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ABSTRACT

UNDERSTANDING THE LIVED EXPERIENCES OF COUNSELORS-IN-TRAINING IN A TRAUMA CERTIFICATE PROGRAM

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Northern Illinois University, 2022
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Psychological trauma is common in mental health, the recent pandemic, the ongoing social justice issues, and the sociopolitical environment add to an already high rate of trauma in the general population. The literature revealed a paucity of adequately trained trauma counselors across the mental health field. Many counseling programs do not offer specialized training despite the prevalence of trauma. Further, the literature revealed that many counseling programs have a training clinic at the university that serves the campus community. The prevalence of trauma in the general community, the prevalence among university students, the likelihood of a clinic at the university, and the ongoing social issues we all face is why counseling programs should offer this training. This qualitative phenomenological study explores the lived experience of trauma counselors-in-training. The midwestern university, where this study took place, is one of few that has a trauma certificate. This study was designed to learn about the students' lived experience, to learn about how secondary traumatic stress, vicarious trauma, and burnout may affect trauma counselors-in-training. Further, this study was designed to fill a gap in the literature to help define what trauma counselor training is, how trauma counseling can be taught to a potentially traumatized student, and to explore the asynchronous nature of this specialized training. Conclusions are drawn from general themes that emerged from the study and

recommendations are made for the field of trauma counseling, future course design, research, supervision, and future teaching.

Keywords: traumatic therapeutic alliance, trauma counselor training, trauma supervision, trauma counseling, phenomenological qualitative study

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DE KALB, ILLINOIS

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UNDERSTANDING THE LIVED EXPERIENCES OF COUNSELORS-IN-TRAINING IN A TRAUMA CERTIFICATE PROGRAM

BY

MIKE CAVERLY
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A DISSERTATION SUBMITTED TO THE GRADUATTE SCHOOL

IN PARTIAL FULFILLMENT OF THE RERQUIREMENTS

FOR THE DEGREE

DOCTOR OF PHILOSOPHY

DEPARTMENT OF COUNSELING AND HIGHER EDUCATION

Doctoral Director:
Adam Carter

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CHAPTER I

THE PROBLEM

A 2016 survey administered in 24 countries across six continents, including the United States, revealed that 70% of participants reported at least one traumatic event in their lifetime; 30% reported four or more traumatic events during their lifetime (Benjet et al., 2016). Post-Traumatic Stress Disorder is defined by the *Diagnostic and Statistical Manual 5*, also known as the DSM-5 (American Psychological Association [APA], 2013) as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or close friend; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s). (p. 456)

Sadly, these statistics may not accurately represent the actual prevalence of trauma in society as a whole today, as these statistics do not encompass the global COVID-19 pandemic, which has significantly impacted every country in the world. At the time of the writing of this dissertation, more than 430 million people had contracted the virus and roughly six million people had died from Covid worldwide; in the U.S., nearly 80 million cases were reported and 941 thousand deaths (WHO, 2022).

Furthermore, since 2016, people living in the United States have experienced unique

forms of trauma. The 2016 election cycle heightened the political polarization in America. The murder of George Floyd that energized the Black Lives Matter movement has heightened awareness of the violence perpetrated on Black msen in particular and people of color in general in American society (Eichstaedt et al., 2021). The insurrection of January 6, 2021 caused trauma not only for the Capitol police (Dominus & Broadwater, 2022) and members of Congress (Kane et al., 2022), but also for many Americans who witnessed the events through news coverage (Nissen, 2021). Further, the current COVID-19 pandemic, the required social distancing, the murder of George Floyd, and many issues that will occur may be traumatizing the entire world and this adds to an already prevalent population of trauma survivors.

Trauma is also prevalent in mental health counseling (Isawi, 2016; Land, 2018; Substance Abuse and Mental Health Services [SAMHSA], 2014). Mental health counselors are often exposed to secondary trauma through their counseling work; this trauma is compounded by the trauma they experience in their own lives. Mental health workers are struggling to meet the overwhelming demand for services (Caron, 2021). Much of this is attributable to the pandemic, which has contributed to the increased demand for services and also exacerbated secondary trauma for healthcare workers, including counselors (Muller et al.,2020; Prasad et al., 2021).

Statement of the Problem: A Lack of Training

Despite the prevalence of trauma, research shows that just 38.8% of participants received more than one year of trauma counseling training during their Master's of Counseling degree program (Isawi & Post, 2020). Fewer than 30.0% of the Licensed Clinical Social Workers (LCSW) reported trauma training during their degree (Layne et al., 2011). Kumar et al. (2019)

found that 68.1% of participants reported not feeling adequately trained in assessing clients with a history of trauma and 75.3% reported that they did not feel adequately trained in the treatment of trauma following an assessment. There appears to be a general lack of adequate training across mental health professions, as evidenced by 64.0% of practicing psychologists requesting more training on trauma counseling (Cook et al., 2019).

Despite the prevalence of trauma in society and the probable increase in traumatic experiences due to the current environment in the U.S., counselors-in-training (CITs) are not adequately trained in trauma counseling during their degree programs (Isawi & Post, 2020; Land, 2018). However, it is unrealistic to hold Counseling Education and Supervision (CES) programs to the standard that all the students are ready to become trauma counselors.

The Importance of Teaching Trauma in Master's Programs

One could argue that trauma counseling should be taught following the Master's of Counseling degree program, giving students more experience actually doing counseling before starting the specialized training. This argument is based on two assumptions; first is the delicate nature of trauma counseling and second are the relational skills that are needed to develop a strong therapeutic alliance (Schore, 2012; Siegal, 2012). However, there are five compelling reasons to include trauma training in Master's of Counseling programs. First is the issue of meeting accreditation standards of Accreditation of Counseling and Related Education Programs (CACREP) accreditation. Second is the prevalence of trauma in counseling at university clinics (Benjet et al., 2016; CCMH, 2019; SAMHSA, 2014). The third is the increase in trauma in U.S. society and the world. Fourth is the ethical mandate to no harm (ACA, 2014; CCMH, 2019;

Lauka et al., 2014). Finally, the skill set needed to do trauma counseling and the ethical context of training a CIT that may have their own history of trauma.

CACREP Accreditation

First, the CACREP sets standards that "crisis, disaster, and trauma" when teaching CITs about human growth and development (p. 3). The accreditation standards require that Master of Counseling programs teach students about "crisis intervention and trauma-informed" strategies when teaching students about counseling and helping relationships (p. 12). Accreditation also requires programs to teach students about the "procedures for identifying trauma" within assessment and testing (p. 12). Trauma is mentioned in the standards a total of seven times; thus, CACREP clearly requires counseling programs to teach students about trauma. Thus, the first reason that trauma counseling should be taught during the degree program and not following it is that CACREP requires it under the standards (CACREP, 2016).

While many CES programs seek CACREP accreditation, not all programs seek accreditation or are even ready to seek accreditation (CACREP, 2016). Thus, this argument is focused on the CES programs that seek CACREP accreditation; however, CACREP standards for teaching about trauma counseling are currently in development (L. Land, personal communication, 5 April, 2020).

CES programs may teach trauma content, or it is being integrated it into classes that already exist to meet the requirement to teach trauma during the degree (CACERP, 2016). However, some researchers argue this approach may not be beneficial (Deprice & Newman, 2011). Others suggest such an approach may lead to wide variability in quality and outcomes,

evidenced by studies of counselors who report inadequate training on trauma during their degree programs (Isawi & Post, 2020; Land, 2018).

Many counseling programs have CACREP accreditation, resulting in one of three strategies for meeting the CACREP standard to teach trauma. First, some programs do in fact cover trauma counseling during the degree program. Isawi (2016) studied perceptions of training, finding that 40.0% of participants did not feel adequately prepared as a result of their degree to do trauma counseling. Furthermore, the programs that the participants attended may have taught trauma counseling with wide variability and quality. This limitation should be considered when developing trauma training or educational content about working with clients who have experienced a trauma.

Second, CACREP accredited programs are providing training but it is infused in a program, and this can be problematic (Deprice and Newman, 2011). More likely, CES programs are in fact covering trauma in their programs and infusing the knowledge in the coursework already provided (Deprice and Newman, 2011). However, the problem with infusing trauma into the course work, is that there is little information about how to infuse trauma into courses, scant information about the best practices of teaching trauma, and there is little information regarding trauma training (Adams, 2019; Black, 2006; Deprice and Newman, 2011; Isawi & Post, 2020; Land, 2018). This context could be considered as well when CES programs develop trauma related content.

Third, trauma is being taught to CITs during the practicum courses while they are likely seeing traumatized university students at their counseling training clinic (Center for Collegiate

Mental Health, 2019; Lauka, et al., 2014). While this infusion is likely common, the concerning issue is that students may not be prepared to manage the effects of vicarious trauma, secondary traumatic stress, and burnout (Butler et al., 2016; Jenkins et al., 2017; Sommer, 2008).

Furthermore, the concerning issue is that trauma is on the rise at university counseling centers (CCMH, 2019). The CITs may be treating traumatized clients at their training clinic, as the literature reports that "at least 60% of the clients [at the training clinic] are university students" (Lauka et al., 2014, p.11). The CCMH (2019) study reports that 41.4% of university students are reporting a history of trauma.

The literature does suggest that many CES programs (58%) have training clinics at the university and many may be seeing university students (60%) that are reporting a history of trauma (41.4%). Thus, there may be some university students attending these training clinics and CITs need to be prepared to do trauma counseling because of the rise in trauma in the university student community (CCMH, 2019).

While this infusion is likely common, the concerning issue is that CITs may not be adequately prepared to do trauma counseling in their practicum because of the lack of training (Adams, 2019; Isawi & Post, 2020; Land, 2018). Best teaching practices should be created in order to meet the apparent prevalence of clients that present with a history of trauma (Benjet et al., 2016; Kilpatrick et al., 2013). Especially, given that "at least 60%" (Lauka et al., 2014, p.11) of the clients attending CES counseling training clinics are university students (Lauka, et al., 2014), many of whom (41.4%) report a history of traumatic experiences (CCMH, 2019).

Trauma in University-Based Practicum Clinics

This leads to the second reason that trauma counseling needs to be taught during the degree, and likely, prior to the practicum. Because of the percentage of university students that have experienced a trauma (41.4%; CCMH, 2019) and because of the percentage of university students that attend CES training clinics, 60% (Lauka et al., 2014, p.11). In other words, CITs are likely going to work with a university student that have experienced a trauma and it would be ideal if they did so from a trauma informed lens because of the prevalence of trauma at universities among university students (CCMH, 2019; Lauka, et al., 2014). This context should be considered as well when making decisions about trauma counseling training. This also raised an important issue: the current pandemic and sociopolitical issues facing our society. This is discussed in the next section.

Increased Trauma in Society

The third reason addresses the current environment affecting the world. The experiences of the COVID-19 pandemic may result in traumatic experiences for health care workers and first-responders (Muller et al.,2020; Prasad et al., 2021). Social isolation has affected virtually everyone. Social distancing is not normal for humans; our brains are wired to socialize and to engage in human contact (Grawe, 2006). Furthermore, Schneider (2020) argued that social distancing, the fear of death, and the many other deleterious effects of the pandemic have left many with a sense of "groundlessness" that has "shaken us out of the routine and familiar, a tear in the fabric of what is known, and that can be horrifying." While CES programs cannot be held responsible for a pandemic or the many traumatizing effects of the pandemic, coupled with

myriad other current issues facing our society, create an important context that must be considered when creating trauma counseling training. We do not fully understand the nature of the “new normal” that will emerge as we move beyond the pandemic, but it will undoubtedly entail healing significant trauma.

It is also likely that CITs will work with a traumatized client following their degree, due to the prevalence of trauma in the general population (Benjet et al., 2016; Kilpatrick et al., 2013; SAMHSA, 2014) and due to the potentially traumatizing effects of the current pandemic, the murder of George Floyd, the other incidents involving Breonna Taylor, Daunte Wright, and many other black Americans who have been mistreated by law enforcement. While teaching during the degree is important, it could be argued that trauma can be taught prior to the practicum because of the likelihood that CITs will work with a traumatized university student at the training clinic (CCMH, 2019; Lauka, et al., 2014).

Ethical Context for Clients

The fourth reason trauma counseling needs to be taught during the degree, and ideally, prior to practicum, is because of the ethical context to do no harm (American Counseling Association, 2014). Black (2008) argued that psychological interventions can be traumatizing in and of themselves, and although this is rare, re-traumatization of a client is a risk for the untrained counselor (Malloux, 2013). The lack of adequate training that takes place in the current programs (Cook & Newman, 2014; Cook, et al., 2019; Isawi, 2016; Isawi & Post, 2020; Kumar, et al., 2019; Land, 2018) and the risk of re-traumatizing clients (Mailloux, 2013) could also violate the beneficence principle to act in the best interest of the client (ACA, 2014). Further,

Adams (2019) argued that the lack of adequate training means that CITs may be forced to operate out of the scope of their practice because they are not trained in trauma counseling. Therefore, there is an ethical context that can be included when considering trauma training for CITs that may work with clients that have experienced a trauma.

