American Psychological Association
Society for the Advancement of Psychotherapy
Psychotherapy

0033-3204/19/$12.00
2019, Vol. 56, No. 3, 409–421
http://dx.doi.org/10.1037/pst0000233

Trauma Training: Competencies, Initiatives, and Resources

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Traumatic stress is currently not a required component of the standard curricula in graduate-level education in clinical and counseling psychology. However, due to the high prevalence of trauma and its potentially deleterious physical and mental health effects in the general and clinical populations, it is imperative that psychology graduate students and practitioners understand the relevance of trauma in their clients' lives and its impact in clinical research. A comprehensive model of trauma-focused empirically informed competencies (knowledge, skills, and attitudes) was developed at a national consensus conference in 2013 and approved by the American Psychological Association in 2015 as part of that organization's education and training policy. These trauma competencies predated the American Psychological Association's Posttraumatic Stress Disorder Guidelines, and provided consensus about the scientific, theoretical, ethical, and professional foundational knowledge, skills, and attitudes for all trauma-informed professional practice, not solely treatment. The two endeavors are related and potentially synergistic, but separate. Intended to guide training programs' curriculum development and psychologists' self-monitoring, the trauma competencies serve as aspirational goals for psychologists. Training issues in these and other trauma competencies are discussed. Perhaps, most importantly, the scientific literature on trauma is constantly evolving, and thus embracing an ever-evolving curriculum and lifelong-learning approach is essential.

Clinical Impact Statement
Question: To what extent is and should training in traumatic stress be a required component of graduate-level training in the clinical and counseling psychology fields? ***Findings:*** This article provides information on current training efforts and areas for ongoing development and refinement to improve clinician competency in the treatment of traumatic stress. ***Meaning:*** Given the deleterious effects trauma can have on individuals' mental and physical health, clinicians working with this population need specialized training to improve the likelihood of positive outcomes for survivors. ***Next Steps:*** This article provides information on current training efforts and areas for ongoing development and refinement to improve clinician competency in the treatment of traumatic stress.

Keywords: posttraumatic stress, psychotherapy, competencies, evidence-based practice, clinical training

Exposure to potentially traumatic events, such as child neglect, sexual, emotional, or physical abuse, family/domestic violence, sexual assault, interpersonal violence, school and community violence, serious accidental injury, catastrophic medical illness, traumatic bereavement, or mass casualty events, is widespread. Indeed, general population surveys in 24 countries across six continents assessed lifetime exposure to 29 potentially traumatic events (Benjet et al., 2016). More than 70% of participants reported experiencing a traumatic event, with more than 30% reporting exposure to four or more such experiences. Though the majority of individuals (especially adults) who directly experience a traumatic event will not develop major mental health disorders or posttraumatic stress disorder (PTSD), a significant number will (Roberts, Gilman, Breslau, Breslau, & Koenen, 2011). Trauma has

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The consensus conference described was primarily supported by Award R131R13HS021602 from the Agency for Healthcare Research and Quality (AHRQ). The American Psychological Association (APA) Division of Trauma Psychology, the APA Board of Educational Affairs, the Department of Veterans Affairs' National Center for Posttraumatic Stress Disorder, and National Center for Homelessness also supported this endeavor. The content is solely the responsibility of the authors and does not necessarily represent the official views of the AHRQ or the U.S. Department of Veterans Affairs.

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been linked as a contributor or cause for a number of psychiatric disorders and symptoms, including PTSD, complex traumatic stress disorder, acute stress disorder, dissociation, depression, substance abuse, suicidality, and self-injurious behaviors. Trauma also has been linked to physical health problems, such as ischemic heart, and negative health behaviors, such as smoking and severe obesity (for review, see Kendall-Tackett & Klest, 2013). The reverberating effects of trauma can include disorders of the self, impaired interpersonal relationships, poor occupational functioning, and decreased quality of life (Cavalcanti-Ribeiro et al., 2012). It is now acknowledged that traumatized patients seek mental health and medical services in disproportionate numbers and the rates of trauma and associated negative psychological and social consequences are high in clinical populations (Adams et al., 2016; Bishop, Benz, & Palm Reed, 2017; McElroy et al., 2016), requiring clinical intervention. Although not all clinicians who work with trauma-exposed individuals can be expected to have specialized trauma training, there is an urgent need for basic competency in traumatic stress for mental health for specialists and nonspecialists alike. The current lack of training has serious actual and potential consequences including nonrecognition, misdiagnosis, and mistreatment that can lead to additional harm rather than healing. Many clients have reported suffering additional damage that was iatrogenic, that is, caused by the treatment.

A survey was conducted by the American Psychological Association (APA) Practice Organization, which assessed the number of hours per month that practicing psychologists estimated they spent treating trauma survivors and their interest in additional clinical training on trauma-related issues and topics (Cook, Rehman, Bufka, Dinnen, & Courtois, 2011). Of those who reported any clinical work with trauma survivors ($n = 206$; 84%), the mean number of hours was 16.9. Almost 64% of practicing psychologists who completed the survey expressed interest in participating in educational endeavors to learn more about trauma-related clinical topics. This suggests that a need exists and that more training opportunities, primarily in the main training curriculum and its related practicum and internship experiences and in ongoing continuing education offerings, would be of great benefit in meeting this need.

It is likely that under-recognition and detection of traumatic exposure and related symptoms could lead to inadequate assessment, diagnosis, and treatment plans, resulting in administration of poorly focused or inappropriate treatment. Eleven studies were identified that either examined the prevalence of childhood sexual abuse (CSA) inquiry documented in patient medical records, or directly asked mental health professionals about their own practice inquiring about trauma histories (Hepworth & McGowan, 2013). Results suggest that although many health care providers acknowledged the importance of such questioning, most do not routinely ask about trauma history. Relatedly, 13.9% of 1,946 psychiatric patients in a health care system screened positive for PTSD that was not detected by treating clinicians (Lewis, Raisanen, Bisson, Jones, & Zammit, 2018). Hence, there is a need for nonspecialists to gain competency in trauma-related screening.

