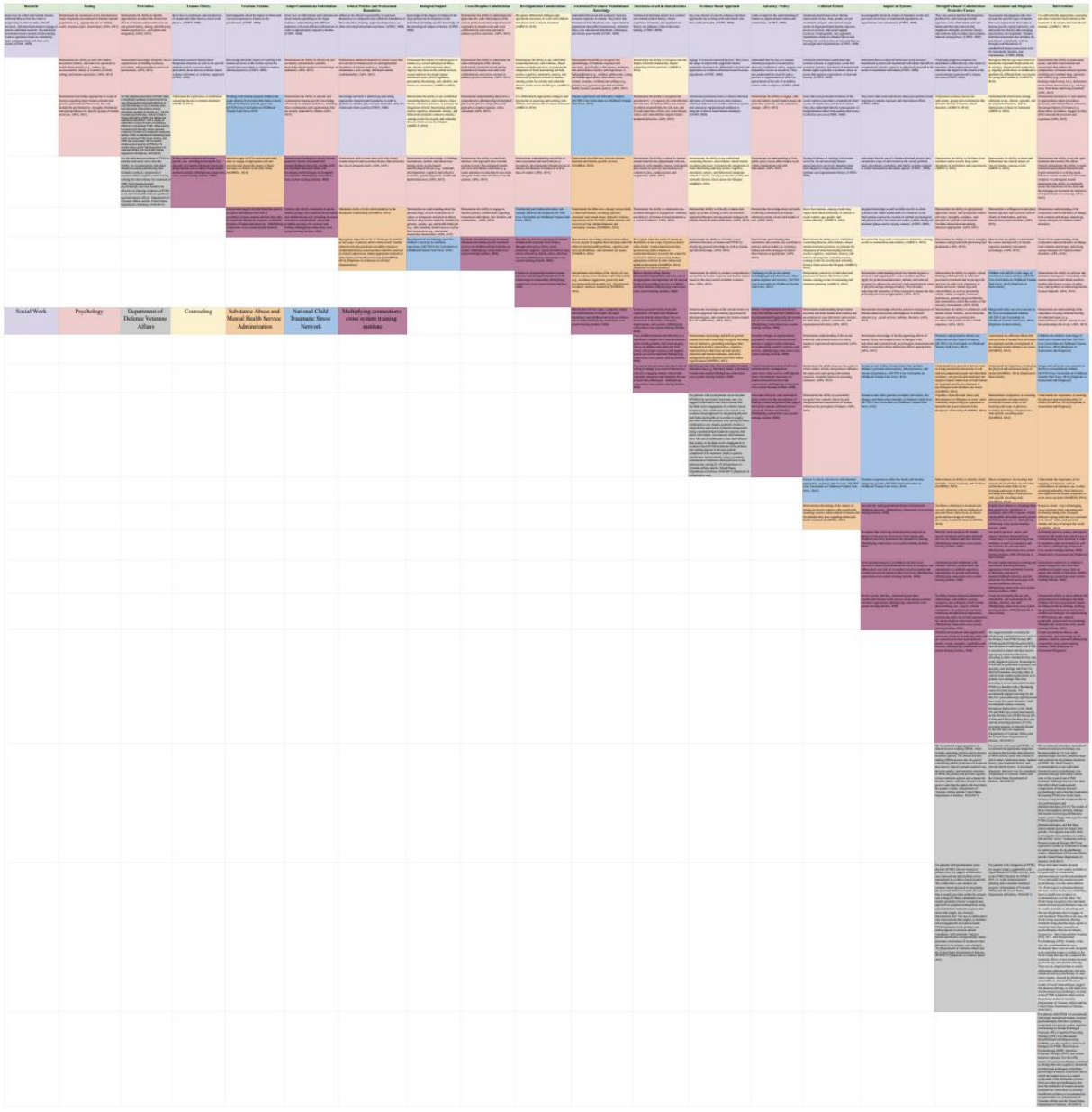
	system, brain, nervous system, pharmacology		systems	
Cross-Discipline Collaboration	Interdisciplinary collaboration, cross-discipline collaboration, sharing of information across disciplines, referral, refer-out	Any cross discipline sharing of resources or information to enhance client care	A practitioner's ability to engage with professionals outside of their own field to increase positive client outcomes.	This is not the same was collaboration with clients, this is collaboration with other professionals
Developmental Considerations	Development, attachment, child, adolescent, youth, caregiver	Considerations on how trauma impacts the development of psychological well-being and/or physical development	A practitioner's ability to conceptualize how trauma may have impacted or will impact a client's developmental trajectory	Distinct from system, these are considerations that are client specific. If they focus on broader relationships such as peers or family than it would be in the systems category
Awareness/ Prevalence/ Foundational Knowledge	Foundational knowledge, basic information, statistics, prevalence, terms, vocabulary, types of trauma, risk factors, symptoms	Any mention of foundational information that is used to inform practice.	Practitioners should have a foundational knowledge of what trauma is including symptoms, risk factors, prevalence, and typically terminology or vocabulary utilized to describe the phenomenon.	Not tied to action, but information that the practitioners should know to provide optimal client care. Diverged from awareness of self, as an awareness of the concept of trauma
Awareness of self and characteristics	Reflection, awareness of self, characteristics of the practitioner, personal trauma history, belief, values, interpersonal, reciprocal, subjectivity	Statements that encourage growth in practitioner ability to recognize their own history, perspectives, demeanor, and beliefs may impact work with clients	Overarching thought that the way counselors feeling, think, and act based on their own belief system impacts the work they do with clients	Could also include vicarious trauma, but vicarious trauma is separate due to its specificity to awareness of trauma work.
Evidence-	Evidence-	Clinicians using	Practitioners know	Distinct from