There are many reasons that trauma counseling should be taught during the degree. First it is the overall prevalence of trauma in counseling (Benjet et al., 2016; CCMH, 2019, SAMHSA, 2014). That is one reason in of itself. However, those CES programs that have or are seeking CACREP accreditation, should teach that trauma during the because the CACREP (2016) standards require it. The third reason is to do no harm because the of the rising prevalence of trauma at universities and the likelihood that the CES program has a training clinic (ACA; 2014; CCMH, 2019; Lauka, et al., 2014). Moreover, the current pandemic, the many deleterious effects, we are experiencing is the fourth reason that counselors should be taught about trauma during their degree. However, there are other ethical considerations to consider. The skill set needed to do trauma counseling and the ethical context of training a CIT that may have their own history of trauma.

Ethical Context for CITs

The ethical mandate to do no harm also applies to the CITs themselves (ACA, 2014). CITs themselves may have experienced trauma, ranging from 33.0% of trauma workers (Jenkins et al., 2106) to 44.8% of LCSW students (Butler et al., 2017). While these statistics are not specific to CITs, they may be reflective for students who decide to enroll in a graduate program in counseling, bringing their own history of trauma as a primary motivation (Jenkins et al.,

2106). Thus, there needs to be some intentionality on how to teach "trauma without traumatizing" the CITs (Black 2008, p. 22). Additionally, CITs are often not emotionally prepared to distance themselves to prevent becoming too invested in their client's story. Furthermore, CITs may not know how to empathize without fully experiencing the client's trauma. This requires strong training; which some programs are not providing (Adams, 2019; Isawi & Post, 2020; Land, 2018; Law, 2012).

The ethical context thus becomes two-fold: to do no harm to clients and to do no harm to the CITs. To do no harm to clients, CITs need to be trained in best practices in trauma counseling before entering their practicums, where they will likely see a university student that has experienced a trauma (CCMH, 2019; Lauka et al., 2014; Land, 2018; Mailloux, 2013). Second, training must take into account the potential that the CITs themselves are bringing trauma into the classroom.

CIT Motivation

Jenkins et al. (2016) examined sexual assault and domestic violence professionals and their primary motivations for doing trauma work. This study reported that it was the only published article that examined the motivation for doing trauma work. The participants had either a Master's degree (46.5%) or a Bachelor's degree (36.6%) in a mental health field (62.4%). A third (33.0%) of participants were survivors of or new a survivor of domestic violence or sexual abuse. These participants reported that their own history of trauma was their primary motivation for doing trauma work. In other words, in a class of 25 students, that would mean

that just over eight of those 25 students have their own experience of trauma (Jenkins et al., 2016).

While it is not valid to simply assume that 33.0% of CITs have experienced trauma, this is a good indicator of how many CITs may have experienced trauma before enrolling in a CES program. This study suggests that some CITs may enroll in counseling programs motivated directly by their own history of trauma. Further, it is important that all students, regardless of a history of trauma, are taught trauma counseling ethically (ACA, 2014).

Although there is not much literature on how many students enroll with this primary motivation (Jenkins et al., 2017). This creates a need for special consideration for trauma counseling training, especially given that the trauma certificate is asynchronous. CES programs should create trauma training from a trauma-informed lens and with consideration that CITs may have their own experience with trauma (Black, 2008; Jenkins et al., 2017). Furthermore, Sommer (2008) argues that CITs need to be prepared to manage burnout, secondary traumatic stress, and vicarious trauma; this may be different for a CIT with a history of trauma. Finally, CITs and counselors are not immune to trauma and designing the trauma counseling training with this in mind because of the prevalence in the general community (Benjet et al., 2016; Kilpatrick et al., 2013), the possible prevalence in CES programs (Butler et al., 2016; Jenkins et al., 2017), and because taking a trauma-informed lens to doing trauma counseling and/or teaching about trauma does not hurt anyone.

Teaching Trauma While Not Traumatizing CITs

Psychology and counseling programs have many different expectations and requirements during and following graduation. Thus, CIT-specific trauma training needs to be explored here. Most of the literature focuses on psychology but has important implications for counseling programs. Black (2008) proposed three main strategies to prevent traumatization in psychology courses addressing the treatment of trauma. The goal was to help manage the emotional impact of learning about traumatic material during training.

The first strategy is creating a "personal choice and sense of control" that forms the foundation of the class (Black, 2008, p. 268). A norm was set where students were told when potentially traumatic material would be presented; students were encouraged to leave class if needed. However, they were also told that exposure to potentially traumatic material is necessary to learn about trauma counseling; but, becoming emotionally overwhelmed was acknowledged as not being helpful to learning about trauma counseling. The connection to CIT trauma training is obvious; CIT programs should provide students with trigger warnings and behavioral strategies for managing them while emphasizing the importance of meeting trauma face-to-face in the curriculum.

The second strategy Black (2008) suggested was to provide "in-class resourcing," which used calming pictures to help the students focus on something else; he argued that funny videos could be played to help manage the emotional experience of learning about trauma (p. 269). This is also called "titration of exposure," the idea that traumatic material can be presented in small

doses, returning to a calmer space to help ground the students and manage the emotional experience of traumatic material (p. 269).

The third strategy Black (2008) suggested was “reciprocal inhibition.” Similar to titration of exposure, this technique entails exposure to trauma and reprogramming the response to trauma (p.269)” Black (2008) advocated that “pairing relaxation with exposure is designed to remove the power of the trauma response and replace it with the more adaptable relaxation response” (p. 269).

Teaching in this way can help model the ways of using these concepts in counseling, but this also highlights the need for psychological safety and control in the counseling process, which are key to trauma treatment (Cozzolino, 2016; Schore, 2016; Siegal, 2012). Teaching in this way also provides a sense of control over the trauma course, for a group of CITs that may be traumatized, and their own history may be their primary motivation for enrolling in a counseling program (Butler et al., 2017; Jenkins et al., 2016).

Purpose Statement

The purpose of this study was to explore the lived experience of learning trauma counseling. What was the lived experience of participants in an asynchronous online trauma certificate? This research question was sensitive to the potential experience some participants may have with trauma, as Butler et al., (2016) found 44.8% of LCSW students experienced a potentially traumatic event. Although these are not master or counseling students, they are LCSW students that may share some common traits (altruism, value for education, social justice, etc.)

Next it is important to discuss the mode of instruction. As the trauma certificate program for this study was completely online in an asynchronous format. The existing literature on counselor training models online were explored and implications for this study are presented. The qualitative study used a phenomenological design (Moustakas, 1994). The participants were CITs that are enrolled in a Master of Counseling program and the trauma certificate program, including four classes, at the Midwestern university.

Research Question

What was the lived experience of participants in an asynchronous online trauma certificate? Some CITs may have a history of trauma, Butler et al., (2016) found 44.8% of LCSW students experienced a potentially traumatic event. Although these were not master of counseling students, they were LCSW students that may share some common traits (altruism, value for education, social justice, etc.). Further, Jenkins (2016) found 33% of trauma workers were primarily motivated by their own history of potentially traumatic event(s). Thus, the trauma certificate may exacerbate some students that have their own history of trauma and trauma can be taught without traumatizing the CIT (Black, 2006).

This begs the question, what was the lived experience of learning trauma counseling? It begs the question because the lived experience of learning trauma counseling, may have significant outcomes for CITs, as CITs that may have experienced their own trauma, may learn trauma counseling in a different way than a CIT that may not have experienced a trauma (Butler et al., 2016; Jenkins et al., 2017). Further, learning more about the lived experience of a Masters of Counseling program, is something that is always valuable to CES. As the program itself, can

be a transformative experience (McAulffie & Eriksen, 2011). The central research question and research design are discussed more in depth in chapter three.

Significance of this study

The significance of the study is in three distinct parts. First, there is a significance for clients that may be seen at the CES training clinic and on the CITs who only work at the university clinic during their practicum. However, this is only speculative at this stage. Because the potential direct effects of the study, may have clinical benefits, this study will not collect data from clients and the significance is only speculative and potential at this stage. The significance here is also around the ethical context to do no harm to the client that presents to the counseling training clinic. The significance of this study is also in the training of counselors that are simply not trained in how to do trauma counseling (Cook & Newman, 2014; Cook, Newman & Courtois, 2019; Isawi, 2016; Isawi & Post, 2020; Kumar, et al., 2019; Land, 2018). Providing adequate training to counselors in trauma is significant, because of the prevalence of trauma in our society (Benjet et al., 2016; Kilpatrick et al., 2013; SAMHSA, 2014).

The second part of the significance of the study is about the CITs. If 33% of CITs have experienced a traumatic event, then that would mean that in a class of 25, just over eight of the CITs have a history of their own trauma (Jenkins et al., 2016). The significance here is around the ethical context to do no harm to the CIT. To provide adequate training so they can manage vicarious trauma, secondary traumatic stress, and burnout. Studies suggest that those with their own history of trauma can learn to manage vicarious trauma, secondary stress, and burnout (Jenkins et al., 2016).

The third part of the significance of the study is concerning current affairs and the COVID-19 pandemic (Silver, 2020). The pandemic has shined a light on the oppression of marginalized groups in society, the lack of health care options, the prevalence of subtle racism, and the differences in power and privilege. The Black community has experienced awful police brutality for far too long and the black community has been hit hard by COVID-19 (Blow, 2020). Black men are afraid to adhere to the Center for Disease Control guidelines to wear masks to prevent the spread of COVID-19 because of fears of being confused for a criminal (Taylor, 2020). Again, social distancing, the fear of death, and the many other deleterious effects of the pandemic have left many with a sense of “groundlessness” as said Schneider (2020) in his podcast.

Overall, the significance of this study is concerning a world that is likely being traumatized by the pandemic and the many effects it has on our society. The world is going to need strong trauma counselors to meet the need that may arise following the end of the pandemic and the issues that will arise in the future.

Definition of Terms

Trauma

Trauma is defined by the Diagnostic Statistical Manual 5 (APA, 2013) as “exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) directly experiencing the traumatic event(s); (2) witnessing, in person, the event(s) as it occurred to others; (3) learning that the traumatic event(s) occurred to a close family member or

close friend; (4) experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (p. 456).

Counselors-in-Training (CITs)

Counselors-in-Training (CITs) are defined as students currently enrolled in a Master's of Counseling .

Counselor Education and Supervision (CES)

Counselor Education and Supervision (CES) is the development of professors and supervisors who have knowledge and skills in training and supervision, advanced knowledge of the theories of counseling, extensive practice in counseling, and the skills to do research that is related to counseling, counselor education, and counselor supervision (CACREP, 2016).

Phenomenology

Phenomenology is defined as research focusing wholly on the description of participant experiences and less on presumptions about those experiences (Creswell & Poth, 2017; Moustakas, 1994). Phenomenology is the exploring of experiences, not the explanation or analysis of those experiences (Cordes, 2014; Moustakas, 1994).

Epoche

Epoche is the extinction of presumptions and presuppositions in order to access knowledge about those presumptions (Moustakas, 1994).

Intentionality

Intentionality is remaining cognizant of the internal experience and remaining "conscious of something; thus, the act of consciousness and the object of consciousness are intentionally related" (Moustakas, 1994, p.32).

Social Justice and Multicultural Implications

The myriad of social justice and multicultural implications begins with clients. The issue is that CITs do not seem to be adequately trained during their degree (Adams, 2019; Isawi & Post, 2020; Land, 2018; Law, 2012), they may not perceive training as adequate, and this obviously is an issue. The first reason is that the CITs will likely encounter clients with a history of trauma during their practicum (CCMH, 2019; Lauka et al., 2012). This is an important social justice implication because CITs should be trained to treat potentially traumatized university students during their practicum. This is also a social justice issue because some of the CITs may have a history of trauma themselves (Butler et al., 2016; Jenkins et al., 2017). These CITs may not be adequately trained to manage secondary traumatic stress, vicarious trauma, or burnout (Butler et al., 2016; Jenkins et al., 2017).

Another issue is currently with the pandemic, the issues facing our society, the current political environment, and the many other issues the pandemic has. The unfortunate reality is that many black Americans do not receive the same level of support as other communities and COVID-19 has disproportionately hit these communities (Blow, 2020). This may too be traumatizing along with the many other issues our society is facing in the current political environment and the other issues facing America in 2020 and beyond.

The next issue is for the field of CES. One could argue that it may be unethical to not train CITs on how to manage vicarious trauma, secondary traumatic stress, and/or burnout as a result of trauma counseling (Sommer, 2008). The issue here is that CITs are not emotionally prepared to distance themselves and not become too invested in their client's story. Further, the CIT may not know how to empathize without fully experiencing the client's trauma. This requires strong clinical supervision and some programs may not be adequately training their students during the degree (Adams, 2019; Isawi & Post, 2020; Land, 2018; Law, 2012).

This study will lend itself well to future studies to help broaden the CES definition and skills associated with trauma counselor training. Further, the multicultural issues do not end with the ones stated above, the multicultural issues will be returned to in future studies and this study will inform the design of those studies. The multicultural implications of this study are thus endless, because many of those clients and CITs that may have experienced a trauma, are from lower-socio-economic status (Chiu, et al., 2011).

Summary

Trauma is ubiquitous (CCMH, 2019; Land, 2018) today, especially with the ongoing global pandemic, social unrest, and horrific police brutality in the United States. Despite this, most counselors are not trained during their degree programs to treat clients that have experienced a trauma (Isawi & Post, 2020; Land, 2018). These CITs are likely to encounter traumatized clients in their CES training clinics (CCMH; 2019; Lauka et al., 2014). They are likely to come across traumatized clients in their future practice because of the prevalence of

trauma in the community (Benjet et al., 2016; SAMSHA, 2014). Additionally, there is a clear CACREP requirement to train CITs on trauma during their degree (ACA, 2014).