Trauma survivors may not mention or recognize their trauma histories or associated mental health problems, and/or they may not realize that any reactions they have are associated with a traumatic event. In fact, it appears that patients are more likely to disclose a trauma history when explicitly asked rather than volunteer such information automatically (Briere & Zaidi, 1989; Read & Fraser, 1998). Thus, numerous efforts have been made to ensure routine inquiry about trauma in standardized admission procedures and for providing clinicians with training in how to assess and respond in an affirmative manner (Agar, Read, & Bush, 2002).

It is unclear why health care providers do not routinely assess for trauma. Some research suggests that they may have concerns about offending or distressing the client, find other more immediate pressing concerns that they feel need to be attended to, believe they lack training on how to ask or respond to disclosures, or just tend to avoid (Read, Hammersley, & Rudegeair, 2007). A comprehensive audit of 250 randomly selected files from four community mental health centers in New Zealand indicated that who is being asked about trauma histories and who is asking about trauma may vary by demographics (Sampson & Read, 2017). Namely, male clients were asked less often about their trauma histories than females, and male staff less frequently assessed for trauma histories than female staff. Clearly, more research needs to be conducted to help identify barriers and facilitators of clinical trainees and licensed providers directly assessing for traumatic exposure and related difficulties.

Patient–clinician relationships also may be impacted by inadequate training and competency for the complex nature of trauma and its consequences. For example, clinicians may inadvertently forge an unhealthy alliance with a patient who experiences high levels of mistrust or strong dependence on the provider due to their trauma history, strategies found to lead to poorer outcomes in treatment (Norcross & Wampold, 2011). Further, in a systematic review, Ellis, Simiola, Brown, Courtois, and Cook (2018) found several studies established a positive association between evidence-based relationship variables and a reduction in symptomology among trauma survivors. Provider burnout, compassion fatigue, vicarious trauma, and secondary or "contact" traumatic stress disorder may also result when working with trauma-exposed individuals who can be highly dysregulated in their interactions and in their lives. To prevent these issues (or at the very least to be aware of their possibility), researchers and clinicians have emphasized the need to adequately prepare for issues that may arise during the therapeutic relationship through training, education, supervision, and consultation in traumatic stress studies (Chu, 1992; Pearlman & Saakvitne, 1995; Salston & Figley, 2003).

What Psychology Students Are Learning and Providers Doing

Multiple agencies have recognized that trauma and its consequences are public health problems requiring specialized training for mental health professionals working with its survivors (Institute of Medicine, 2014; Substance Abuse and Mental Health Services Administration, 2014). This has led to an initiative entitled trauma-informed care (TIC; Bloom, 2013; Clark, Classen, Fourt, & Shetty, 2015; Harris & Fallot, 2001) that has become more widespread nationally and internationally in recent years. It calls for increased recognition of trauma and its consequences in professional service settings and explicitly identifies the need for ongoing organizational and supervisory training and support for providers. Despite all, a number of studies indicate that students are not learning broad-based foundational knowledge about trauma, its consequences, and treatment nor are they learning

evidence-informed practices regarding trauma, a deficit found across all levels of psychology training. Doctoral clinical and counseling psychology programs including their associated internships and practicum appear lacking in trauma focus and trauma education; as a result, practicing psychologists and most psychologists seem ill prepared to treat these issues (Cook et al., 2011).

Graduate-level training in trauma psychology appears to be inconsistent and sparse. In an investigation over 150 doctoral-level programs across the United States, Cook, Simiola, Ellis, and Thompson (2017) found only one in five offered a trauma psychology course and a practicum specifically working with traumatized populations. Similarly, in a separate study of psychology internship programs, Simiola and colleagues (2018) found that although nearly all sites reported at least one training activity (i.e., supervision or didactic) focused on trauma/PTSD, the breadth and depth of training was low, with less than a third of programs offering training opportunities in trauma/PTSD above the median threshold, which was operationalized based on the frequency and range of training activities offered by the programs (i.e., the number of hours and type of didactic training and/or supervision in trauma/PTSD). Further, of the 259 internship programs surveyed, only one third (34.7%) offered training in evidence-based treatments for PTSD. Sigel and Silovsky (2011a) found that although at least one evidence-based treatment for children and families with a history of maltreatment was taught by 89% of graduate psychology courses, only 45% taught the treatment meeting the highest standard of evidence at the time, namely, trauma-focused cognitive–behavioral therapy (TF-CBT). Similarly, in a separate study of 137 psychology internships (Sigel & Silovsky, 2011b), training in at least one evidence-based treatment for maltreatment was provided, with 51% providing training in trauma-focused cognitive–behavioral treatment. This is consistent with the findings from a review of graduate-level coursework in trauma (Gleaves, 2007). A particularly upsetting finding was that much of the coursework on CSA focused on false memories rather than more accurately on the vagaries found in childhood memories and the differences that have been identified in memories for traumatic versus normal events, making it appear that students were being trained to respond with disbelief toward clients who reported CSA (Gleaves, 2007). Further, in an evaluation of undergraduate textbooks, the overwhelming majority lacked key information about childhood maltreatment; namely, many did not present information consistent with current research findings, and focused on controversies in the field (Wilgus, Packer, Lile-King, Miller-Perrin, & Brand, 2016).