based approach	informed, research-informed, evidence-based, research-supported	research to inform clinical practice	how to use, know where to find, and use practices that are	intervention and assessment to include a broad understanding of the need for all aspect of treatment to be informed by evidence
Advocacy/ Policy	Policy, advocacy, organization, trauma-informed, organization, public policy, institutions, legal	Practitioners advocating for policy change to support clients outside of the therapeutic relationship	Practitioners engage without outside organization including policy makers to attend to increase access and quality of services for individuals that have been through a traumatic experience.	Different from systemic because this does not necessarily include the client and often times is advocating on their behalf
Cultural factors	Unique client features, gender, age, race, ethnicity, nationality, intersectionality, marginalization, oppression, culture	Consideration of the unique features, circumstances, history of the client	Practitioners are aware and actively consider the different culture factors that may be impacting their clients	Extremely broad, essentially any statement
Impact on systems	System, family, community, school, environment, context, social, society, organization	The impact of trauma reaches beyond the individual and the current time to impact communities, families, peer groups, and organizations across time.	Practitioners are able to see that traumatic experience and recovery from that experience often extends beyond the individual	Includes the client as a part of the system
Strengths-based / collaboration/ protective factors	Strengths-based, collaboration, empower, protective factors, strengths, resilience, coping skills, support, resources,	Interventions, assessment, correspondence, and any interaction with clients should help support resilience, growth, and be tailored to the individual strengths of the client	Practitioners understand that clients that have encountered a traumatic event often free shame, disempowered, and helpless. Practitioners attempted to help clients realize their potential, strengths, and the adaptive	Note a collaboration between the client and the community, but collaboration between counselor and client. Divergent from intervention, because it is broader than just the interventions and includes the other all

	growth, choice		nature of their trauma response.	philosophy
Assessment and diagnosis	Assessment, diagnosis, symptoms, clinical diagnosis, screening	The collection and organization of client information concerning symptoms, distress, and history of exposure to traumatic events in a way that does not re-traumatize the client	Practitioners are able to collect and organization client information from a variety of sources and across therapeutic sessions to have a who list conceptualization of what is happening for the client and what should happen to address distress	This is different from testing because this is no necessarily
Interventions	Treatment, intervention, procedures, tailoring interventions, effective interventions/ treatment, change, therapeutic relationship, cognitive behavioral therapy, mindfulness, safety during session, techniques, manualized	The actions, techniques, environment, and procedures utilized during the therapeutic process to alleviate distress and enhance the change process	Practitioners have an understanding based on assessment, diagnosis, training, testing, and other foundational knowledge what needs to happen during the therapeutic process to foster change, growth, and alleviate feelings of distress caused by traumatic experience	Anything that is purposefully done by the practitioner including environmental factors like relationship, action-oriented