Trauma training is in its infancy and very little literature exists on how to train CITs to do trauma counseling (Isawi & Post, 2020; Land, 2018). CIT-specific trauma training needs exploration because of the lack of training, the prevalence of trauma that already exists, and the issues increasing trauma in American society. Equally important, trauma curricula must be created with a focus on the potential of the CIT's own history of trauma. The goal of this study was to begin to understand these issues through the lived experiences of CITs in a trauma training certificate program. The goal was to inform trauma counseling training and to create a positive impact for counseling clients, CITs, and the field of CES as a whole.

CHAPTER II

LITERATURE REVIEW

For the purpose of this chapter, it is important to first define what a traumatic event is to ensure that there is some cohesiveness to the definition. The Diagnostic and Statistical Manual 5 (DSM; American Psychological Association, 2013) will be used to provide an umbrella term of what constitutes a traumatic experience. Although psychological trauma, does not always lead to a Post-Traumatic Stress Disorder diagnosis (Ozer et al., 20003), it is defined here to operationalize the term. The DSM-5 defines PTSD as:

> Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: (1) Directly experiencing the traumatic event(s). (2) Witnessing, in person, the event(s) as it occurred to others. (3) Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event must have been violent or accidental. (4) Experiencing repeated or extreme exposure to aversive details of the event. (APA, 2013, p. 271)

Prevalence of Trauma

Reports of the prevalence of trauma in the general population range. For example, in an international survey done in 26 different countries across six continents, Benjet et al., (2016) found that 70% of participants reported exposure to one traumatic event, as defined by the above definition from the DSM-5. Thirty percent of participants in this study reported exposure to four or more traumatic events (Benjet et al., 2016). However, Kilpatrick et al., (2013) found 89.7% of

US citizens reported experiencing a traumatic event. To provide more context, a survey of 16,000 Americans was done by the National Institute of Justice and the Centers for Disease Control, it found that 55.0% of women reported physical or sexual assault and 66.8% of men reported physical or sexual assault (Tjaden & Thoennes, 1998). The results included, 17.6% of women and 3.0% of participants reported completed or attempted sexual assault, 22% of these women reported they were under 12 years old at the time they were sexually assaulted, 32% reported they were 12-17 years old when they were sexually assaulted. Asian women were least likely to report physical or sexual assault, and Indigenous Americans/Alaska native women were more most likely to report sexual assault (Tjaden & Thoennes, 1998).

More recently, the Center for Collegiate Mental Health (CCMH, 2019) collected data from 163 university counseling centers, encompassing 207,818 university students that attended a counseling session. Twenty-five percent of university students reported they have had unwanted sexual contact or experiences, 37.9% reported experiencing harassment, controlling, and/or abusive behavior, and 41.4% reported one traumatic experience during their lifetime (CCMH, 2019).

Of the students that reported exposure to a traumatic event, 17.2% students reported it occurred one time, 14.2% reported it occurred two to three times, 2.5% reported four to five times, and 7.4% reported a traumatic event occurred more than five times. Some reported that the event was recent, as 37.9% of students reported the traumatic event occurred within the last one to five years. The most common trauma reported was childhood emotional abuse (45.7%), sexual assaults (34.7%), military-related experiences (28.9%), and childhood physical abuse (17.8%).

This data is important for CES because 58% of CACREP accredited programs have a training clinic at their university and “at least 60%” of their clientele were university students (Lauka, et al., 2014, p.11). This information is pertinent for these training clinics and for the Counselor-in-Training (CIT) that will likely see a university student that has experienced a trauma.

These percentages range, but they also shed light on the already prevalent nature of trauma. Especially in the university population. It is clear that trauma is prevalent in our society and counselors need to be trained to meet this need. It should be noted, that the CCMH (2019) study was done on students that attended the counseling center, not students in general, and the 41.4% of students that reported a history of trauma, maybe a higher percentage in the general population, as found in other studies (Benjet et al., 2016; Kilpatrick et al., 2013). Trauma is prevalent in mental health counseling, counselors need to be trained to meet this need, counseling programs should be preparing CITs on trauma counseling because of the prevalence of trauma at universities. Because CITs will likely work with a traumatized university student at their program’s training clinic (CCMH, 2019; Lauka, et al., 2014)

However prevalent trauma may already be, the reality is that the entire world may currently become traumatized by the COVID-19 pandemic and the current social events. Silver (2020) argued that the psychological impact of this pandemic may be traumatizing. The impact of social isolation may traumatize many that cannot obtain access to mental health care because of financial concerns. Again, this “new normal” is not normal at all. Our brains are wired to be social beings (Grawe, 2006) and social distancing does not meet our sociological needs. Furthermore, the fear we all live in currently and the many things that will happen by the time

this study is completed could also be traumatizing us all. COVID-19 has seriously affected, and is continuing to affect, the entire world's mental health, which already has a high rate of trauma even before the pandemic (Benjet et al., 2016; Kilpatrick et al., 2013).

Trauma Counselor Training

Despite this prevalence, trauma counseling has not typically been taught during the degree. For example, Isawi (2016) found that 40% of clinicians received training during their degree. Bride et al., (2009) found that 82% of substance abuse counselors reported they received trauma training after their degree, meaning 18% received training during their degree.

Kumar et al., (2019) found that 68.1% of participants did not feel comfortable in their assessment of trauma and 75.3% did not feel comfortable in their treatment of trauma. Cook et al. (2011) found that 68% of psychologists expressed interest in obtaining additional training in trauma. Layne et al., (2011) found 30% of Licensed Clinical Social Workers (LCSW) students reported specialized training in their degree and 10% of their supervisors received formal training on trauma treatment (Layne et al., 2011). It is clear that a vast majority (40-82%) of clinicians did not feel adequately prepared in trauma counseling during their degree and this is a problem because of the prevalence already stated. This is also a problem given the nature of the COVID-19 pandemic, the issues affecting our society, and the shared trauma we all may be experiencing beyond 2020.

Counselors are not typically trained during their degree (Isawi & Post, 2020; Land, 2018) despite the prevalence of trauma in our society (Benjet et al., 2016; Kilpatrick et al., 2013) and despite the current issues affecting our society. This is troubling for a couple of reasons, but the

most important reason is the client. Counselors that do not possess adequate training may re-traumatize a client, and as a result, that client may never attend counseling again, and the consequences of that re-traumatization are endless.

The lack of adequate training during the degree is concerning for a few reasons. First, there is an ethical context that revolves around the concept of nonmaleficence, beneficence, doing no harm, and services for which counselors are trained (American Counseling Association; ACA 2014). The second reason is a CIT is likely to do counseling with a traumatized university student (CCMH; 2019; Lauka, et al., 2014). Third, some CITs may enroll in a Counseling program with their primary motivation being from their own history of trauma (Butler et al., 2017; Jenkins et al., 2016). Therefore, trauma counseling should be taught because of the prevalence of trauma in our society, because of the current pandemic, and because CITs are likely to come across a traumatized university student(s) during their practicum. However, there must be some intentionality in the training model, as some CITs may enroll in a Counseling program with their primary motivation being from their own history of trauma (Butler et al., 2017; Jenkins et al., 2016). It is also important to note, however, that although many clinicians reported a lack of adequate training, and this could be a result of their developmental level. As some may not feel confident in assessing and/or treating trauma, whereas, they were trained on how to do so, but they lack the confidence to properly assess or treat trauma. Although there are some risks that CES may not want to take if they are not going to train students on trauma counseling. This may be unlikely, however, as the mean years of experience was 12.42 years and

26% of this population received trauma training during their graduate degree (Kumar et al., 2019).

An Ethical Context: Risks of not Training Counselors on Trauma

The first goal of any counseling relationship is do no harm to the client; this dates to the time of the ancient Greeks and the writing of the Hippocratic oath. The concept of nonmaleficence, "avoiding actions that cause harm," is the second professional value of the ACA code of ethics (2014, p. 3). However, the lack of adequate training during a degree program may result in counselors harming clients because of the inadequate training; this is robustly supported in the literature (Cook et al., 2011; Isawi & Post, 2020; Kumar et al., 2019; Land, 2018; Layne et al., 2011).

Second, the ACA (2014, p.11) ethics state that "counselors use only those testing and assessment services for which they have been trained and are competent." Again, 68.1% of participants did not feel comfortable in their assessment of trauma and 75.3% did not feel comfortable in their treatment of trauma (Kumar et al., 2019). The mean years of experience for this population was 12.42 years and 26% of this population received training during their graduate degree (Kumar et al., 2019). Around half of this population (56.3%) had a master's degree or post-graduate diploma, suggesting that some participants could be counselors or LCSWs (Kumar et al., 2019). It appears that CES programs are not meeting the ACA ethical guidelines for teaching counselors how to do trauma counseling.

Third, the ACA ethics (2014, p.3) defined beneficence as "working for the good of the individual and society by promoting mental health and well-being." The lack of adequate

training during the degree may be violating this ethical code as well, as counselors without training may not be working for the good of their clients. Adams (2019) argued that counselors without adequate training may be counseling out of their scope of practice because of the lack of training currently in counselor education and supervision.

Ethical Context During Training

Sommer (2008) argued that the lack of training that was being done in 2008, puts CITs at risk for developing Vicarious Trauma (VT). Sommer (2008) also argued that the CIT needs to develop skills to manage VT and the lack of adequate training in trauma counseling does not prepare the students for that end. One such consideration is the harm that may potentially be done to the CIT.

One study that may give insight into the CIT lived experience of learning trauma counseling is from Butler et al., (2017). The study was done on 195 Licensed Clinical Social Worker (LCSW) students. The study explored Aversive Childhood Experiences (ACEs) for this group. ACEs are linked to traumatic experiences, but the relationship is complex (Butler et al., 2017; Ozer et al., 2003). The study found that 44.8% of LCSW students reported one or more potentially traumatic experiences during childhood (sexual, physical, or emotional abuse, or exposure to domestic violence). The two most reported items were household mental illness (49.5%), household substance abuse (40.5%), emotional abuse (32.4%), emotional neglect (29.7%), sexual abuse (21.3%), physical abuse (19.5%), mother treated violently (14.2%), incarnated family member (9.7%) and physical neglect (7.0%).

This study assumes that ACEs are potentially traumatic experiences and while that relationship is complex, it did shine a light on how many CITs may have their own history of trauma, given that these participants enrolled in an LCSW program. Although these were not master or counseling students, they were LCSW students that may share some common traits (altruism, value for education, social justice, etc.). This study was also not conclusive, but it did shine a light on the prevalence of trauma in the current population and the possibility of CITs having their own history of trauma.

Another study, Jenkins et al., (2016) examined sexual assault and domestic violence workers and their motivations for doing trauma work. This study reported that it was the only published article that explored the primary motivation for doing trauma work. The study went on to explore how the counselor was affected by trauma counseling. The participants that experienced a trauma did not report more negative changes in themselves personally, however, they were more likely to report symptoms of Secondary Traumatic Stress (STS), Vicarious Trauma (VT), but not burnout. It was unexpected, but this group did report experiencing more positive changes as a result of trauma work (Jenkins et al., 2016).

Another study by Gilin & Kauffman (2015) examined LCSW students that have experienced ACEs and who are enrolled in a Master of Social Work program. This study was more indicative of results found in the general population (Felitti et al., 1998). The study found 78.3% of current LCSW students had experienced one or more ACE, 56.1% of students experienced two or more ACEs, and 27.3% had experienced four or more ACEs. For additional context, Felitti et al., (1998) data on the general population is reported: 36.1% of participants

experienced no ACEs, 26.0% of participants experienced at least one ACE, 41.9% of participants experienced two or more ACEs, and 12.5% experienced four or more ACEs (Felitti et al., 1998; as cited in Gilin & Kauffman, 2015). These statistics on LCSW students line up, somewhat, with the national study on the general population by Felitti et al., (1998).

These statistics in this study, highlighted the need to design the study intentionally concerning the potential for CITs to have their own history of trauma. Further, these statistics suggested that trauma counselor training should be designed with this in mind as well. Especially given the asynchronous nature of the trauma certificate, and this will be discussed in depth later on in this chapter. Finally, these statistics suggest that CITs may learn from their own history and that may be their primary motivation for doing trauma counseling (Butler et al., 2017; Jenkins et al., 2016).

Although, there is relatively little known. These studies also provide evidence for Sommer (2008) claim that CES needs to help prepare CITs for vicarious trauma, secondary traumatic stress, and burnout. CITs that have their own history of trauma may experience trauma counseling courses differently than CITs that do not have a history of trauma, and there must be some intentionality put into the development of trauma counseling classes (Black, 2008).

The Therapeutic Alliance

Research has consistently suggested for nearly two decades, that the therapeutic alliance is key to positive therapeutic outcomes (Prochasksa & Norcross, 2007; Prochaska & Norcross, 2018; Wampold et al., 2001). Furthermore, the burgeoning field of neurocounseling (Beeson & Field, 2017) also suggests, that the therapeutic alliance may be challenging for clients that may

have a history of trauma, because of the very nature of trauma (Cozzolino, 2016; Dahlitz & Hill, 2018; Schore, 2012). In very simple terms, the brain's defensive state may become activated during counseling, because the client is petrified of developing the trust that was taken away during the traumatic event (Cozzolino, 2016; Dahlitz & Hill, 2018; Schore, 2012). The client, thus, must learn to feel safe enough and to be able to tolerate the therapeutic alliance (Dahlitz & Hill, 2018; Schore, 2012; Siegal, 2012).