In addition, research shows that although practitioners are treating trauma survivors, many have not had sufficient training or may not be engaging in evidence-informed practices but are interested in learning more (Cohen, Mannarino, & Rogal, 2001; Cook et al., 2011). In one study, 78% of providers reported they were never trained in evidence-based treatment approaches for CSA survivors, despite treating such survivors in clinical practice (Czincz & Romano, 2013). Further research demonstrated that despite many mental health clinicians holding favorable views of evidence-based treatments for PTSD, many are not using them in practice despite their proven efficacy (Gray, Elhai, & Schmidt, 2007; Shiner et al., 2013). But, it should also be noted that many clinicians resist evidence-based manualized approaches as too formulaic and prefer to treat their traumatized client using other methods. Commonly cited barriers to the use of evidence-based approaches across settings include inadequate time and resources such as insufficient funds and limited time for training, lack of administrative support including supervision and consultation, and concerns about generalizability of empirical findings to various populations (Cook et al., 2015; Gray et al., 2007; Hanson et al., 2014).

Competencies Needed for Trauma Mental Health Treatment

In April 2013, a national consensus conference entitled, "Advancing the Science of Education, Training and Practice in Trauma" was held at Yale University with more than 60 leading experts in the field of traumatic stress (Cook, Newman, & the New Haven Trauma Competency Group, 2014). The conference was built on the foundation of the APA 2002 Competencies Conference for Professional Psychology (Kaslow et al., 2004), and on the cube model of competency development (Rodolfa et al., 2005). The overarching goal of the conference was to identify empirical and clinical consensus-informed knowledge, skills, and attitudes competencies that mental health providers (e.g., psychologists, psychiatrists, counselors, and social workers) must have when working with trauma-exposed children, adults, families, and communities (these can also apply to those in allied fields of study and service [e.g., police and justice personnel, medical professionals]). These include *foundational* (e.g., scientific knowledge, individual and cultural diversity, ethical, professional, and legal issues) and *functional* (e.g., assessment, intervention) benchmarks for establishing minimal competency standards in trauma mental health across three disciplines (psychology, social work, and psychiatry). Although the trauma mental health competencies differ in content and the specified population (i.e., trauma survivors), the foundational and functional competencies are structurally similar to those of other psychology specialties (Rodolfa et al., 2005), although some might need to be modified or tailored to special populations. The New Haven Trauma Competencies were created such that they may be applied to the varying stages of education and training in psychology (e.g., graduate, predoctoral internship, and postdoctoral fellowship) and were developed as expectations for a psychologist at entry level of practice. They were also discussed in terms of "tiers," with the lowest and more general tier applicable to all mental health professionals including administrators and support staff and more specialized expertise in additional tiers.

Based on previous work on competencies produced by the APA, eight cross-cutting competencies and five broad competencies (*scientific knowledge*; *psychological assessment*; *psychological intervention*; *professionalism*; *relational and systems*) were articulated (Cook et al., 2014). Table 1 includes a description of each of the five broad categories, the number of competencies identified within each domain, and an example of each. A list of the eight cross-cutting competencies is provided in Table 2. This empirically informed trauma competency model, dubbed the New Haven Competencies, was designed to apply across trauma-exposed groups and theoretical stances. It has been approved by the APA as part of its official policy as guidelines for education and training for practice in the United States (APA, 2015). This competency model articulates minimal expectations recommended for a psychologist at entry level to practice in the United States. It was

Table 1
Overview of the Five Broad Core Trauma Competencies

Competency	Definition	Number identified	Example
Scientific knowledge about trauma	Ability to recognize, respect, and critically evaluate up-to-date foundational scientific trauma-specific knowledge and apply it appropriately and ethically to clinical situations	5	Demonstrate the ability to recognize the epidemiology of traumatic exposure and outcomes, specifically: a. Prevalence, incidence, risk and resilience factors, and trajectories b. Subpopulations and settings
Psychosocial trauma-focused assessment	Apply up-to-date assessment measures developed, normed, validated and determined to be psychometrically suitable for use with trauma survivor given any potential unique trauma-specific client presentations	10	Demonstrate the ability to understand the course and trajectory of trauma responses and tailor assessment accordingly.
Trauma-focused psychosocial intervention	Knowledge about the extant science on research-supported trauma interventions including specific evidence about pharmacological treatment and mechanisms of change	11	Demonstrate the ability to employ critical thinking and work collaboratively to tailor and personalize any psychosocial and pharmacological treatment and its pacing with survivors. This approach involves being responsive to particular trauma survivors' trauma type and comorbidities, as well as culture, personality, values, strengths, resources, and preferences within the context of the recovery environment.
Trauma-informed professionalism	Values, skills, and attitudes to work ethically on behalf of trauma survivors both within traditional therapeutic situations and within organizations and systems	5	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, and confidentiality).
Trauma-informed relational and systems	The ability to effectively and conscientiously interact with trauma-exposed individuals, groups, and/or communities	7	Demonstrate the ability to engage in interdisciplinary collaboration regarding traumatized individuals and communities.

Note. Excerpts from this table are adapted from "A consensus statement on trauma mental health: The New Haven Competency Conference process and major findings," by J. M. Cook, E. Newman, and The New Haven Trauma Competency Group, 2014, *Psychological Trauma: Theory, Research, Practice, and Policy*, p. 304. Copyright 2014 by the American Psychological Association.

intended to be aspirational in nature, as opposed to prescriptive or exhaustive.

Several competency or competency-like models for training in trauma have been developed (Bisson et al., 2010; Council on Social Work Education, 2012; Danieli & Krystal, 1989; Hobfoll et al., 2007; Walsh et al., 2012; Weine et al., 2002); however, none of them created minimal standards for work across a diversity of ages and types of trauma survivors or across theories or disci-

Table 2
Eight 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.
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), 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.
5. Demonstrate understanding about how trauma impacts a survivor's and organization's sense of safety and trust.
6. Demonstrate the ability to recognize the practitioners': (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.