Appendix I

Chart of Competencies Sorted by Theme
Link to the spread sheet:
https://docs.google.com/spreadsheets/d/1EmgbOPh5VLQ_6xn4lptQUVAt0eJi4_C-L_4tbvRIi9A/edit?usp=sharing



Appendix J

Multiple Case Study in Education and Social Science

Citation	Number of Cases	Type of Data Collected	Source type
Thomas, D. A. (2009). Reaching Resilience : A Multiple Case Study of the Experience of Resilience and Protective Factors in Adult Children of Divorce.	5 Individuals	A demographic survey, two artifacts (artwork), interview	Counselor Education Dissertation
Reyes, N. (2007). *Addressing Culture in Therapy: A Multiple Case Study*.	3 Counselor-Client dyads	Videotaped therapy sessions, assessment packets from clients, intake forms from clients, therapists case notes, two cultural competence assessments for therapists	Marriage and Family Dissertation
Rectanus, A. (2017). *Training and Assessing Trauma-Focused Counselor Competency: A Multi-Case Pilot Study*. Johns Hopkins University. Retrieved from http://jhir.library.jhu.edu/handle/1774.2/44705	4 CIT	Activity logs, survey responses, training logs, competency assessments, and group interviews	Education Dissertation

Wester, K. L., Downs, H. A., & Trepal, H. C. (2016). Factors Linked With Increases in Nonsuicidal Self-Injury: A Case Study. *Counseling Outcome Research and Evaluation*, *7*(1), 3–20. https://doi.org/10.1177/2150137816632849	8 Counselor - client dyads	Surveys from the client and the counselor. Client: Demographic form, deliberate self-harm inventory, brief coping with programs experienced, and brief symptom inventory. Counselor: theoretical orientation and interventions survey.	Counseling Article
Doré, R., Dion, É., Wagner, S., & Brunet, J. (2002). High School Inclusion of Adolescents with Mental Retardation: A Multiple Case Study. *Education and Training in Mental Retardation and Developmental Disabilities*, *37*(3), 253–261.	2 students	Observations of participants, interview with instructor	Adolescent Education Article
Shaw, R. D. (2014). The work-life balance of competitive marching band teachers: A multiple case study. *Bulletin of the Council for Research in Music Education*, *200*(200), 63–80. https://doi.org/10.5406/bulcouresmusedu.200.0063	4 Marching Band Teachers	Interview, email correspondence	Primary School Education Article

Baher, J. (1999). Articulate Virtual Labs in Thermodynamics Education: A Multiple Case Study*. *Journal of Engineering Education*, (October), 663–668. https://doi.org/10.1002/j.2168-9830.1999.tb00470.x	3 Classrooms	Observation of students, interview with faculty, survey to students	Engineering Education Article
Green, B. F., Johansson, I., Rosser, M., Tengnah, C., & Segrott, J. (2008). Studying abroad: A multiple case study of nursing students' international experiences. *Nurse Education Today*, *28*(8), 982–993. https://doi.org/10.1016/j.nedt.2008.06.003	8 United States students and 14 Swedish Students	Individual interviews, group interviews, and document analysis	Nursing Education Article

Appendix K

Traumatology Interest Network Feasibility Post

Original Message:
Sent: 09-17-2018
From: Charmayne Adams
Subject: Crisis and Trauma Course

My name is Charmayne Adams and I am a doctoral candidate at the University of Tennessee in Knoxville. I am currently preparing my dissertation proposal and assessing the feasibility of my ideal methodology. This is **not** a recruitment email or any indication of commitment to research participation, I am currently trying to understand the landscape of who may be teaching a crisis or trauma course in the coming semester.

I was wondering if anyone will be teaching a crisis and/or trauma course in spring 2019 or if someone in your department may be teaching a crisis and/or trauma course in Spring 2019. If you went to a university that offered a crisis and trauma course, that would also be extremely helpful. I could reach out to them and see if one is being taught in the spring.