The therapeutic alliance in trauma counseling can be marred by fear and distrust (Cozzolino, 2016; Schore, 2012; Van der Kolk, 2014). Such fear can drive the narrative as clients begin to psychologically avoid the implicit experience of trust because their brains are wired to defend themselves from psychological safety in trusting relationships (Cozzolino, 2016; Dahlitz & Hill, 2018; Schore, 2012; Van der Kolk, 2014). This distrust and fear can be a result of attachment trauma early on in childhood. As Bowlby (2008) found that children who have been abandoned by their primary caregiver, or attachment figure, experienced guilt and became chronically distrustful of relationships (Bowlby, 2008; Van der Kolk, 2014). Further, this can lead to a chronic distrust of relationships, of other individuals, and can lead to disassociation (Bowlby, 2008; Van der Kolk, 2014). This defensive state makes sense because of the very nature of trauma (Schore, 2012). Clients are petrified of feeling the positive experiences that were ripped away in childhood (Bowlby, 2008; Score, 2012; Van der Kolk, 2014).

This can be true in relational traumas (Schore, 2012) when clients may have experienced (for example) abuse, domestic violence, and/or sexual assaults (Van der Kolk, 2014). However, this may also be true in non-relational traumas. Van der Kolk (2014, p.28) discussed clients that

served in the Vietnam War and "Somehow the very event that caused them so much pain had also become their sole source of meaning. They felt fully alive only when they were revisiting their traumatic past." Further, other research has suggested that the amygdala, the brain's alarm system, can become activated when clients begin to process the traumatic experience (Cozzolino, 2016; Schore, 2012; Siegal, 2012; Van der Kolk, 2014). Whatever that traumatic experience may be.

Establishing a positive therapeutic alliance with a client that has experienced a trauma, is delicate and involves the "window of tolerance" that Siegal (2012, p. 55) discussed. The client may be able to tolerate some psychological trust with the counselor; however, psychological safety may be an entirely different experience that they may not be able to tolerate. This is because of the brain's defensive state, the fight-flight-or-freeze response in the limbic system, and because of their history of trauma (Cozzolino, 2016; Dahlitz & Hill, 2018; Siegal, 2012; Schore, 2012; Van der Kolk, 2014).

Trauma Counseling is Delicate

This is why trauma counseling is so delicate, because of the fear inherent for clients that may have experienced a trauma (Cozzolino, 2016; Dahlitz & Hill, 2018; Siegal, 2012; Schore, 2012; Van Der Kolk, 2014). The client is fearful of eye contact (Steuwe, 2014), they are petrified of trusting again (Schore, 2014; Van Der Kolk, 2014), and clients are afraid of the psychosocial experience of the traumatic narrative (Van Der Kolk, 2014). Trauma counseling is delicate because it requires a different type of psychological safety (Dahlitz & Hill, 2019; Siegal, 2012; Schore, 2014; Van Der Kolk, 2014). Needless to say, in trauma counseling, neurological systems

are working against that trust (Steuwe, 2014; Siegal, 2012; Schore, 2014; Van Der Kolk, 2014). That is why, the therapeutic alliance is delicate in trauma counseling, because of the brain's defensive state, the window of tolerance, and the fear of trusting relationships (Cozzolino, 2016; Dahlitz & Hill, 2018; Siegal, 2012; Schore, 2012; Van Der Kolk, 2014).

Given that, for nearly two decades, the literature suggests therapeutic alliance is key to positive therapeutic outcomes (Prochaska & Norcross, 2007; Prochaska & Norcross, 2018; Wampold et al., 2001). Also, given that the therapeutic alliance is delicate because of the very nature of trauma (Cozzolino, 2016; Dahlitz & Hill, 2018; Siegal, 2012; Schore, 2012; Van Der Kolk, 2014), it is important to establish the reasoning for asking CITs about the therapeutic alliance. It is clear by now, that the therapeutic alliance is key for counseling (Prochaska & Norcross, 2007; Prochaska & Norcross, 2018; Wampold et al., 2001) however the therapeutic alliance is also a delicate relationship that clients may not be able to tolerate (Cozzolino, 2016; Dahlitz & Hill, 2018; Siegal, 2012; Schore, 2012; Van Der Kolk, 2014). Therefore, it was important to explore how CITs viewed the therapeutic relationship during trauma counseling, what makes trauma counseling a specialty, and why the therapeutic alliance may be so delicate. Further, it was important to explore if the Counselor Educator (CE) was able to model the therapeutic alliance, as the trauma certificate courses in this study, are asynchronous. Black (2008) argued that the CE can model the therapeutic alliance, however that was during a face-to-face trauma class. The implications for these findings may have long-lasting effects on the way counseling is taught.

Current Knowledge: Trauma Counselor Education

Adams (2019) completed a qualitative study to understand how CEs facilitated and designed the trauma curriculum. The study used a multiple case study design, and three CEs were interviewed because they taught trauma-specific courses. The results revealed some intentionality in how these CEs were teaching their trauma classes. One participant reported that they "teach very similarity to the way I supervise" and there was "definitely a relational component to what I'm doing, so sort of trying to provide a safe holding environment for students" (Adams, 2019, p.142).

Another CE reported that she anticipates the student's responses around different trauma topics, and she starts "asking students to be mindful of their own reactions" to the traumatic material (Adams, 2019, p.150). Another CE reported that his role is "more of a facilitator than as a disseminator of content" (Adams, 2019, p.187) and there is an "emphasis on facilitating the connection between himself and his students" in the trauma class. This highlighted the intentionality to build cohesion in the trauma class. This sense of connection is also something this CE is modeling for the CITs. The CE also discussed his trauma-informed practice. He stated "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 later that that's not an issue" (Adams, 2019, p.176).

Adams (2019) study highlighted how some CE are teaching trauma, the reasons why they are building cohesion in their classes, and their intentionality in how they were teaching their

courses. This study could benefit the field of trauma counselor training, but this field is also in its infancy. Especially given the asynchronous nature of the trauma certificate and this is discussed in depth later on in this chapter.

Land (2018) completed a study to develop benchmarks for trauma counselor education based on knowledge, skills, and attitudes. The Delphi method was conducted on 20 CE that self-identified as trauma counseling experts. This is a limitation of the sample, as anyone can self-identify as a trauma counseling expert even though they were not trained and/or have skills in trauma counseling. Land (2018) found that the therapeutic alliance was key to treating traumatized clients because at the core of trauma, was abuse, betrayal, helplessness, a lack of trust, disempowerment, suffering, and disconnection from social relationships (Land, 2018).

Land (2018) also argued that counselors are not well prepared for trauma counseling, because of the lack of adequate training during their Master of Counseling program. Further, a socioecological model can be applied to trauma counseling (Vygotsky, 1978; Land, 2018) because of the sociological impact of trauma (Land, 2018). Third, the study called for a trauma-informed and culturally responsible (Frierson, Hood & Hughes, 2010) approach to teaching trauma counseling. The study explored the knowledge, skills, attitudes, and characteristics of trauma counselors based on an expert panel of trauma counselor educators. The results revealed the keys to trauma counseling and themes that emerged from the study (Land, 2018).

The theme of response and resisting re-traumatization emerged with the subcategory of strong emotional regulation skills and strong assessment skills to encourage the physical/psychological safety of the client (Land, 2018). The results of the study suggested that

CITs need the critical skill of doing no harm. Further, CITs even in the first couple years of their development, need to know how to "do no harm and use minimally invasive treatment interventions while establishing and supporting physical and emotional safety" with the client (Land, 2018, p. 221). Finally, the subcategories of skills found by Land (2018, p. 226) were: "assessment, intervention, treatment, counselor self-care, counselor emotional regulation, and physical and emotional safety of the client."

While the ACA is currently developing trauma competencies (Land, 2020, personal communication), this research by Land (2018) was helpful to delineate which specific skills trauma counselors will need. The study also provided some insight on the knowledge and attitudes needed for trauma counselors. The study finally called for CITs to be trained before their enrollment in their practicum courses, to do no harm to the clients may see at the training clinic.

Isawi & Poth (2020) research also suggested there is a paucity of literature on how CITs are taught trauma counseling, and that trauma training needs to be included in counseling programs. The study explored social workers (44.9%), counselors (26.5%), psychologists (22.4%) and Marriage and Family Therapists (5.1%). 40% of clinicians in that study reported they received training during their degree (Isawi, 2016; Isawi & Post, 2020). In another study, 38.8% of the participants reported that they had taken multiple courses on trauma counseling and 53.1% reported they attended multiple workshops on trauma counseling following their degree (Isawi & Post, 2020). This suggested these clinicians may have needed more training on trauma counseling. The findings revealed that a majority of participants in these studies, received

training following their degree, via workshops, rather than formal education as part of their mental health field (Isawi, 2016; Isawi & Post, 2020).

Another article examined how to teach Licensed Clinical Social Workers (LCSWs) about trauma (Gilin & Kauffman, 2015). This article had direct suggestions about how to teach trauma counseling to LCSW students. For example, the authors suggest that faculty teach their students about Vicarious Trauma (VT) and vicarious resilience (or post-traumatic growth and the CIT becoming resilient because of that post-traumatic growth in the client).

Further, faculty should teach about burnout and professional self-care during classes that have discussions about trauma. It is also suggested that faculty could teach self-regulation skills following videos or case vignettes that describe a client's experience with trauma. There were suggestions that faculty "give away the ending" of videos to lessen the psychosocial and emotional experience of the video (Gilin & Kauffman, 2015, p. 390). Personal logs and journals can be used to record the positive experiences due to self-care and/or increased self-awareness. Finally, Gilin & Kauffman (2015, p. 391) cite Rothschild & Rand (2006) and report that "being empathetic does not require workers to fully visualize the experience of abuse and neglect that their clients have suffered." Overall, the article suggested that the faculty members can help their students feel safe during the trauma classes but also provide time during class for students to process the emotional experience of the traumatic content (Gilin & Kauffman, 2015).

This could be an important context for the development of trauma counselor training and has informed this study about the CITs' lived experience of learning trauma counseling. Given that 27.3% of LCSW students reported four or more ACEs and 56.1% of LCSW students noted

two or more ACEs (Gilin & Kauffman, 2015). This suggested that trauma counseling training could be developed in the context of those statistics (Gilin & Kauffman, 2015) and could also be developed in the context of asynchronous literature, which will be discussed later on in this chapter. Given how many LCSW students (33%) reported their own experience of trauma and that being their primary motivation for doing trauma counseling (Butler et al., 2016; Gilin & Kauffman, 2015, Jenkins et al., 2017). While these are not CITs, LCSW students may share similar traits as CITs and this should be taken into context during this study.

Another article examined the questions about how to teach traumatic material to students that may not be developmentally ready to experience the traumatic narrative (Campbell, 2004; McAuffie & Eriksen, 2011). The CITs may not have the requisite coping strategies and self-care strategies to emotionally distance themselves from the emotional experience of the traumatic narrative (Campbell, 2004). In other words, the traumatic material may be too personal to the CIT given how many LCSWs reported four or more ACEs (27.3%) and how many reported two or more ACEs (56.1%; Gilin & Kauffman, 2015). In a class of 30 students, that would mean, that about 17 students have experienced two or more ACEs, and about eight students have experienced four or more ACEs (Gilin & Kauffman, 2015). Thus, the traumatic material may be outside of students' zone of proximal development (Vygotsky, 1978). Further, it may "needlessly traumatize" the CIT (Campbell, 2004, p. 309).

Campbell (2004) also argueed that it is important that CITs become exposed to traumatic material in the safety of the classroom, to begin to build the necessary coping skills and self-care strategies. One suggestion is to use case vignettes that describe, in some detail, traumatic stories

without going into specifics about the traumatic experience. For example, a 23-year-old male was involved in a significant trauma involving a family member. Another strategy is to discuss national issues (e.g., COVID-19) that have received wide media coverage because the CIT has likely already experienced the emotion related to the issue. This is less likely to elicit a strong emotional reaction because they have already experienced the emotion personally. Further, another issue that may arise, is that CITs may share traumatic material during group supervision or during class and the other students may not be emotionally ready to hear such material. Students may "dump" traumatic material during a class, and one way to manage this is to encourage students to warn the class if they are going to share traumatic material (from themselves or a client) and to present the material professionally, giving factual information without emotionally experiencing the facts of the case (Campbell, 2004). Next, the faculty member can then encourage group reflection and group processing of the traumatic material to validate students' experiences during the class (Campbell, 2004). Such inappropriate discussion of the personal history of trauma may occur given how many LCSW students reported their own history of ACEs (four or more 27.3% and two or more 56.1%; Gilin & Kauffman, 2015). It is suggested that this disclosure may leave CITs vulnerable to vicarious trauma (Campbell, 2004). One way to mitigate this risk is to give students enough time during class to process the distressful emotions and reactions that occurred (Campbell, 2004).

Overall, there seems to be an apparent gap in the current literature on how to teach trauma counseling (Adams, 2019; Isawi, 2016; Land, 2018). This field seems to be in its infancy and more literature should explore the intentionality that CES programs can use to teach CITs

about trauma, especially if a CIT has their own history of trauma. Next, counselor self-efficacy is explored to continue to explore trauma counselor training and the current landscape that is in its infancy. It is also important to continue to explore what is already known about trauma counselor training and asynchronous literature on teaching counseling. Further, other fields in Counseling and Clinical Psychology may also offer insight into how to teach trauma counseling and this can be valuable insight as well.