Note. Excerpts from this table are adapted from "A consensus statement on trauma mental health: The New Haven Competency Conference process and major findings," by J. M. Cook, E. Newman, and The New Haven Trauma Competency Group, 2014, *Psychological Trauma: Theory, Research, Practice, and Policy*, p. 303. Copyright 2014 by the American Psychological Association.

plines. Other prominent national organizations have identified a need for trauma-informed training among health professionals, such as the National Child Traumatic Stress Network (NCTSN; Layne et al., 2011) and have developed a core curriculum on childhood trauma for social workers (NCTSN Core Curriculum on Childhood Trauma Task Force, 2012; Strand, Abramovitz, Layne, Robinson, & Way, 2014).

General Differences Between APA Trauma Competencies and APA PTSD Guidelines

As stated previously, the competencies were developed at a national consensus conference in 2013 and approved by the APA in 2015 as part of their education and training policy. Though numerous groups were seminal in the funding and produce of the competencies (e.g., Agency for Health Care Research and Quality, the APA Board of Educational Affairs, the Department of Veterans Affairs' National Center for PTSD and National Center for Homelessness), it was largely spearheaded by the APA Division of Trauma Psychology.

Separately, in 2010, the APA initiated a process for producing clinical practice guidelines providing research-based recommendations for the treatment of particular disorders. In August, 2011, the APA Clinical Practice Guidelines Advisory Steering Committee narrowed the focus to depressive disorders, obesity, and PTSD. The APA Clinical Practice Guideline Panel for the Treatment of PTSD in Adults meet for over 2 years reviewing the scientific evidence on the efficacy of interventions, weighing the benefits and harms of interventions, and noting patient values and preferences. The document was approved as APA policy by the Council of Representatives on February 2017 (APA, Guideline Development Panel for the Treatment of PTSD in Adults, 2017b). The APA PTSD guideline is aspirational. There has been tremendous progress in research in how to treat adults with PTSD and was very important to share the consolidated findings with a wider audience. It was intended to be informative, illuminating, and a heavy burden lifted off practitioners to have to do this synthesis themselves. The process was comprehensive, thoughtful, balanced, and transparent. Panel members were an interdisciplinary group from professions including psychology, social work, primary care, and psychiatry—and included consumer members. The clinical practice guidelines are based on the best available evidence at the time and should not, of course, be construed as a standard of care or prescribing a specific course of treatment.

As the APA, Guideline Development Panel for the Treatment of PTSD in Adults (2017b) acknowledge, there still are gaps in the current empirical literature regarding treatment comparisons, evaluation of moderators of treatment effects, inclusion of participants with complicated comorbidities, measurement of potential side effects and harms. Although the research evidence is strong for the efficacy of particular treatments for adults with PTSD, many other treatments are being used or are under development. Those need to be rigorously investigated in future trials.

The APA, Guideline Development Panel for the Treatment of PTSD in Adults (2017b) encouraged providers to be trained in these treatments, and perhaps even receive supervision or consultation in their effective delivery. They noted that it was important to provide traumatized patients with information about these treatments and participate with them in shared decision-making. That is, providers were encouraged to discuss the process and procedures of these treatments, their effectiveness, their risks–benefits, and associated emotional and practical demands.

Although the trauma competency model noted the importance of understanding and utilizing evidence-based assessments and psychosocial interventions for PTSD, competent practice in trauma also requires other unique knowledge, attitudes, and skills. For example, traumas involving interpersonal violence, particularly those that occur during childhood, are important because they can interfere with forming trusting relationships, which in turn can generate, intensify, or change the posttrauma environment and trauma reactions. Working with survivors with severe and prolonged trauma can be both complex and intense and may have negative impacts on the clinician such as burnout, compassion fatigue, or issues of countertransference (Figley, 1995; Salston & Figley, 2003). The competency model included information on understanding of the importance of using relational healing for relational injury (e.g., trustworthiness) and the capacity to use the relationship effectively. It noted the importance of paying 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). The competencies noted the importance for psychologists to have capacity for self-reflection and tolerance for intense affect and content and emphasized the importance of self-awareness of how one's own history, values, and vulnerabilities impact trauma treatment delivery. It covered nuances like how to understand the course and trajectory of trauma responses and tailor assessment and treatment accordingly. For example, the competencies discussed the importance of identifying and understanding the professionals' and clients' intersecting identities (e.g., gender, age, sexual orientation, disability status, racial/ethnicity, socioeconomic status, military status, rural/urban, immigration status, religion, national origin, indigenous heritage, gender identification) as related to trauma and articulating the professionals' own biases, assumptions, and problematic reactions emerging from trauma work and cultural differences. In addition, the competency model noted the importance of sensitively interfacing with legal and other external systems in ways that safeguard trauma survivors and enhance outcomes.

Several of the treatments put forth in the APA, Guideline Development Panel for the Treatment of PTSD in Adults (2017a, 2017b) involve the processing of traumatic material. The competency model noted that it is important for psychologists to know that focusing only on the index trauma that brings individuals to treatment may miss clinically relevant issues associated with exposure to other traumas and can complicate treatment.

Similarly, the competencies noted how the conditions of trauma can create characteristics in many survivors that have been empirically shown to make it difficult for people to participate effectively in the treatment process, such as difficulties with trust and problems of emotion regulation. Psychologists working with such clients should be trained to recognize and address such client characteristics, and also be trained in the development of those practitioner characteristics that have been empirically demonstrated to enhance the likelihood of success with these clients. Thus, the competency model was designed to help psychologists improve their practice with a wide range of trauma survivors including those with complicated presentations and life circumstances.