Thank you in advance for any help! Please feel free to email me directly at cadams49@vols.utk.edu

Warmly,
Charmayne

Appendix L

Feasibility Email to Colleagues

[Instructor's Name]

I hope this email finds you well. My name is Charmayne Adams and I am a doctoral candidate at the University of Tennessee in Knoxville. I am currently preparing my dissertation proposal and assessing the feasibility of my ideal methodology. I received your name from [referral name] at [University of the referral name]. This is not a recruitment email or any indication of commitment to research participation, I am currently trying to understand the landscape of who may be teaching a crisis or trauma course in the coming semester.

My dissertation study is on teaching methods in crisis and trauma courses for master's students, with an ideal methodology of multiple case study. I was wondering if [University of the instructor] will be offering a trauma and/or crisis course in Spring 2019? If so, do you know who will be teaching that course?

Thank you for taking the time to respond to my inquiry.

Warmly,

Charmayne

Appendix M

Recruitment Email

Subject line: Participant Request: Teaching Trauma Theory and Practice to Master's Level Counselors-In-Training

[Instructor name],

My name is Charmayne Adams, and I am a doctoral candidate at the University of Tennessee in Knoxville; my advisor is Dr. Casey Barrio Minton. I am currently conducting my dissertation titled: *Teaching Trauma Theory and Practice to Master's Level Counselors-In-Training: A Multiple Case Study*. I would like to invite you to participate in this research study.

Purpose: My goals are to better understand (1) How counselor educators choose which trauma content to address in master's level trauma theory and practice courses and (2) Which teaching methods counselor educators utilize to facilitate significant learning experiences in master's level trauma theory and practice courses.

Inclusion Criteria: The researcher encourages counselor educators to view the study details at the below link if they have taught a three-credit hour course with over 50% trauma content within the past year, are willing to participate in two interviews, and are able to submit artifacts.

Participation: If you wish to participate, please sign the informed consent and complete the short survey located at [link]. I will contact participants selected as a case to schedule the initial interview by [date].

If you have questions about the study or the procedures, please be sure to contact me at cadams49@vols.utk.edu.

Warmly,
Charmayne Adams

Appendix N

Revised Recruitment Email

Subject line: *Recruitment Criteria Expanded* Participant Request: Teaching Trauma Theory and Practice to Master's Level Counselors-In-Training

Hello,

The recruitment criteria for this study have been expanded to include online and hybrid courses and any primary instructor of the course regardless of if you created the course. Please consider participating in this study if you qualify based on the expanded the criteria.

My name is Charmayne Adams, and I am a doctoral candidate at the University of Tennessee in Knoxville; my advisor is Dr. Casey Barrio Minton. I am currently conducting my dissertation titled: *Teaching Trauma Theory and Practice to Master's Level Counselors-In-Training: A Multiple Case Study*. The University of Tennessee Institutional Review Board has approved this study (*UTK IRB-18-04848-XP*). I would like to invite you to participate in this research study.

Purpose: My goals are to better understand (1) How counselor educators choose which trauma content to address in master's level trauma theory and practice courses and (2) Which teaching methods counselor educators utilize to facilitate significant learning experiences in master's level trauma theory and practice courses.

Participation will consist of two qualitative, open-ended interviews, which will last approximately 60 minutes each; completion of an opened ended questionnaire; and submission of the course syllabi, reading lists, and assignment descriptions. All interviews and syllabi will be de-identified for confidentiality. Results of this study will help in the completion of my dissertation and future publications and presentations.

Inclusion Criteria:

1. Counselor educator who has taught a face-to-face, hybrid, or online:
    a. Three-credit hour trauma course intended for master's level counselors taught in CACREP Accredited or Aligned program between Fall 2017 and Fall 2018
    b. Most of the course content is focused on trauma
2. Counselor educator is the primary instructor for the course or has been in the past year
3. Counselor educator has the ability to submit the course syllabi, reading lists, and assignment descriptions

Participation: If you are interested in participating in this study, please sign the informed consent and complete the short survey (2-5 minutes) located at

https://goo.gl/forms/w2wECRz9mhFiWqUk1. Based on the responses to the recruitment email 4 – 6 instructors will be selected to participate in the study, not all individuals that complete the screening survey will be selected. I will contact participants selected as a case to schedule the initial interview by January 10, 2019. If you have questions about this study, please feel free to contact me via email at cadams49@vols.utk.edu or by phone at (616) 308-4822. If you have any questions and/or concerns, you may also contact my Committee Chair, Dr. Casey Barrio-Minton at cbarrio@utk.edu. If you have questions about your rights as a participant, you may contact the University of Tennessee IRB Compliance Officer at utkirb@utk.edu or (865) 974-7697.