Law (2012) study was on Counselor Self-Efficacy and Trauma Counseling Competence and this study was the first of its kind to explore these two constructs. 6000 participants were part of the study, 91.7% of the participants were licensed Mental Health Counselors and 8.3% were not yet licensed. The sample found that 34.5% had between 1-5 hours of trauma training and 40.0% of the sample had more than 20 hours of trauma training. Further, 62.8% of the sample did not receive training during their degree and 75.2% of the sample sought training following their degree. The results revealed a significant relationship between the hours of trauma training sought following a degree and the counselor's self-efficacy in trauma counseling. However, those with more trauma training scored lower on the trauma skills inventory, which Law (2012) related to their perception of their skills, and their belief in their abilities to do trauma counseling, not their actual skill set.

Law (2012) and Isawi (2016) found similar results relating to the perception of counselors' skills in trauma, and their actual skills that counselors may not believe they have. This is notable because a scale should be developed to measure actual trauma skills and not counselors' perceptions of those skills (Isawi, 2016). Further, Law (2012) study provides more

evidence of the lack of adequate training currently being provided in counseling programs, as 75.2% of the participants sought training following their degree. Finally, the study provides a good context of where to focus efforts for future studies, ideally on how trauma counseling is taught, and how the professor can model the skills needed to do trauma counseling.

Overall, trauma counseling training simply does not exist, but these studies explored here may begin to build the foundation of the intentionality around trauma counselor education (Adams, 2019; Campbell, 2004; Gilin & Kauffman, 2015; Isawi & Post, 2020; Land, 2018; Law, 2012). The argument would be strengthened if peer-reviewed literature were reviewed, however, there is little peer-reviewed work on trauma counselor training (Butler et al., 2016; Black, 2008; Jenkins et al., 2017 Sommer, 2008) so these studies are presented to provide some insight into trauma counselor training.

Further, counselor specific knowledge needs to be developed because of the prevalence of trauma in the general population (Benjet et al., 2016; Kilpatrick et al., 2013), because of the CACREP standards (CACREP, 2016), because of ACA (2014) ethical context, and because it is likely that a CIT will work with a university student that has experienced a trauma during their practicum (CCMH, 2019; Lauka, et al., 2014). Thus, it may be best if CITs were trained in trauma prior to their practicum because of the likelihood of seeing a university student that has experienced a trauma (CCMH, 2019; Lauka, et al., 2014). The current literature on how to teach trauma counseling is written by members of psychology departments (Black, 2008; Cook & Newman, 2014; Newman, 2011) and social work departments (Butler et al., 2016; Jenkins et al., 2017). This literature may be helpful in the context of other counseling-specific literature (Land,

2018). Thus, it is explored below because of the paucity of literature on how to teach trauma counseling to counseling students (Adams, 2019; Isawi, 2016; Isawi & Post, 2020; Land, 2018; Law, 2012).

In 2014, a conference took place to create a consensus on traumatology and competencies for Licensed Clinical Social Workers (LCSWs) and Psychologists (Cook & Newman, 2014). The conference created five broad foundational and functional competencies in trauma-informed practice and trauma-informed scientific knowledge (Cook & Newman, 2014). The panel consisted of 60 Social Workers, Psychiatrists, and Psychologists. The keys areas of competency for the education of trauma clinicians are: "Trauma-focused and trauma-informed scientific knowledge, psychosocial assessment, psychosocial interventions, professionalism" and relational systemic issues that can be traumatic (e.g., the legal system; Cook & Newman, 2014, p. 300).

The key areas were then delineated by the panelists, into eight competencies that included the specific expectations of trauma clinicians (Cook & Newman, 2014, p.303). The first key area focused on "Cross-Cutting Trauma-Focused Competencies," or briefly, an understanding about trauma symptoms, interventions, and assessments, and the ability to tailor treatment to account for multicultural factors (Cook & Newman, 2014). The second was about the "Scientific Knowledge about Trauma," which broadly calls for clinicians to understand the epidemiology of traumatic exposure and outcomes, prevalence, populations, models, and social/historical constructs (Cook & Newman, 2014, p.303). Third, was the Trauma-Focused Psychological Assessment, broadly stated as the ability to demonstrate an awareness of and capacity to adjust procedures and skills as necessary for clients' sense of safety in the therapeutic alliance (Cook &

Newman, 2014, 304). Fourth, was the "Trauma Focused Psychological Intervention," which is broadly categorized as the ability to work as part of a team to treat the trauma holistically, and the ability to build an empathetic, non-judgmental environment while maintaining mastery in the symptomology of trauma (Cook & Newman, 2014, p.304). Fifth was the Trauma-Informed Professionalism that involves the ethical expectations of trauma clinicians (Cook & Newman, 2014, p.304). Finally, the Trauma-Informed Relational and Systemic issues involve the ability for clinicians in training to understand the disorganizing effects of trauma at all levels, which also requires the ability to engage in interdisciplinary collaboration with other mental health communities (Cook & Newman, 2014, p.305). The key theme of this study was the development of a scientist-practitioner approach, and it also highlighted the importance of a psychologically safe therapeutic alliance which was noted by Isawi (2016) and Land (2018).

The competencies line up, somewhat, with Land (2018) five skills needed for trauma, assessment, treatment/intervention, and physical/psychosocial safety (Cook & Newman, 2014; Land, 2018). Cook & Newman (2014) encouraged a holistic and/or systemic approach to trauma counseling, which Land (2018) called for in the future directions section. There is some general agreement between these studies' conclusions. However, counseling and psychology have much different expectations and requirements during and after graduation. Thus, CIT-specific trauma training needs exploration because of the differences between psychology and counseling, the apparent lack of adequate training, the prevalence of trauma that already exists, the current social issues, and it needs to be created with regard to the CITs possible own history of trauma.

Conceptual Framework

The conceptual framework for this study is rooted in a neuro-humanistic approach to counseling, with the principles of unconditional positive regard, accurate empathy, and a non-judgmental approach to counseling (Rogers, 1951). Given the nature of trauma, especially in relational traumas (e.g., sexual assault), a normal level of trust can be too intimidating for clients to experience following a trauma (Schore, 2012). This is due to the brain's defensive network, which activates the fight-flight-or-freeze response and can prevent clients from feeling psychologically safe enough to engage in the therapeutic alliance (Cozzolino, 2016; Dahlitz & Hill, 2018; Grawe, 2006; Schore, 2012).

In very simple terms, the traumatized client borrows the emotional stability of the counselor’s brain, to safely process the experience of the trauma (Dahlitz & Hill, 2018). It is because of this defensive network in the brain, that counselors need to highlight psychological safety at the core of their counseling (Cozzolino, 2016; Dahlitz & Hill, 2018; Schore, 2012; Siegal, 2012). It is also because of this neurological defensive state, that I have chosen a neuro-humanistic approach to explore the education of trauma counselors.

The neuro-humanistic model highlighted a safe working alliance as key to trauma treatment (Cozzolino, 2016; Dahlitz & Hill, 2018; Grawe, 2006; Schore, 2012; Siegal, 2012). Trauma can activate the clients’ limbic system, the area responsible for the brains’ defensive neurobiological states (including the fight-flight-or-freeze) and this can remain active during trauma counseling (Cozzolino, 2016; Dahlitz & Hill, 2018; Grawe, 2006; Schore, 2012; Siegal, 2012). Psychological safety, on the other hand, can de-activate the clients’ defensive

neurobiological state during counseling (Cozzolino, 2016; Dahlitz & Hill, 2018; Grawe, 2006; Schore, 2016; Siegal, 2012).

This safety sets the stage for limbic resonance, the capacity for a counselor to attune to their client's emotional experience, and this attunement can facilitate a strong therapeutic alliance (Siegal, 2012). This sense of control and safety is central to a Humanistic approach that values the clients' worldview (Rogers, 1951). Thus, I define trauma counseling as to how counselors establish a sense of safety with a client, to develop the trust and permission, to access a world they are petrified of. It is only after counselors gain their permission, that we are provided the opportunity to change their perception of the trauma. This definition is based on neurobiological research on how the brain processes psychological trauma and it is provided because trauma counseling needs to be defined in the broad conceptual framework to this study (Cozzolino, 2016; Dahlitz & Hill, 2018; Grawe, 2006; Schore, 2016; Siegal, 2012)

This neuro-humanistic approach guided the study. It helped the researcher become an instrument in the study (Merriam, 1998). It also helped the researcher create the study intentionally (Yin, 2018) because of the CITs have their own history of trauma (Butler et al., 2016; Jenkins, 2016). The conceptual framework also models the ways a counselor can establish a sense of safety during the qualitative interviews (Black, 2008).

Counselor Development

Next it is important to discuss the counselor development process because the participants in this study were at various levels of development. Stoltenberg & McNeill (2010) describe four levels of counselor development and different experiences along the trajectory of

counselor development. First, is the Level 1 CIT, which may be experiencing equal loads of excitement and anxiety about learning in a counseling program (Stoltenberg & McNeill, 2010). Further, students at this level may bring a zest for learning and fresh perspectives but may also require declarative explanations about what the counseling process is, to fit the concrete thinking patterns many may become stuck in at this stage. Students may be able to learn complex material, like the verbal definition of building a therapeutic alliance, and they may be able to regurgitate that information on command. However, they do not possess the skills to build a strong therapeutic alliance at this stage developmentally. The student is focused on the relationship they have with themselves in counseling, their skills, their knowledge, and their development. Rather than attending to the relationship, they have with the client. Thus, it is important to highlight structure as part of this developmental stage to help CITs manage the inherent anxiety when learning counseling (Stoltenberg & McNeill, 2010).

The Level 2 student is exposed to more complex issues like diagnosis and client conceptualizations (Stoltenberg & McNeill, 2010). The CIT at this level is able to expand their knowledge beyond concrete thinking patterns and able to integrate multiple sources of information that may overwhelm another student that is earlier on in their development. The Level 2 CIT is now able to focus on the relationship with the client rather than the relationship they have with their skills. They can recognize the discrepancies that clients may present with but may not be able to integrate this into diagnosis or case conceptualization (Stoltenberg & McNeill, 2010). The supervisor at this level may need to challenge the supervisee on their case conceptualizations and/or diagnoses to help the CIT continue in their developmental trajectory

(Benard & Goodyear, 2019). Clinical supervision is discussed here to explain the second level of counselor development, however supervision is out of the scope of inquiry for this study on trauma counseling training.

The Level 3 CIT can attend to the relationship they have with the client, allowing for nearly automatic performance under specific conditions in counseling (Stoltenberg & McNeill, 2010). The Level 3 CIT can assess several issues that may seem irrelevant for the CIT earlier on in their development and ability to integrate this information into the case conceptualization and potential diagnosis. Further, the Level 3 CIT may not require as much structure during this developmental level (Benard & Goodyear, 2019; Stoltenberg & McNeill, 2010).

The final stage, Level 3-integrated, is when a CIT is closer to full-licensure and able to personalize their approach to counseling (Benard & Goodyear, 2019). There are strong skills across case formulation and conceptualization, assessment, and intervention (Stoltenberg & McNeill, 2010). There may be some oscillation between different counseling theories as Level 3-integrated counselors may integrate new things into their practice with clients (Benard & Goodyear, 2019; Stoltenberg & McNeill, 2010). These stages are briefly summarized below.

It is important to note here that these levels are also subjective, as licensed counselors with many years of experience, may seek new training in particular specialties like trauma counseling (Benard & Goodyear, 2019). Level 3 counselors that do not have any skills or experience in trauma counseling would mirror this developmental process as they develop new skills (Benard & Goodyear, 2019). Thus, supervisors should be aware of that issue as clinicians develop skill.

Table 1

Stages of Counselor Development (Stoltenberg & McNeill, 2010)

Developmental Level	Experiences and Challenges	Considerations for CES
Level 1	Excitement for the profession; anxiety, and concrete thinking patterns	Validating anxiety as part of the learning process and providing strong structure and scaffolding to help students manage anxiety
Level 2	Expand their knowledge beyond concrete thinking patterns and able to integrate multiple sources of information but also may require structure and feedback to hone counseling skills	Less structure at times but supervisors may need to challenge the supervisee on certain interventions as the CIT continues in their development
Level 3	Personalized approach to counseling and able to assess a number of issues and integrate those into case conceptualization	Provide some autonomy as CITs develop some independent practice
Level3-integrated	Supervisees begin to reach Level 3 across all domains of case formulation, assessment, and intervention	Provide consultation as needed

Next, it is important to discuss the mode of instruction. The trauma certificate program in this study was completely online in an asynchronous and synchronous format. The existing literature on counselor training models online was explored and implications for this study presented.

Synchronous

Over the past twenty years, online instruction has become increasingly popular at universities, as 69% of universities considered instruction online to be a key part of their long-term strategy, as opposed to 32% in 2002 (Allen & Seaman, 2013). Although there is some debate in CES, as theory-based courses (e.g., career counseling, counseling theories and ethics) could be taught online, counseling skills require face-to-face because of the interpersonal learning that takes place in person (Murdock et al., 2012). However, Murdock et al. (2012) found no differences in skill acquisition for CITs in the online synchronous counseling skills class, when compared to the face-to-face classes.