Trauma Training Issues and Resources

To date, it is unclear how to best train students and practitioners in the trauma competencies; however, numerous efforts are underway to fill an identified need. Data from a survey of more than 2,000 North American psychotherapists found that the three biggest influences for the adoption of new practices were significant mentors or role models, training in graduate school, and informal discussions with colleagues (Cook, Schnurr, Biyanova, & Coyne, 2009). In addition, books addressing treatment issues were identified as considerably more influential than peer-reviewed empirical research articles with respect to changing current practice. These findings have numerous training potential implications, from reaching students early in and throughout the course of their training to creating and disseminating information of evidence-informed and other best practice guidelines for trauma treatment in mental health books.

Thus, in preparation for the New Haven Trauma Competency conference, a survey of 106 published experts from two professional trauma organizations on recommended trauma books and resources was conducted (Cook, Simiola, Newman, & Thompson, 2017). In total, 696 books or resources were recommended by the participants. Of these, only seven different books and one website was recommended by at least 10% of the sample. These are listed in Table 3. Among other things, the number of resources referenced indicates the robust nature of the available information regarding trauma. Information about trauma and its consequences has developed exponentially over the past 40 years, leading to the contemporary development of the field of traumatic stress studies. It is expected that this growth will continue unabated, as the general public is now much more aware of issues of trauma and aftereffects and is increasingly seeking information.

Some trauma scholars have provided detailed information on teaching courses in trauma psychology and implementing trauma clinics within graduate training programs. Newman (2011) described the process of developing an advanced course in trauma psychology. In particular, she discussed how she constructed the course, challenges to teaching the material and proposed solutions, and attention to and the integration of affective responses to trauma stimuli by students. In particular, she noted the importance of normalizing reactions to traumatic material, provided tips for how to counteract the risk of burdening inappropriate self-disclosures, and advocated for the use of a variety of self-care practices.

Relatedly, Butler, Carello, and Maguin (2017) investigated the impact of trauma-related content, stress, and self-care among 195 students in a graduate social work training program at a large northeastern university. Although almost 60% reported no, little, or moderate secondary stress, the rest reported moderate to severe levels of emotional distress in reaction to case material in coursework readings, videos, presentations, and shared stories as well as fieldwork and/or reactivations from their own histories. It is clear that although clinical training and work with trauma survivors can be rewarding, it can also be stressful, distressing, and even damaging. Thus, these authors advocate for, among other things, close supervision, where clinical trainee attunement to their own emotional states challenges is taught.

More specifically, Shannon, Simmelink, Im, Becher, and Crook-Lyon (2014) presented the findings from a subset of graduate students, in a semester-long graduate course on trauma treatment, who self-identified as trauma survivors. Although they tended to report fewer and less intense emotional reactions over time, most of the students explained that they reacted to traumatic course material through the lens of their own traumatic experiences. Many reported being unprepared at the start of the course for the impact the class would have on them. They reported that they wished they had been better prepared for such potential and promotion of engagement in a wide variety of self-care strategies, including not reading course materials directly before going to bed.

In addition to how best to teach trauma material to students, there is an acknowledgment of potential time and resource limitations in teaching a stand-alone course in trauma psychology, particularly in smaller departments. DePrince, Priebe, and Newton (2011) provided a powerful example of how trauma education could be embedded into existing curricula in a sustainable way. More specifically, they included substantive didactic content and opportunity for application on violence against women in a standard research methods course. Students not only showed significant pre–post gains in knowledge of research methods and violence against women, but described caring more and/or working harder in the class because of their perceived importance of the topic. One way to support curriculum change is to use this example

Table 3
Top-Voted Trauma Psychology Resources

Scientific knowledge
- Friedman, M. J., Keane, T. M., & Resick, P. (Eds.). (2007). *Handbook of PTSD: Science and practice*. New York, NY: Guilford Press.
- National Center for PTSD [www.ptsd.va.gov] including PILOTS database
- Herman, J. L. (1997). *Trauma and recovery: The aftermath of violence—from domestic abuse to political terror*. New York, NY: Basic Books.

Psychosocial assessment
- Wilson, J. J. P., & Keane, T. M. (2004). *Assessing psychological trauma and PTSD*. New York, NY: Guilford Press.
- National Center for PTSD [www.ncpstd.org]

Psychosocial intervention
- Foa, Keane, Friedman, & Cohen. (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Publication.
- Foa, E., Hembree, E., & Rothbaum, B. O. (2007). *Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences therapist guide*. New York, NY: Oxford University Press.
- Resick, P. A., & Schnicke, M. (1993). *Cognitive processing therapy for rape victims: A treatment manual* (Vol. 4). Thousand Oaks, CA: SAGE Publications, Incorporated.

as an innovative template for incorporating trauma education into an existing required core course.

Similarly, Gold (1997) described a doctoral practicum placement and internship rotation on the provision of psychotherapy to adult survivors of CSA. He suggested a training curriculum that includes assigned readings, individual and group supervision, and opportunities for trainees to process potential resulting emotional discomfort or distress. Litz and Salters-Pedneault (2008) presented information on the psychology internship training program at the Behavioral Science Division of the National Center for PTSD. This could be used to assist other programs in developing such training experiences or would allow existing programs to compare and contrast practices. Sloan, Vogt, Wisco, and Keane (2015) described a postdoctoral training program in the Department of Veterans Affairs (VA) designed for individuals pursuing academic careers in research on traumatic stress disorders and its treatment and discussed how similar training programs in other settings might be structured.

Interestingly, recent content analysis of three counseling journals from 1994 to 2014 was conducted to determine coverage of traumatic stress topics as well as potential trends (Webber, Kitziner, Runte, Smith, & Mascari, 2017). Though the overall frequency of trauma articles was low, one emerging topic was trauma supervision. Indeed, Knight (2018) provided a discussion of the application of trauma-informed principles to clinical supervision with case examples employed to illustrate significant roles, responsibilities, and tasks in a special issue of the journal *Clinical Supervisor* devoted to trauma-informed supervision.