Warmly,
Charmayne Adams

Appendix O

Participant Screening Form

Thank you for participating in my study. This form is the participant screening form and will be used to determine the case study participants. If you have any questions or concern, please contact Charmayne Adams at cadams49@vols.utk.edu.

1. Name [open response]

2. Email Address [open response]

3. Is the course a trauma course, or a trauma and crisis course?
    a. Trauma-specific (only trauma content)
    b. Crisis with at least 50% trauma content

4. What semester was the course taught?
    a. Fall 2017
    b. Spring 2018
    c. Summer 2018
    d. Fall 2018
    e. Spring 2019 (Concluding by May 31, 2019)

5. Did you participate in the design of the course, including choosing course content and instructional methods?
    a. Yes
    b. No

6. Are you available to complete two 45 minute - 60-minute interviews between January 2019- May 2019?
    a. Yes
    b. No
    c. Maybe

7. What region do you teach? (Note: If you teach in an online or hybrid program and your students are outside of the region you teach from, indicate what region you are in and also select "online program") [All that apply]
    a. North Atlantic Region (CT, DE, ME, MA, NH, NJ, NY, PA, RI, VT)
    b. North Central Region (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, OK, SD, WI)
    c. Rocky Mountain (CO, ID, MT, NM, UT, WY)
    d. Southern (AL, AR, DC, FL, GA, KY, LA, MD, MS, NC, SC, TN, TX, VA, WV)

e. Western (AK, AZ, CA, HI, NV, OR, WA)
f. Online Program

8. What is/was the format of the course you taught or will be teaching?
    a. Face-to-face
    b. Online
    c. Hybrid

9. Are you able to submit at least 5 week's worth of course artifacts?
    a. Yes
    b. No

10. What course artifacts are you able to submit? [All that apply]
    a. PowerPoints
    b. Instructor notes
    c. Case Studies
    d. Course assignment details
    e. Grading Rubrics
    f. Videos
    g. Pictures
    h. Writing prompts
    i. Reading lists
    j. Other_____

11. Please attach a copy of the syllabus of the trauma or crisis course you teach [file upload]

Appendix P

Revised Participant Screening Survey

Participant Screening Form

Thank you for participating in my study. This form is the participant screening form and will be used to determine the case study participants. If you have any questions or concern, please contact Charmayne Adams at cadams49@vols.utk.edu.

1. Name [open response]

2. Email Address [open response]

3. Is the course a trauma course, or a trauma and crisis course?
    a. Trauma-specific (only trauma content)
    b. Crisis and trauma content

4. What semester was the course taught by you? [select all that apply]
    a. Fall 2017
    b. Spring 2018
    c. Summer 2018
    d. Fall 2018

5. Are you the primary instructor of this course or have been the primary instructor of this course in the past year?
    a. Yes
    b. No

6. Are you available to complete two 45 minute - 60-minute interviews between January 2019- May 2019?
    a. Yes
    b. No
    c. Maybe

7. In which region do you teach? (Note: If you teach in an online or hybrid program and your students are outside of the region you teach from, indicate what region you are in and also select "online program") [All that apply]
    a. North Atlantic Region (CT, DE, ME, MA, NH, NJ, NY, PA, RI, VT)
    b. North Central Region (IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, OK, SD, WI)
    c. Rocky Mountain (CO, ID, MT, NM, UT, WY)

   d. Southern (AL, AR, DC, FL, GA, KY, LA, MD, MS, NC, SC, TN, TX, VA, WV)
   e. Western (AK, AZ, CA, HI, NV, OR, WA)
   f. Online Program

8. What format is the course taught? [All that apply]
   a. Face-to-face
   b. Online
   c. Hybrid

9. Please attach a copy of the syllabus of the trauma or crisis course you teach [file upload]

Appendix Q

Selection Email for Individuals Not Selected

[Instructor name],

Thank you for your willingness to participate in my dissertation research study. It appears I have obtained enough cases to proceed with my study, and I will not need you to proceed with the interviews. I truly appreciate your willingness to support me while I complete my dissertation study.