Further, Dietrich and Bowers (2018) conducted an exploratory study that examined the changes in self-perception of counseling skills for CITs. The 21 CITs were enrolled in an online synchronous counseling skills course and were assessed pre-course and post-course. Students reported their counseling skills were positively affected by the course. Specifically, CITs demonstrated significant changes in their ability to identify a theme in the client's dialog, clarify, and respond empathetically. Further, CITs demonstrated significant changes in their ability to assess strengths in their client and demonstrated significant ability to help their client develop goals, among other skills that students typically learn in a counseling skills course (Dietrich &

Bowers, 2018). Although this may seem quite obvious, the notion that students in a counseling skills class learned counseling skills, the important distinction here is that these students learned in a synchronous online format where skills were practiced online through video chat software only. Not face-to-face. This is important for this study, as the trauma certificate at the midwestern university was completely online in an asynchronous format.

Asynchronous

Holmes & Reid (2019) conducted a study on 41 CITs that took four separate courses (introduction to mental health counseling, introduction to rehabilitation counseling, assessment, and diagnosis and treatment). The data suggested that students in the asynchronous course learned as much as the students in the face-to-face class and this was not limited to one counselor-educator or one class (Holmes & Reid, 2019). Taken together, these studies supported the use of online CIT instruction across a wide variety of courses and formats; counseling skills class, assessment, diagnosis and treatment, introduction to mental health counseling, and introduction to rehabilitation counseling (Dietrich & Bowers, 2018; Holmes & Reid, 2019). Further, this is important in the context of other work on asynchronous instruction, as the trauma certificate is taught was an asynchronous format. This may also provide some evidence of counselor development across the trauma certificate, however, that is speculative at this stage and would need further investigation.

Summary

Trauma is ubiquitous in our society (Benjet et al., 2016; CCMH, 2019; Kilpatrick et al., 2013). Despite this prevalence, counselors are not trained during their degrees (Adams, 2019;

Isawi & Post, 2020; Land, 2018). On top of that problem, trauma has been on the rise at university counseling centers (CCMH, 2019). Given how many CES programs (58%) have a counseling training clinic that sees university students (60%), there is a good chance that a CIT will work with a university student that has experienced a trauma (CCMH, 2019; Lauka, et al., 2014).

Training CITs in trauma during their degree is also mandated by CACREP, there is also an ethical dilemma when CITs are treating traumatized university students without adequate training. There is an ethical dilemma when CITs may have experienced trauma themselves, they start doing trauma counseling, and they are not prepared to manage vicarious trauma or secondary traumatic stress (Sommer, 2008). Therefore, CITs need to be trained during their degree to mitigate these ethical issues because CACREP mandates trauma training during their degree.

Many counseling programs have, or are seeking, CACREP accreditation. However, they may not be teaching trauma during their degree, evidenced by the percentages of licensed counselors that report inadequate training during their degree (Isawi, 2016; Isawi & Post, 2020; Land, 2018). Perhaps, these programs are teaching trauma counseling through a learn-by-doing format during the practicum. That may lead to its own ethical issues, but more likely, trauma may be infused throughout the entire curriculum. However, it does not appear that this infusion is resulting in counselors that feel comfortable in assessing or treating trauma (Kumar, et al., 2019). CITs that are trained during their degree, should be taught trauma counseling ethically as

well, because of the number of students that have experienced a trauma, 33% to 44.8% (Butler et al., 2016; Jenkins et al., 2017).

In other words, trauma counseling training, while non-existent, needs to be explored in order to understand the students' experience in during their degree and perhaps, before their practicum. Especially given the asynchronous nature of the trauma certificate. This experience is important to explore because of the prevalence of trauma in mental health clinicians (Butler et al., 2017; Jenkins, et al., 2016). Further, this experience is important to explore because many licensed counselors are not reporting that they were trained during their degree and they sought training following their degree because it was a need for them (Isawi, 2016; Isawi & Post, 2020; Kumar, Brand & Courtois, 2019; Land, 2018; Law, 2012).

It is pretty clear that these clinicians sought their own training because of a few reasons. First, they needed it because of the prevalence (Benjet et al., 2016; Kilpatrick, 2013). Second, they felt unprepared by their degree to assess and unprepared to treat trauma (Kumar et al., 2019). Third, they may have their own experience with trauma and may be struggling to manage vicarious trauma, secondary traumatic stress, and burnout (Butler et al., 2017; Jenkins et al., 2016). Fourth, they may have felt ethical obligations to "do no harm" and CES has its own ethical obligations to prepare counselors to meet the apparent needs. Finally, the social issues affecting the entire world and the effects of COVID-19 illustrate the need for strong trauma counselors.

This argument is in the broader context of counselor development and online counselor education, as many CES programs seem to utilize online counselor education (Murdock et al.

(2012). It is also important to consider how asynchronous classes can be taught, as the study used participants enrolled in an online asynchronous trauma certificate that was delivered completely online.

CHAPTER III

METHODOLOGY

Studying trauma counselor education has been studied in previous research (Adams, 2019) but most of the literature on trauma counselor education were quantitative studies (Isawi, 2016; Law, 2012; Land, 2018). Fisher (2006) defines qualitative research as "what it's like to be in a particular state or situation; quality refers to the character of the real-life world" (p. 5). This provides qualitative context to quantitative data in these studies and served the field by providing a richer context of "a particular state or situation" and it helped delineate what trauma counselor education is (Fisher, 2006, p. 5). Also, the data obtained in this a qualitative study explored what it is like to experience trauma counselor education and provided interesting context to what is already known in trauma counselor education (Adams, 2019; Fisher, 2006, Isawi, 2016; Land, 2018; Law, 2012).

Introduction to Phenomenology

The goal of this qualitative dissertation research project was to understand one thing very well (Stake, 2006). One way of reaching this goal was to use a phenomenological design, that described the experiences of trauma in the lived experiences of CITs (Moustakas, 1994). The descriptions of lived experience were focused on the participants' lived experiences, not my interpretation or presumption about what they experienced (Moustakas, 1994). For new ideas to

emerge, it was important to set aside any presumptions or presuppositions about the study or the participants before the interviews (Moustakas, 1994). This approach made sense given how many CITs have their own history of traumatic experiences (Butler et al., 2017; Jenkins et al., 2016). Furthermore, this approach made sense because I was able to be intentional in how the study was designed (Cordes, 2014; Moustakas, 1994). This was done to create a novel understanding of the phenomenon of CIT trauma training (Yin, 2018)

Phenomenology as an Approach

The overall goal of phenomenology was to focus on the description of the participants' lived experiences and less on presumptions about those experiences (Creswell & Poth, 2017; Moustakas, 1994). This study focused on the "appearance of things, a return to things just as they are given, removed from everyday routines and biases" (Moustakas, 1994, p. 94). This study focused on participants' experience during a trauma training certificate program, removed from researcher assumptions about how they experience it. The phenomenon examined in this study was how CITs experienced trauma counseling training; as a phenomenological study, the researcher explored this topic from many angles, sides, perceptions, and perspectives (Moustakas, 1994).

Theoretical Underpinnings

Epoche

Epoche is the extinction of presumptions and presuppositions to access knowledge above those presumptions (Moustakas, 1994). Epoche is a philosophical term that helps prepare the researcher for new knowledge, which may not develop if underlying assumptions or

presuppositions are driving the narrative during the study (Cordes, 2014; Moustakas, 1994). In other words, it was about removing my own bias, prejudgments, values, and filters that are typically used to create meaning (Bloggett, 1996).

Transcendental Phenomenology

In transcendental phenomenology, each experience that was described during this study was explored by itself, described, and perceived to provide a fresh account of the phenomenon (Moustakas, 1994). Its focus was around structural descriptions, rich textual descriptions, and the underlying essence of the study (Cordes, 2014; Creswell & Poth, 2017; Moustakas, 1994). By taking this stance, the researcher was able to be open to new experiences, new ideas, and a new consciousness (Cordes, 2014; Moustakas, 1994).

The approach was a social constructivist approach in and of itself; in simple terms, it described the experiences of the participants affected by the phenomenon (Creswell & Poth, 2017; Moustakas, 1994). It did so without assumption, which was challenging; however, the lack of assumptions allowed the researcher the opportunity to access new knowledge (Moustakas, 1994). In this study, the transcendental phenomenology approach consisted of the "what" the CITs experienced during their trauma certificate training and "how" they experienced the trauma content of the class (Creswell & Poth, 2017; Moustakas, 1994).

Intentionality

Intentionality is remaining cognizant of the internal experience and remaining "conscious of something; thus, the act of consciousness and the object of consciousness is intentionally related" (Moustakas, 1994, p. 32). In other words, it was remaining aware of the goal of the

study (i.e., examined the lived experiences of CITs in a trauma certificate). It was also remaining aware of the CITs own potential experience with trauma; this data was collected on the demographics form before the interview, described in the next chapter (Butler et al., 2017; Jenkins et al., 2016). Furthermore, intentionality in this way, was remaining present to the issues in society and the world during the time the study is completed (e.g., the pandemic, civil unrest, racial reckoning) and I recognized that the participant (i.e., CIT) and the environmental context are inseparable (Moustakas, 1994). This was an example of intentionality during a phenomenological study, according to Moustakas (1994).

Horizontalization

Horizontalization refers to the horizon of our own experiences: as we learn new things, our experiences widen and our horizons grow (Moustakas, 1994). Each angle, each new perception, each new development of knowledge adds to one's understanding of a given topic or a phenomenon (Moustakas, 1994). Thus, horizontalization is the "recognition that every statement has equal value" (Moustakas, 1994, p. 105).

The process also included, transcribing the interview, reading, and re-reading the interviews to allow new ideas to emerge (Cordes, 2014; Moustakas, 1994). I then coded the data and focused on significant statements (Moustakas, 1994). In simple terms, I opened the data up to new horizons and valued all statements. That allowed the CITs' experiences to be explored without my own bias affecting and guiding the interviews or data analysis. It allowed for new ideas to emerge in trauma Counselor Education and Supervision.

Clustering into Themes

A theme is a consistent phrase or a driving narrative across different interviews. Describing the phenomenon required the discovery of these themes that emerged among different participants and added to the rich description of the phenomenon (Cordes, 2014). These themes that emerged, helped guide data analysis and helped me develop new knowledge based on the participants' lived experience of the phenomenon (Cordes, 2014).

Textual Descriptions of the Experiences

The description of experiences was separated into two separate descriptions. The first is textual descriptions, which referred to the vivid description of what the CITs experienced during the trauma certificate (Cordes, 2014; Moustakas, 1994). Nothing was excluded from the description, as equal attention was paid to all dimensions of the CITs experience. That helped examine the phenomenon from multiple perspectives and to allowed new knowledge to develop (Moustakas, 1994). It is from this extensive textual description, that the researcher described how the phenomenon (the trauma certificate) affected the participants (CITs; Moustakas, 1994). Further, Moustakas (1994, p. 68) suggested that this allowed the researcher to focus on the "conditions, the textual qualities, the feelings, sensations, experiences, and thoughts" that participants shared during the study. In other words, was how the participant experienced the trauma certificate.

Structural Descriptions of the Experiences

Simply put, the structural descriptions, included the "what of the phenomenon" (Moustakas, 1994, p.68). The structural description focused on the background and the subtle

underpinnings of the phenomenon (Moustakas, 1994). Further, it was the conscious act of re-collecting data, judging, imagining, and thinking about the responses (Moustakas, 1994). The intent was to explore the structure that was inherent in the participants' responses (Moustakas, 1994).

Sampling Procedure and Selection Criteria

First, participants were CITs in a Master of Counseling program that have been, or currently were, enrolled in the online trauma certificate program. Students that were not currently, or have not been enrolled, in the trauma counseling certificate were thus excluded from the study. Participants also had not graduated from a Master of Counseling program either. Participants were selected until thematic saturation, or when themes consistently emerge, was achieved (Cordes, 2014; Moustakas, 1994). Saturation was expected after six to eight participants are interviewed (Moustakas, 1994). The final sample size was determined by thematic saturation that fell within recommended guidelines for phenomenological studies (Creswell & Poth, 2017; Cordes, 2014; Moustakas, 1994).

I recruited participants for this study via email, it was sent to students that are currently enrolled in the trauma certificate and that had not graduated yet with their MA, see Appendix A. The CITs who met the selection criteria were given a concise description of the study, given informed consent (Appendix B), and were awarded a $20 Amazon gift card that encouraged participants to enroll in the study. The CITs were recruited were in their practicum or internship and they have likely encountered a university student at the training clinic (Lauka et al., 2014) that had experienced trauma (CCMH, 2019) although I was not able to control for this specific

population. I was not able to control for this specific population because I was interested in the lived experience of trauma counselors-in-training, not the university student's mental health in this study.

Ethical Considerations

Chapter II outlined the ethical concerns that may be inherent in trauma counselor education. The first ethical concern was the possibility that the CITs have their own experience with traumatic experiences, as research suggests that some CITs may have experienced trauma (Butler et al., 2017; Jenkins, et al., 2016). Thus, this study was designed intentionally. To reiterate, intentionality was remaining aware of how the CITs experienced the study and the questions. Especially given the current pandemic and other issues facing society in 2020 and beyond. Additionally, Chapter II outlined the ethical concerns that were inherent in trauma counselor education. The first ethical concern was the possibility that the CITs had their own experiences with traumatic experiences, as reported in the research (Butler et al., 2017; Jenkins, et al., 2016). Thus, this study was designed intentionally, as I remained aware of CITs' experiences of the study itself, especially given the current pandemic and other issues facing society at the time of this study. Students were made aware that they could decline to participate in the study with no fear of reprisal; additionally, they were able to stop the interview at any time or revoke consent completely at any time.