Though there are excellent models with substantive suggestions for innovative programming, placement, and supervision in trauma mental health, it may not be possible for the majority of current doctoral or internship programs to do this at present. For example, in the national survey of doctoral programs discussed earlier, the two most commonly identified barriers to trauma training were limited capacity for elective courses and limited time and resources (Simiola, Smothers, Thompson, Cook, 2018). For example, because accredited clinical psychology doctoral programs follow a packed, largely APA-recommended curriculum, it would likely be much more feasible, and more effective to incorporate issues of trauma content into already existing courses (e.g., developmental, family studies, psychopathology) as opposed to having faculty teach entire courses in trauma psychology. This would go a long way toward recognizing the ubiquity—and even the normalcy—of traumatic events and experience in human existence, rather than avoiding or denying them, as has previously been the case. Further, it may be innovative to design and offer trauma-related courses outside of the psychology department. For example, interdisciplinary courses partnering with legal/criminal justice, medicine, law, public health/public policy, social work, and religious studies may address trauma.

It is well-known that working clinically with trauma survivors, especially those who were interpersonally victimized, can be challenging to the clinician in many ways. Experts in the treatment of such individuals—who are often diagnosed with PTSD/complex PTSD as well as other comorbidities—emphasize that the quality of the treatment relationship and specific common relational factors enhance the treatment, whatever the modality used (Kinsler, 2017; Kinsler, Courtois, & Frankel, 2009). This use of self may be especially taxing for the therapist working with traumatized individuals, as their relational demands are often more difficult than those experienced with nontraumatized clients. Without specialized knowledge and training about these dynamics and how to manage those, therapists may be very prone to burnout, compassion fatigue, vicarious traumatization (Figley, 1995; McCann & Pearlman, 1990), and even secondary traumatic stress disorder (Sprang, Ford, Kerig, & Bride, 2018). For example, in a sample of psychotherapists working with clients with significant trauma histories, Pearlman and Mac Ian (1995) found that those with a personal trauma history showed more negative effects from the clinical work than those without such a history. Training, education, supervision, and consultation related to trauma can likely prevent some of these negative effects (Salston & Figley, 2003). Importantly, Adams and Riggs (2008) reported that psychology graduate students with trauma-specific training were less likely to report secondary traumatization than those who did not receive such training.

To teach, mentor, and supervise in the field of traumatic stress, special trauma-aware pedagogical skills are required (Carello & Butler, 2014; Newman & Kaloupek, 2009; Zurbriggen, 2011). Carello and Butler (2014) warned that some instructors engage in potentially risky pedagogical practices involving trauma exposure or personal disclosure of one's own trauma history. A trauma-informed approach to teaching that recognizes potential distress and prioritizes student emotional skill and sensitivity in learning is paramount. Suggestions for promoting emotional skill and sensitivity in university classrooms include teaching strategies, self-care, empowerment, and social support (Newman & Kaloupek, 2009; Zurbriggen, 2011). Strategies for research mentoring in trauma studies are also available (Campbell, 2002).

Trauma Training Initiatives and Investigations

Since Courtois and Gold's (2009) seminal call to action for the inclusion of trauma in the curriculum for all mental health training programs, multiple groups have recommended specialized training for health care professionals working with trauma survivors (Cook et al., 2014; Institute of Medicine, 2014; Substance Abuse and Mental Health Services Administration, 2014). In fact, tremendous efforts have taken place over the past 15 years to train providers across many disciplines in evidence-based trauma assessment and treatment. Such efforts are happening in psychology, social work, and other mental health professions both within and outside the United States. These efforts have differed in numerous regards such as terms of amount (e.g., one day, year-long) and type (e.g., general TIC, specific training in an evidence-based psychotherapy for PTSD) of training, participant populations (e.g., social workers, substance abuse counselors), and country (e.g., United States, Germany, New Zealand). A few highlights are shared below.

Short General Trauma Training Evaluations

Some research has been conducted on the effectiveness of trauma-related training on mental health professionals' knowledge, attitudes, and behavior. For example, Cavanagh, Read, and New (2004) presented information on the design and preliminary evaluation of a training program designed to improve confidence and competence in relation to inquiring about sexual abuse, and responding to disclosures. Participants reported that the program was

highly valued. In addition, for a proportion of the staff, the program was effective in improving participants' confidence, knowledge, and some beliefs, as well as improving actual clinical practice. Relatedly, in a statewide needs assessment of North Carolina mental health professionals, those who had received any training in domestic violence reported engaging in more comprehensive assessment and intervention practices (Murray et al., 2016).

After a 1-day trauma-informed training, the vast majority of practicing mental health participants reported that they had gained knowledge and skills to inquire about abuse and respond to disclosure in the appropriate way (Donohoe, 2010). Another study examined the impact of the curriculum-based trauma-informed training on the knowledge, beliefs, and behaviors of 261 staff trainees in 12 trainee groups at five child congregate care agencies (Brown, Baker, & Wilcox, 2012). After completion of the training, trainees reported significant improvements in knowledge about the core concepts of the training as well as favorable beliefs toward and behaviors congruent with TIC. An additional investigation evaluated the effectiveness of a trauma-informed training program for more than 200 professionals employed at child advocacy centers in Florida (Kenny, Vazquez, Long, & Thompson, 2017). The workers' trauma-informed knowledge significantly increased after training and was maintained at 12-month follow-up. However, the authors advised that training efforts should be conducted frequently to ensure that workers get repeated exposure to the trauma-informed information and model.