Warmly,
Charmayne

Appendix R

Selection Email for Individuals Selected

[Instructor name],

Thank you for agreeing to participate in my dissertation research study. I have selected you to serve as one of the case studies for this inquiry. Thank you so much for your participation. The case study portion of this inquiry involves two 45 minute to 60-minute interviews that will take place approximately two weeks apart, an instructor and course context questionnaire, and submission of course artifacts.

Would you please indicate your preference for your first and second interview:
First interview January 14-18; Second Interview January 28 - February 1
First interview January 14 -18; Second Interview February 4 - February 8
First interview February 4 - February 15; Second Interview February 25 - March 1
First interview March 4 - March 15; Second Interview March 25 - April 1

When the interview schedules are planned, I will send you an email to schedule the exact date and time of your interview. I ask that you complete the [name of it] prior to your first interview. Find the demographic survey at [link]. You can complete it anytime between now and your interview, and I will send you a reminder when I email to confirm your interview date and time.

I will provide you with information on how to submit your artifacts during your initial interview, but I want to confirm that you indicated you are able to submit [insert name of artifacts they indicated in the screening questionnaire]. Please confirm this in your reply email.

Thank you again for agreeing to participate. A copy of the informed consent is attached to this email for your review.

Action Items:

- Indicate your preference for interview times
- Complete instructor and course context questionnaire
- Confirm the artifacts you are able to submit

Warmly,
Charmayne

Appendix S

Instructor and Course Context Questionnaire

Demographic Survey

Professor

1. Age: [open response]

2. Gender Identity
    a. Cisgender Woman
    b. Cisgender Man
    c. Transgender
    d. _____

3. Race or ethnic identity [all that apply]
    a. African American/ Black
    b. Caucasian/ White
    c. Asian
    d. Latinx
    e. Indigenous American or Alaska Native
    f. Native Hawaiian/Pacific Islander
    g. Multiracial

4. How many years have you been a professional counselor? [open response]

5. How many years have you been a counselor educator? [open response]

6. Faculty member rank/type of appointment (e.g., tenure-line assistant professor)

7. How many times have you taught the trauma course? [open response]

8. What is your educational background in trauma education? [open response]

9. What is your clinical background in trauma education? [open response]

10. Do you have any certificates or specific training in trauma or crisis? [open response]

11. Would you consider trauma one of your specialty areas?
    a. Primary
    b. Secondary

The Trauma Course

12. What tracks are offered through your program? [all that apply]
    a. Mental health
    b. School counseling
    c. Student affairs
    d. Rehabilitation counseling
    e. Marriage and family counseling
    f. Other _____

13. How many students are in the program? [open respond]

14. At what point during the program do students take the trauma course? [open response]

15. What is the typical size of the trauma course?
    a. How many students typically enroll?
    b. What is the maximum course enrollment or cap?

16. What level of student takes the trauma course?
    a. Undergraduate
    b. Master's
    c. Doctoral
    d. Mixture

17. Is the trauma course required for students in one or more specialty areas?
    a. Yes
    b. No
    c. Yes, but only for our some students [which track]
    d. Other _____

18. What students take the course?
    a. Counseling students only
    b. Other disciplines (e.g., social work, psychology)
    c. Mixture of counseling students and those from other disciplines

19. Including summers, how many semesters has this course been offered?
    a. 1 – 2 semesters
    b. 3 – 4 semester
    c. 5 – 6 semester
    d. More than 6 semesters

20. In which format is the course offered? [all that apply]
    a. Face-to-face
    b. Online
    c. Hybrid
    d. Other:_____

21. What are the primary instructional methods (e.g., lecture, case-based learning, service learning, guest speakers)? [open response]

22. Are co-instructors or teaching assistants utilized in this course? If so, how?

The Community

23. What is the population of the town or city your university is located in? [open response]

24. Is it how would you describe the town or city your university is located in (e.g., rural, urban, suburban? [open response]

25. What types of traumatic events appear to be most prevalent in your local community? [open response]

26. Are there specific populations that have been particularly impacted by traumatic events in your community? [open response]

27. What, if any, are there types of traumatic events that have impacted your local community at large (e.g., natural disaster, mass shooting)? [open response]

28. What type of resources are available in your area for individuals who have experienced traumatic incidents? [open response]

Appendix T

Instructor and Course Context Questionnaire

Thank you for participating in my study. This form is the instructor and course context questionnaire. The instructor and course context questionnaire will ask about your professional background, the trauma course you teach, and the community you teach in. Some of the questions about community will ask you to talk about traumatic events that have happened. You are able to skip any questions without penalty. If you have any questions or concern please contact Charmayne Adams at cadams49@vols.utk.edu.