Setting

The second part of the selection procedure was the setting. It was important to discuss the setting of the study to ensure confidentiality. Due to the pandemic, it was important that this

study was completed online, which can also ensure confidentiality. According to the institution where the study took place, Microsoft Teams was HIPPA compliant (institution website). Therefore, TEAMS was used to protect confidentiality. The meetings were recorded, as long as the participant consented, and the meetings were saved to the HIPPA compliant Microsoft OneDrive online cloud. The transcripts were also saved to SharePoint, as it was part of the closed captioning recording, and needed some modification after the interview due to technical errors in spelling, mishearing words, etc.

Operationalizing Theoretical Underpinnings

Third, it is important to discuss epoche: Again, this was the becoming aware of presumptions and presuppositions to access knowledge above those presumptions (Moustakas, 1994). To do this, I was able to conduct the interviews on separate days and I used my abilities as a counselor. It was challenging to remove bias, and the complete extinction of presumptions and completely removing biases was likely, unrealistic, to happen during this study (Moustakas, 1994). However, becoming consciously aware of my own bias did help me remove the bias (Fetterman, 1998; Cordes, 2014).

Intentionality operationalized

The fourth part of the procedure operationalizes intentionality, it may be possible that some CITs may have their own history of trauma, according to the literature, 33% to 44.8% (Butler et al., 2016; Jenkins et al., 2017) of the participants may have their own history of trauma. If this research lines up, that meant that two to four of eight participants may have their own history of trauma (Butler et al., 2016; Jenkins et al., 2017). Thus, it was important to use

my own counseling skills when conducting the study, the skills of empathizing, building rapport, helping the participants realize they are in control of what we talk about, among other micro counseling skills was also helpful.

Intentionality was remaining cognizant of my own internal experience and remaining “conscious of something; thus, the act of consciousness and the object of consciousness is intentionally related” (Moustakas, 1994, p.32). It was remaining aware of how the trauma certificate may impact the students and how I used myself as an instrument in the research process. For this study, I was mindful of the experiences of COVID-19 and current social injustices as well. Because of this context and the potential of the participants’ history of traumatic experiences, this study needed to be designed intentionally, and remained cognizant of the internal experience, and remained conscious of the participants’ experience during the interview. This occurred consciously or unconsciously. Learning trauma content may not be something they can tolerate if they do have a personal history of trauma and have not sought their own individual counseling. A history of trauma may affect these students’ emotional brains and they may become overwhelmed during the study (Cozolino, 2014; Schore, 2016; Siegal, 2012). One way to manage this was to facilitate control and provide some psychological safety during the interview (Cozolino, 2014; Schore, 2016; Siegal, 2012).

One way to build a relationship during the interview was to use warm-up questions that helped students become more comfortable and I informed them of the confidentiality of the study. Also, multiple interviews were needed to reach saturation and these interviews provided

the opportunity to develop a positive relationship with the participants. Such a relationship yielded more significant results than only one interview.

Research Questions

Research questions were the driving force of this study that aimed to examine a phenomenon and capture the underlying essence of lived experience (Cordes, 2014; Moustakas, 1994). The research question focused on a phenomenological study and related the findings to this question (Moustakas, 1994). The question helped define the selection of participants and it formed the core and focal point of the study, that provided a "rich and layered foundation for the development of the study" (Cordes, 2014, p. 29). This study had one overarching research question and two sub-questions:

1. Research Question (RQ): What was the lived experience of CITs during an asynchronous online trauma certificate program?
2. Research Sub-Question 1A (RQ 1A): What was the experience of learning trauma counseling in an asynchronous trauma certificate?
3. Research Sub-Question 1B (RQ 1B): How did their experience in the trauma certificate impact their perception of trauma counseling?

The research called for the implementation of trauma counseling practices in the training of trauma counselors (Black, 2008). Furthermore, the literature has pointed to a gap and called for an interdisciplinary and integrative approach to training CITs in trauma (Adams, 2019; Black, 2008; Cook et al., 2019; Land, 2012). It was also important to do so prior to their enrollment in their practicum (Land, 2018), given how many university students present to CES

training clinics (Lauka et al., 2014) and how many university students reported an experience of trauma (CCMH, 2019). The students' lived experiences in the trauma classes were important because previous work had explored the counselor educators' experience of the trauma classes (Adams, 2019; Land, 2018) and not students' experiences.

Literature to Support Interview Questions

It was important to explore how the trauma certificate affected the students' counseling skills, as Land (2018) found that five skills are important in trauma counseling (assessment, treatment/intervention, and physical/psychosocial safety). Thus, was interesting to see if these skills line up with Land's (2018) study. I asked about the knowledge, skills, and understanding of trauma counseling. I also asked the students about how trauma counseling is different because it is a specialty (Cozzolino, 2016; Dahlitz & Hill, 2018; Schore, 2012; Siegal, 2012). There are specific skills that are needed and I assumed first, that knowledge can lead to indirect, and ideally some direct, skill acquisition (Black, 2008), and that Land (2018) skills did present themselves in the study.

Perception of Modeling

Further, applied learning can be an effective teaching strategy (Acharya et al., 2018), and I asked the CITs about this. As it may be helpful for program evaluation, future CES studies, and CES curriculum design. I was interested in how the CE of the course modeled the therapeutic alliance, how the CE may have affected the understanding of the trauma certificate, and how the CE affected their trauma counseling skills (Black, 2008). As, modeling the skills needed for trauma counseling was highlighted in the literature as an effective teaching strategy when

teaching counseling (Black, 2008; McAuffie & Eriksen, 2011). I was interested in this because the CE could have a positive effect on trauma counselor development because they modeled the skills needed for effective trauma counseling and because the CE also modeled the therapeutic alliance with their relationship that they have with the CIT (Black, 2008; McAuffie & Eriksen, 2011).

Asynchronous nature

I was also interested in how the CIT experiences the asynchronous nature of these courses. I was interested because the students engaged and discussed the content of the course, as asynchronous classes may have enhanced participation and discussion (Acharya et al., 2018; Comer, 2013). Black (2008) argued that trauma can be taught synchronously so that the CE can provide some psychological control over the content and exposure to the content. On the other hand, it may be easier to physically leave an asynchronous class because the student can simply walk away from their computer.

I was also interested in how they regulated their emotions because the CE cannot assess emotionally overwhelmed students in asynchronous classes because they are not live, and there are some studies on the effectiveness of asynchronous education in CES (Sheperis et al., 2020). However, the inclusion of counselor education and distance learning is limited (Sheperis et al., 2020). This is why it was important to ask about the asynchronous nature of the class. The interview questions are in Appendix C.

Data Collection

Next, it is important to discuss transcendental phenomenology during the data collection process, or, how each experience was explored alone (Moustakas, 1994). The purpose was to obtain a fresh account of the phenomenon under study, or a fresh account of how students were experiencing the trauma certificate, the professor of the course, and the skills that they are ideally, learning and obtaining. This fresh account of the phenomenon under study was why it was important to explore my own bias as a researcher.

Intentionality was key here, given that 33% to 44.8% (2.31 to 3.14 out of 7) of CITs may have their own history of trauma (Butler et al., 2016; Jenkins et al., 2017). I was mindful of how they were experiencing my line of questions. The goal was to explore the underlying essence of the study, or the themes that emerged throughout the process, the underlying assumptions students' held about trauma counseling, underlying anxiety about their abilities to become trauma counselors, etc. Next, the data was then analyzed intentionally as well, to ensure that bias and presupposition were not marring the study.

Data Analysis

The steps for data analysis according to Moustakas (1994) are as followed. Horizonalization, clustering into themes, textual descriptions of the phenomenon, and structural descriptions of the phenomenon Moustakas (1994). These are outlined below.

First is horizonalization, or how our experiences widen as we gain new horizons of understanding and meaning (Moustakas, 1994). I granted all responses from the participants equally. As the responses were collected during the interview, they were transcribed by the

Microsoft TEAMS platform, they were edited for some technological issues (e.g., typos from the software). Next, the responses were not originally judged as useful or helpful, they were simply be recorded into an excel document for data analysis. The unit of analysis was a specific word, or a sentence, that reflected the content of the participants' response (Roller & Lavrakas, 2015).

The second step was to cluster the responses into themes after they are recorded into an excel document. To reiterate, describing the phenomenon required discovery of these themes that emerged among different participants, and this added to the rich description of the phenomenon (Cordes, 2014). When these themes did emerge, they were color-coded to match each emerging theme. The consistent narrative, or theme, that emerged was then coded as a clustered theme.

Third, I described the experiences and separated them into two separate descriptions. Textual descriptions referred to the participants' answer to each question, the vivid description of what each CIT experienced from their own perception of the trauma certificate (Cordes, 2014, Moustakas, 1994). Those descriptions were not excluded from analysis, because equal attention was paid to all the responses to examine the phenomenon from multiple perspectives (Cordes, 2014, Moustakas, 1994). In other words, I simply described what the participants stated without interpreting their responses. That allowed new knowledge to develop (Cordes, 2014, Moustakas, 1994).

The fourth step was structural descriptions of the experiences and focused on the background and the subtle underpinnings of the phenomenon (Moustakas, 1994). This was done following the interview, as I used my own counseling skills to clarify and paraphrase and used myself as an instrument during the interview. I then focused on the background and subtle

underpinnings of what the CIT's experienced during the trauma certificate. I then focused on their relationship with the counselor educator, given that the trauma certificate is an asynchronous, 100% online, certificate. I then focused on the background and subtle underpinnings of the CIT's experiences during the trauma certificate, but was not using micro-counseling skills (e.g., reflecting an emotion) because this interview was not a counseling session and that was not my role in this study.

Researcher Positionality

Next, it is important to discuss the bias I hold as a researcher. It is well established in qualitative research that the researcher can be used as an instrument in the research (Adams, 2019; Merriam & Tisdell, 2017). My own counseling skills were helpful for the interview if the goal was to “create a rich dialog with the evidence” (Yin, 2018, p. 121). It is also important to discuss my background as a trauma counselor. As of the date of this draft, I am not a survivor of trauma. I also did not attend a CACREP accredited Master of Counseling program, the MA program I attended was through an Australian university, and thus I have a different type of training than the CITs at the CACREP accredited midwestern university.

Summary

Trauma classes can be taught with intentionality, with a sense of psychological control, with reciprocal inhibition, and with titration of exposure (Black, 2006). CEs that teach trauma classes can also model the strong sense of psychological safety and control needed to do trauma counseling (Black, 2006; Siegal, 2012; Schore, 2016). A question remained, about how the CITs themselves, experienced the trauma certificate because trauma is prevalent in our general society

and prevalent in counseling programs as well (Butler et al., 2017; Jenkins et al., 2016; Land, 2018). It was important to consider the CIT's lived experience while learning the trauma content and some of the literature has considered CES experience teaching trauma courses (Adams, 2019; Land, 2018) and not the CIT’s experience.

Therefore, a phenomenological approach was taken to explore the underlying lived experience of learning the CITs during the trauma certificate. Such an approach, according to Moustakas (1994) highlighted the description of the experiences for the CITs, rather than the interpretations, or assumptions, the researcher holds (Creswell & Poth, 2018; Moustakas, 1994). The concept of epoche encouraged the researcher to set aside assumptions that drove the narrative behind the central research question and the interview questions (Creswell & Poth, 2018). In this way, the research was transcendental, or “everything is perceived freshly, as if for the first time” (Moustakas, 1994, p. 34). While Moustakas (1994) warned that this state is rarely achieved, it did prepare the researcher for new knowledge. These are the underlying epistemological assumptions of the Moustkas (1994) approach to phenomenology.

CHAPTER IV

RESULTS

The purpose of this qualitative study was to explore the lived experiences of CITs learning trauma counseling in an asynchronous online environment at a university in the Midwest of the United States. This study had one overarching research question and two sub-questions:

1. Research Question (RQ): What was the lived experience of CITs during an asynchronous online trauma certificate program?
2. Research Sub-Question 1A (RQ 1A): What was the experience of learning trauma counseling in an asynchronous trauma certificate?
3. Research Sub-Question 1B (RQ 1B): How did their experience in the trauma certificate impact their perception of trauma counseling?

Overview of Participants

Seven participants were interviewed for this study, all of whom were enrolled in their practicum or internship; all who were on the clinical mental health track. All participants had been in the program five or more semesters; two participants had completed three of the four required classes, and five participants had completed all four classes. There were five women,

one spirit, and one male. The participant that reported their gender as spirit, not two-spirit, is referred to as they/their to reflect their preferred gender pronouns. There were six Caucasian participants and one Latina participant. All seven reported a personal history of trauma (see Table 2, below). Participants were given pseudonyms by the researcher to maintain confidentiality.The interview data fell into three categories: (1) Personal Effects on Counselors-in-Training (CITs), (2) Clinical Impacts, and (3) Academic Influences. These categories encompassed eight themes and four sub-themes. These results are discussed below.

Table 2

Participant Demographics

Pseudonym	Gender	Ethnicity	No. of classes	Reported their own history of Trauma
Ana	Female	White	4	Yes
Bea	Spirit	White	4	Yes
Cat	Female	White	4	Yes
Dan	Male	White	3	Yes
Frankie	Female	Latina	4	Yes
Emma	Female	White	3	Yes
Irene	Female	White	4	Yes

Category One: Personal Effects on CITs

The category of Personal Effects on CITs had four themes: (1) Validating effects of Trauma the Certificate, (2) Self-Care Training, (3) Awareness of Personal Triggers, and (4) Emotional Overwhelm.