A cluster-randomized trial compared a 1-day trauma-informed training intervention, combined with a refresher session, with a waiting control group, in 148 professionals working in 27 outpatient substance use disorder centers in Northern Germany (Lotzin et al., 2018). Providers' knowledge, positive attitudes toward and confidence in trauma assessment and response significantly increased in the intervention group than in the control group at 3-month and 6-month follow-up. Participants perceived learning basic rules of asking about traumatic events and practicing asking about trauma in role plays as most helpful, indicating these may be particularly helpful for future training efforts.

Interestingly, a multicenter, cluster-randomized controlled trial is currently being conducted to improve detection of and response to domestic violence in psychiatric patients by 24 community mental health teams from Rotterdam and the Hague (Ruijne et al., 2017). Twelve teams are receiving knowledge and skills training for mental health professionals about domestic violence, and provision and implementation of a referral system between community mental health and domestic violence services. The investigators hypothesize that the teams who receive the active training condition will increase the rate of detected cases of recent or any history of domestic violence in patients. In addition, information will be collected on the feasibility, sustainability, and acceptability of the intervention. If the findings from this educational intervention are positive, it could serve as model for other practitioners.

Longer General Trauma Training for the Treatment of Children

In 2007, the NCTSN convened a task force of traumatic stress experts to develop the *Core Curriculum on Childhood Trauma*, which was intended to increase training in TIC at the graduate school level and beyond (Layne et al., 2011). These competencies led to the development of the "National Center for Social Work Trauma Education and Workforce Development" (n.d.) in 2009 which has disseminated its curriculum to more than 650 schools of social work to date. Factors contributing to successful implementation of this innovative trauma-informed educational model in social work included organizational leadership, shared commitment, and strong partnerships/collaborations (Popescu, Strand, Way, Williams-Hecksel, & Abramovitz, 2017).

Training in Evidence-Based Psychotherapies for PTSD

Several studies have examined the most effective strategies for training mental health providers in evidence-based psychotherapies for PTSD and trauma-related issues. Broad dissemination of evidence-based psychotherapy efforts took place in Manhattan in the wake of 9/11 for the psychological sequelae of terrorism (Amsel, Neria, Marshall, & Suh, 2005; CATS Consortium, 2007) and Hurricane Katrina (Norris & Bellamy, 2009) for the complicated sequelae of the weather disaster. Other networks such as state welfare systems (Kramer, Sigel, Conners-Burrow, Savary, & Tempel, 2013) and pediatric health care systems are implementing evidence-based training.

One massive training initiative that began prior the APA PTSD Guidelines publication but aligns with the recommendations put forth has been conducted in the VA. Beginning in 2006 and 2007, the VA invested significant resources to provide their mental health workforce with training, supervision, staffing, and implementation support for two Evidences-based Psychotherapy (EBPs) for PTSD: prolonged exposure (Foa, Hembree, & Rothbaum, 2007) and cognitive processing therapy (Resick, Monson, & Chard, 2016).

Training, as well as a variety of other strategies including mandates, provision of organization-level support through involvement of champions, mentors, or supervisors, and an assessment of organizational culture influenced the adoption of evidence-based psychotherapies for PTSD in the VA (Karlin et al., 2010). The adoption of these EBPs has been variable, ranging from high to low, across the VA outpatient PTSD teams (Sayer et al., 2017). However, in a longitudinal investigation of VA residential PTSD treatment programs across the United States, 26 out of 36 programs achieved high adoption of cognitive processing therapy and/or prolonged exposure by the end of a 7-year period (Cook et al., 2019). Although there are opportunities for improvement, the findings from residential settings are relatively encouraging in regard to the implementation and sustained adoption of EBPs for PTSD.

Efforts to disseminate and implement EBPs for PTSD in children and adolescents have also taken place. For example, Allen, Wilson, and Armstrong (2014) found that clinicians trained in TF-CBT reported a significant and large changes in their beliefs toward holding a more structured/directive approach to treatment, as well as that children have the ability to verbally describe their traumas. Clinicians who did not receive such training did not report changes in their beliefs. In another study of more than 400 providers from agencies across 26 states who sought treatment in TF-CBT, more than half of participants endorsed beliefs consistent with the importance of obtaining competent training and supervision to use treatment manuals to guide treatment with child trauma

survivors, and nearly all (87%) reported having access to training (Kolko, Cohen, Mannarino, Baumann, & Knudsen, 2009). Relatedly, Kolko and colleagues (2012) conducted a randomized controlled trial of training strategies and demonstrated that the use of workshop training and consultation in a cognitive–behavioral therapy for families resulted in greater knowledge and use of the treatment than training as usual.

In the APA PTSD Guidelines, clinicians are encouraged to obtain specialized training in EBPs, often consisting of a multiple day, in-person or online training and at least 6 months of consultation/supervision by a content expert to increase adherence and promote intended outcomes. However, these trainings can be time and resource intensive, which may impact clinicians' ability to attend.

National and International Resources to Help With Trauma Training

Established in 2006, the Division of Trauma Psychology was founded within the APA to serve as a central resource for clinicians, researchers, educators, and policymakers who work with trauma and its effect. In addition to numerous publications and social media, the Division has been active in articulating and disseminating education and training resource on trauma. For example, on their website (www.apatraumadivision.org) there are numerous resources such as general tips for educating students about trauma, example syllabi provided as guides for those teaching trauma-related courses and seminars, lists of graduate programs and training sites that are focused on providing trauma-informed curriculum, and information on how well textbooks cover trauma-related issues. In addition, the Division's website offers an expert-reviewed mental health mobile phone application database. This database provides substantive information on over 40 apps for iOS and Android systems and may assist practitioners in augmenting the use of these self-help strategies in their service delivery. In alignment with the APA PTSD Guidelines' (APA, 2015) suggestion to integrate cultural competence and diversity into trauma treatment, they also offer web-based empirically informed materials (i.e., printable fact sheets, YouTube videos, and suggested reading lists) on trauma and its impact in underserved health priority populations, including sexual and gender minorities, racial/ethnic minorities, and economically disadvantaged populations that can serve as valuable resources for mental health trainees and practitioners. Similarly, the International Society of Traumatic Stress Studies and the International Society for the Study of Trauma and Dissociation provide assessment tools, briefing papers, guidelines, self-care resources, practitioner tools, and manuals available to enhance trauma knowledge and training.