Professor

1. Age: [open response]

2. Gender Identity
    a. Cisgender Woman
    b. Cisgender Man
    c. Transgender
    d. _____

3. Race or ethnic identity (all that apply)
    a. African American/ Black
    b. Caucasian/ White
    c. Asian
    d. Latinx
    e. Indigenous American or Alaska Native
    f. Native Hawaiian/Pacific Islander
    g. Multiracial

4. How many years have you been a professional counselor? [open response]

5. How many years have you been a counselor educator? [open response]

6. Faculty member rank/type of appointment (e.g., tenure-line assistant professor)

7. How many times have you taught the trauma course? [open response]

8. What is your educational background in trauma education (e.g., undergraduate or graduate level courses in trauma)? [open response]

9. What is your clinical background in trauma education? [open response]

10. Do you have any certificates or specific training in trauma or crisis? [open response]

11. Would you consider trauma one of your specialty areas?
    a. Primary
    b. Secondary
    c. No

The Trauma Course

12. What tracks are offered through your program? (all that apply)
    a. Mental health
    b. School counseling
    c. Student affairs
    d. Rehabilitation counseling
    e. Marriage and family counseling
    f. Other _____

13. How many students are in the program? [open response]

14. At what point during the program do students take the trauma course? [open response]

15. What is the typical size of the trauma course?
    a. How many students typically enroll?
    b. What is the maximum course enrollment or cap?

16. What level of student takes the trauma course?
    a. Undergraduate
    b. Master's
    c. Doctoral
    d. Mixture

17. Is the trauma course required for students in one or more specialty areas?
    a. Yes
    b. No
    c. Yes, but only for our some students [which track]
    d. Other _____

18. What students take the course?
    a. Counseling students only
    b. Other disciplines (e.g., social work, psychology)

c. Mixture of counseling students and those from other disciplines

19. Including summers, how many semesters has this course been offered? [open response]

20. How long has the course been in existence? [open response]

21. How frequent is the course offered? [open response]

22. Were you involved in the creation of the course? [open response]

23. What are the primary instructional methods (e.g., lecture, case-based learning, service learning, guest speakers)? [open response]

24. Are co-instructors or teaching assistants utilized in this course? If so, how? [open response]

The Community

25. What is the population of the town or city your university is located in? [open response]

26. How would you describe the town or city your university is located in (e.g., rural, urban, suburban? [open response]

27. What types of traumatic events appear to be most prevalent in your local community? [open response]

28. Are there specific populations that have been particularly impacted by traumatic events in your community? [open response]

29. What, if any, are there types of traumatic events that have impacted your local community at large (e.g., natural disaster, mass shooting)? [open response]

30. What type of resources are available in your area for individuals who have experienced traumatic incidents? [open response]

Appendix U

I-Guide First Interview
Trauma Content

[seek permission to turn on recording]

I just want to confirm that you have consented to begin recording, and I have begun recording. This is the first of two interviews; this interview will focus on the trauma content in the course that you teach. We may speak about the teaching process in this interview, but I will try to keep the conversation focused on trauma content. This interview will take 45 minutes to a 1 hour. Do you have any questions about informed consent or the interview process before we begin?

I want to begin by thanking you for submitting your course syllabus and the instructor and course context questionnaire. There may be points during the interview were I ask for clarification or reference those documents. If you have taught a trauma course previously, I would like you to try and focus the answers to the questions in this interview on the trauma course for which you submitted the syllabus.