Several other national trauma organizations exist and include in their mission the dissemination of evidence-informed information about trauma and its treatment. For example, the National Center for PTSD (NC-PTSD) offers evidence-informed online lectures, training programs, and videos through their website (www.va.ptsd.org). In addition, the NC-PTSD developed an online PTSD Treatment Decision Aid to assist those with PTSD, their families, and other health care providers in learning about several mental health treatment options (https://www.ptsd.va.gov/public/treatment/therapy-med/ptsd_treatment_decision_aid.asp). This tool contains videos of providers explaining how these treatments work, allows the consumer to build a chart to compare the treatments they like the most, and prints a personalized summary. Also, NCTSN offers evidence-informed online lectures, training programs, and videos through their website (www.nctsn.org). The materials from the NC-PTSD and NCTSN can aid health care students and professionals in providing state-of-the-art assessment and treatment. Other professional organizations also offer conferences and webinars devoted to trauma and its various treatment topics (e.g., American Professional Society on the Abuse of Children; the International Society of Traumatic Stress Studies; the International Society for the Study of Trauma and Dissociation). All of these organizations offer continuing education offerings, as well as training programs. Some even have supervision and certification—that have developed for various treatment models, some of which are evidence-based and others evidence-informed.

In addition, trauma trainings are often available from psychotherapy treatment developers. Some of these treatments are evidence-based, others are evidence-informed and some are evolving and do not yet have evidence to support their efficacy. The range of training opportunities is plentiful and can be confusing and perhaps even overwhelming for clinicians. Ironically, at present, there is quite a lot of continuing education training in trauma treatment and some of it is heavily advertised. Clinicians may want to be cautious and deliberate in their choice of offerings, and how they expend their time and money.

Furthermore, trauma training and treatment must be culturally sensitive (Weine et al., 2002), which includes understanding and addressing the historical, cultural, political, and spiritual context of trauma exposure and the recovery environment. This includes understanding the intersectionality of identity and the trauma response. Further providers must understand the organizational culture in which trauma and intervention occurs, including its resources and limits (e.g., military culture, first-responder culture, legal context, public health).

Lastly, trauma training and treatment involve ethical standards (Cook et al., 2015). For example, it is imperative that clinicians recognize and reconcile ethical and legal issues with trauma-exposed individuals; know when to seek out information on ethical, legal, diversity, and policy issues; and respect the client's capacity to engage in decision-making in ways that are empowering. Clinical practice with trauma survivors ought to be conducted with personal and professional self-awareness and reflection, with awareness of competencies, and with appropriate self-care. Clinicians need to respect client's welfare and willingness to participate in treatment and the potential damage (to the client and others, including the therapist) that can be wrought by an uninformed practitioner. It is imperative not to engage in harmful practices that can harm trauma survivors at the hands of untrained, uninformed, or even pejorative and hostile practitioners, across professions. Core training on trauma incorporated into the curriculum from its start to finish would assist in changing this situation. Training must also address the stigma from practitioners and organizations that many survivors experience in seeking treatment. Principles of TIC are therefore also important to incorporate.

Conclusion

In conclusion, the APA trauma competencies predated the APA PTSD Guidelines, and focused on broader foundational trauma

knowledge necessary for all forms of practice, not solely treatment. The competencies are much broader and cover what five competency and several cross-cutting categories. Although we are believe the APA PTSD Guidelines were an important and necessary step, additional knowledge, skills, and attitudes are necessary for trauma-informed practice.

Although significant progress has been made since the call to action for better trauma mental health training and implementation, there is still a need for basic training about trauma psychology in general, and the needs of the traumatized, whatever the treatment used. We echo the continued call that psychology students, researchers, educators, and practitioners obtain minimal competencies in working with traumatized populations, including working with those with dissociative symptoms (Brand, 2016). And, as Ko and colleagues (2008) pointed out traumatized individuals interact with many different professionals and para-professionals beyond the health care fields. These include, but are not limited to, educational settings, first responder, and criminal justice systems. As trauma-informed mental health researchers, educators, and clinicians, it would be helpful for us to engage in advocacy for trauma survivors in these other vectors as well as with the public (Cook, 2018). This is happening in a number of ways. For example, a new organization, "Campaign for Trauma-Informed Practice and Policy" (n.d.) has made considerable progress in the national legislative arena, and organizations, such as the Institute on Violence, Abuse and Trauma, have developed interagency sponsorship for various policy and practice initiatives. Also, several additional new journals have been developed and quite a large number of national and conferences are now devoted to scientific findings and treatment approaches. There is also cross-cutting work occurring that unites different specialities and fields (e.g., addictions and trauma, primary care and trauma, infant mental health and trauma, and public health and trauma). One important consideration is tackling if clinicians have adequate or organized pretraining in trauma. Students, practitioners, researchers, and the public need access to reputable, validated information on the effects of and recovery from trauma. Numerous national and international resources exist to help with general trauma training as well as dissemination and implementation of evidence-based psychotherapies for PTSD.

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Received March 7, 2019
Revision received March 30, 2019
Accepted March 31, 2019 ■