1. Describe the trauma course that you taught or are currently teaching.
2. What do you hope students leave knowing when the trauma course is complete?
3. Tell me about the trauma content in course that you taught or are currently teaching?
4. How did you choose what content to teach in the trauma course?
5. Are there any training standards that you utilized to guide the content in your course?
    a. What was it about the set of standards that made you choose those to inform course content?
6. What types of traumatic events do you cover in your course?
    a. How did you decide on these types of trauma to be covered?
7. What trauma models, if any, do you cover in your course?
    a. How did you decide on these trauma models to be covered?
8. What types of trauma-informed or trauma-specific interventions do you cover in your course?

    a. How did you decide on these trauma interventions to be covered?

9. To what degree do you address practitioner distress such as vicarious trauma, burnout, compassion fatigue, vicarious resilience, or self-care in the course you teach?
    a. How did you decide on these topic areas about practitioner distress?
10. What content areas do you place the most emphasis on in your trauma course?
11. What content areas do you place the least emphasis on in your trauma course?
12. Would you like to add anything else about the content that is covered in the course you teach?

Thank you so much for taking the time to participate in the initial interview. Your second interview is scheduled for [date] at [time]. The content of the second interview will focus on your teaching process. If you need to reschedule this interview, please feel free to contact me by email. Prior to the second interview, I would appreciate if you could send me your course artifacts. This will ensure that I have time to analyze them, and we are able to talk about them in the second interview. When this interview concludes, I will send you will an email prompting you to submit your course artifacts. Please submit all artifacts by attaching them to the email. Thank you again for your participation.

Appendix V

I-Guide Second Interview
Course Process

[seek permission to turn on recording]

I just want to confirm that you have consented to begin recording, and I have begun recording. This is the second of two interviews; this interview will focus on the teaching methods and process utilized to facilitate significant learning of trauma theory and practice. We may speak about the teaching content in this interview, but I will try to keep the conversation focused on teaching process and method. This interview will take 45 minutes to a 1 hour. Do you have any questions about informed consent or the interview process before we begin?

1. To begin, could you please explain your teaching philosophy?
    a. How does your teaching philosophy apply to the way you approach teaching this course?
2. What methods do you utilize to teach trauma theory and practice?
    a. If clarification is needed: methods might be things like lecture, guest lectures, case studies, small group discussion, role plays, service learning, and reflections.
    b. How did you decide which methods of instruction to utilize in this course?
    c. Please expand on any additional aspects of course delivery
3. What methods of instruction would you like to use, but have not?
    a. What has kept you from utilizing them?
4. Are any outside modules utilized to supplement in-class content?
5. From your perspective, how is teaching the trauma course similar to or different from teaching other courses in counselor education?
6. How do you pace your course to facilitate student learning?
7. Describe a time when you felt like you created a significant learning experience for students in the trauma course.

8. Describe a time when you felt like the learning experience or environment was not optimal for significant learning in the trauma course.
9. Would you like to add anything else concerning our first interview about trauma content or our present interview focused on course methods and process?

Appendix W

Permission from Publisher

Sunday, October 28, 2018 at 2:17:53 PM Eastern Daylight Time

Subject: Re: Coursepack Permissions Request
Date: Tuesday, October 23, 2018 at 3:17:06 PM Eastern Daylight Time
From: Angela Whalen on behalf of GP Permissions
To: Adams, Charmayne Rae

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Best wishes,
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Appendix X

Permission from Publisher

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VITA

Charmayne R. Adams was born in Grand Rapids, Michigan. She earned a Bachelor of Arts degree in Psychology from Spalding University in 2014 and a Master of Arts in Clinical Mental Health Counseling from Wake Forest University in 2016. Charmayne's professional background includes one and a half years as a professional counselor at an in-patient psychiatric hospital and one and a half years as a professional counselor in a specialized mobile crisis unit serving youth. She is a member of various professional counseling organizations, including the American Counseling Association, American Mental Health Counseling Association, and Association for Counselor Education and Supervision, and she has presented at local, state, regional, and national conferences. During her doctoral studies, she received a number of awards from the University of Tennessee Counselor Educational program, including Outstanding First Year Doctoral Student and the Upsilon Theta Chapter of Chi Sigma Iota Outstanding Doctoral Student Award. She also received Graduate Student of the Year from Smoky Mountain Counseling Association and was recognized as a Leadership Fellow by Chi Sigma Iota International. Charmayne will begin serving as Assistant Professor of Mental Health Counseling at the University of Nebraska in Omaha in August 2019.