Theme One: The Certificate did not Emotionally Overwhelm Participants

The positive effects for the CITs were grounded in how the professors validated and normalized trauma in the trauma certificate classes. Those effects also empowered and encouraged these participants to engage more deeply in the trauma counseling curriculum. For example, Bea reported that the information in the trauma certificate "is presented in an empowering way, I found it helpful, instead of hurtful." They added that given the amount of personal counseling they had done themself, "The trauma certificate allowed me to do even more work. Both on myself and with clients who have experienced a trauma. To work through more of my own stuff."

Cat spoke to the importance of self-reflection, "It was important to do your own self-reflection, give yourself the space to do so and allow yourself to feel those feelings." Concerning feelings, she added "There were a lot of feelings that came up during the trauma certificate. And just because you're in the counselor position doesn't mean that you can't sit there and cry. With your client, in an appropriate way."

Dan described his own experiences with trauma, "There are some people that have experienced trauma very similar to my own, and that was leading me into maybe some negative reactions on my own part." He also spoke to the importance of self-regulation and self-care:

> I'd be thinking about that a lot and thinking about how I felt when that happened, but, the biggest thing was being able to pull myself back and say, Hey, we can work on this at work and we can do what we need to do. But right now, let's focus on something more productive and taking care of yourself.

Emma reported how the program helped her understand trauma in herself and others, she noted that it “I didn't know you don't control whether the fight, flight, or freeze response. You don't control that. Your brain does that for you. I can't explain how much weight that took off my shoulders.”

Irene reported she liked how the professors reinforced effective self-care behaviors and how the professors were available. She said, “I'm not going to schedule my daughter’s birthday party dinner on the day that we're doing the [trauma content].” She shared that she “really appreciated that the professors were there. You know I felt really validated. This is, work is, appreciated. [The professors] know this is hard and that helped me not feel so crazy, so this is normal.”

Theme Two: Self-Care Planning is Key for Participants Well-Being

All seven participants reported their own history of trauma. All seven reported that the class was challenging emotionally and, at times, academically overwhelming. Self-care was integrated into the coursework and students were required to complete a self-care plan. Five of the seven believed this it was important to have a self-care plan. All seven reported they developed skills to manage their own trauma history because of the self-care plans that were integrated across the trauma certificate. Ana even insisted, “No. I was not emotionally overwhelmed” during the trauma certificate or when the traumatic content was presented.

Bea echoed a similar sentiment to Ana, "I put myself into the shoes of the people and the traumatic experiences that we were learning about throughout the trauma certificate, it didn't really [overwhelm] me." However, they added that "it was very heavy. But self-care was very important throughout all of the classes for sure."

Cat described how the professor's encouraged self-awareness and "always made sure to [remind us to] reflect and know our own triggers. Our own limits and boundaries. Obviously, there's always going to be those." She remembered her professor modeling good practices and "talking about his own kind of triggers, limits, and boundaries."

Frankie emphasized the "emphasis on self-care because you can burn out more easily with this work versus if you're just doing like career stuff." Emma reported, "The information just stresses just how important it is to take care of ourselves, to be able to take care of the client the best that we can." Dan echoed Emma, he described how self-care was consistently integrated across the trauma-informed curriculum:

> There is some sort of self-care plan that you have to write for yourself. And it's always, it's hard to say that I don't have any idea how to self-care when you literally had to sit there and write how you're supposed to self-care. That's one of those catches that kind of keeps you and holds you accountable.

Irene admitted that "it was a lot at first, so that's why I do appreciate it so much now because it's not as shocking." She saw the value of the internal work during the program, sharing how "I did get some of my trauma stuff stirred up, and it's better to happen first as a student." She was pleased with the results, adding "I'm happy because now I feel all the better [because of my own counseling] that I've done during and after the trauma certificate. . . I think that with

these classes that helped." She tied this into her practicum experience and she added, "I feel so much more prepared to do trauma counseling now."

Theme Three: Participants developed an Awareness of their own Personal Triggers

Six out of seven participants discussed the emotional experience of learning about trauma counseling. Bea reported that they were thankful that they had their own history of trauma to process through some of the content. They stated "I've been through a lot of stuff, and I now know how to process emotions" related to trauma.

Cat reported a similar experience, "It was up to me to like to read the content and some of the more traumatic things that I had to read. I had to know my own kind of personal struggles. My own kind of mental health." Cat spoke specifically to her "ADHD and avoidance, wanting to avoid things that are difficult to talk about, wanting to avoid those things that are challenging."

Emma reported being challenged by "I had to wrap my head around of the fact that all of these traumas on 9/11, there were an infinite number of traumatic experiences that day. And that's just such an uncomfortable feeling." She then spoke to the challenge of becoming comfortable with trauma, saying "I don't know who would be comfortable with that, but, as counselors, we learn to get comfortable with being uncomfortable."

Emma compared two experiences with the trauma curriculum, admitting that "group counseling didn't bring up stuff, trauma class did! The other classes didn't bring anything up, but trauma really did." She found this to be a positive experience, she stated "I think everything is [in the trauma certificate] was just presented in such an empowering way. I found it helpful instead of hurtful."

Dan noted how the trauma curriculum explored "some of the deepest and darkest portions of people's lives." He wondered, "How do we take that on? And what are our responsibilities as counselors? And I'm hearing this or I'm sitting with a client right now and I'm hearing this." But he added that:

> If I try to take this out of the classroom and make it a part of my life when I'm not here, I know it's going to stick with me and I'm not going to be able to function the way that I can in my personal life.

Frankie discussed the impact of the program, she shared, "The trauma certificate was heavy, fast-paced, and it hit home sometimes. The heaviness of the content because it was just a lot of reading and emotionally challenging." But she also spoke to self-care, sharing:

> I had to take breaks. But, also, sometimes it was like OK, this is kind of hitting too close to home or this is too heavy for me, so let me just take a little break. I know myself, and I did what I had to do.

In a similar vein, Irene reported that during the trauma certificate classes she went back to counseling herself. She also reported that she had started taking medication for her mental health issues because of the classes and the content in the classes. She shared that "it was a lot of hard processing, hard to have that off button." She added:

> It's better to work on [my issues] now, than when you're a counselor with clients. I now feel prepared to do trauma counseling. That would have been really difficult without [the trauma certificate]. It really helped me iron out stuff that the regular program didn't touch on. It wasn't like I needed to go to a counselor! So it was that, that made me want to start my own personal counseling.

Theme Four: The Content did not Emotionally Overwhelm Participants

Five out of seven participants reported the trauma certificate did not emotionally overwhelm them. Those who were not emotionally overwhelmed reported that they felt

comfortable with the content. They did not believe there were too many traumatic narratives or discussions that were emotionally overwhelming. As Ana reported: “When it comes to trauma counseling, I want to understand as much as I can and experience as much as I can.”

Bea reported that they didn’t “think there was [a time where they were emotionally overwhelmed]. I mean, there were times that I would cry watching something, but it wasn't too overwhelming to continue.” She also added how this built empathy, “For example, I would empathize with a story rather than become emotionally overwhelmed by it.”

Cat reported similar sentiments, saying, “I don’t think [it was overwhelming]. Not the amount of the stories. That was not overwhelming.” She spoke particularly to the level of intensity, noting, “The intensity of the case studies that we received or the intensity of the stories we were reading was not overwhelming emotionally.”

Dan admitted that he “had that issue [being emotionally overwhelmed] in the workplace.” But with the trauma curriculum, he contrasted “I believe that it's very well organized. I don't think they try to pile things on to you in any way with the traumatic content that you're going to experience [in class].” He also talked about the care of the faculty, noting:

> There's clearly a lot of care and instruction that goes into making sure that you're getting the information you need without making it too much. There's not so much information being thrown at you at one time that you're not prepared to handle it.

Irene reported that she experienced the trauma certificate as “It was just consistently heavy, and I didn’t feel that, whoa it’s too much. I felt like, I’m in three weeks into this class. You know, it’s a lot.” She specifically mentioned, “the reading, whether it was the pure discussion or the writing or the assignment. It was all trauma-related, so there wasn't much of

any break from just the heaviness." However, she also described how those experiences encouraged her "to do my own self-care and unload that."

Category Two: Clinical Impacts

The category of Clinical Impact had a single theme, Trauma Counseling as a Specialty. This theme had three sub-themes: psychological safety, clinical need, and comfort in addressing trauma. This category explored the lived experience in the trauma certificate program and how it affected these students as CITs. It begged the question. Was there an over-identification with the traumatic content in the course, given that 100% of the participants reported their own personal history of trauma? Furthermore, it was important to examine the role of personal experience in motivating CITs to become trauma counselors. The literature does not address if and how personal trauma history can protect a CIT against the experiences of vicarious trauma, secondary traumatic stress, and burnout. The research was concerned with if and how the trauma certificate program might negatively affect CITs' experiences of vicarious trauma, secondary traumatic stress, and burnout during training or the practicum.

Theme Five: Trauma Counseling is a different type of counseling because of the emotional salience for the client

Six out of seven participants discussed how trauma counseling is a different type of counseling because of the emotional salience and need for a strong therapeutic alliance. The participants' perception that trauma counseling is a specialty was a theme across categories in this study.

The participants' perception of trauma counseling changed as a result of the training. Ana, noted, “Trauma affects you differently, emotionally and physically. And it has to be taken care of differently. Trauma counseling is different to other counseling.” Bea echoed similar sentiments, they argued, “Trauma counseling is heavier.” They also spoke to fear, admitting, “I think it can be a very scary experience because you’re basically trusting someone with your darkest secrets that are hidden under the rug that you don’t tell anyone else. So, I think that can be very scary.”

Cat discussed the relationship that is needed during trauma counseling. She discussed the awareness that’s needed as a trauma-informed counselor. She stated that she was “aware of the different factors and the different things the client may be feeling while they’re in the chair in your office.” She noted how trauma counseling is different, “I have been through my own trauma and I’m interested on how to treat it in a compassionate and more methodical way, and having a formula or a good knowledge base to pull from when treating trauma.”

Emma spoke to time commitment, she reported, “Things take time, we have to be more mindful of trauma.” She also spoke to the challenge of trauma counseling. “What makes it different is the delicacy of it and when it comes to people with trauma, we need to be a little bit more delicate.” She expressed surprise about the prevalence of trauma, “Depression, anxiety are super common too, but trauma is, [even more] common, and it's different and we need to promote the resilience in a different way [than with clients that have not experienced a trauma].”

Frankie described the role of the counselor, she reported “it's just you're the tool that we use as counselors and how we approach clients in a different way.” She also distinguished trauma counseling, “Building that trust can be different with a client who's just going in for

adjustment disorder. Versus heavy trauma. I think all types of counseling are different and I just think trauma work is very different." Frankie added:

> Instead of fixing, it's more guiding the client. So, they'll be saying something and maybe something not really making sense to me. It's about just guiding them and getting them to find out what they want, and how they want to move forward. But facilitating at the same time. Obviously, I am there for a reason, but I want them to feel like they're in control of their life and their choices and just kind of helping them through that process.

Irene discussed the importance of safety, "Something that I've really kept with me always in my head is, are they feeling safe in their body. The window of tolerance and you know where they are with that [window of tolerance]." She spoke to the importance of maintaining client boundaries, "So, I don't want to push them beyond that [level of emotional distress] and I just use the skills of noticing where they're at, connecting the dots and then not pushing them."

Sub-Theme: Trauma Counseling Requires Psychological Safety

It was clear that all seven participants realized the importance of the therapeutic alliance in trauma counseling. As all participants discussed the word "safety" at some point in their interview. Ana admitted that she "Didn't necessarily know before that there's a difference in counseling with someone that has experienced a trauma versus someone that has not experienced a trauma. I think, going through the trauma certificate, helped define that difference." She added, "It's better to have experience and training in it because you don't know what the client is going to bring; already prepped for it, you have that knowledge."

Bea described the time factor, they said "it takes time for that relationship to grow because of the safety needed. The clients [need to] feel that safe space for them to be able to share their traumas." She emphasized, "I think that relationship is super important. I need to be

able to trust you enough so that I can open up to you." Likewise, Cat reported on the importance of knowing if "they [the client] comfortable in the space. Immediately, do they feel they feel safe and warm in this space that you're in." She talked about the small touches, "Do they need water? Do they need a snack? Do they need just basic needs? They need to feel the physical kind of safety immediately."

Dan shared how he builds trust, "I'm not going to sit here and put any part of the blame on you because you don't deserve that. He spoke at length about the power of affirmations:

> I think that affirmations are a big thing, especially in sexual assault. People who are victims are not bad, but they are told they are. They are told that they are wrong. Something bad happened to them and they start to take on that persona as if this trauma that I've experienced is who I am now. Using positive affirmation with people I think really can reset that a little bit. [In other words] you're a person of value who deserves to have a positive life experience and these things that have been told you are wrong.

Emma stated how she believed that "everybody should do this [trauma certificate] because when I'm with a client or if I know the client has trauma, I might focus more on it." She talked about "everything I learned, I feel really unpacked and slowed down the process of building that relationship and how important it is."

Similarly, Irene reported, "If I know they have a history of trauma, then that's what we're doing for the next while, just that relationship. The relationship can take time, it's guaranteed to take time." She also talked about boundaries, noting that not everyone "wants to go beyond that window of tolerance. Of course, I want all clients to be safe, but it's just so huge for trauma, that relationship is important, and I think for the trauma it's just that much more important."

Sub-Theme: Participants know there is a Clinical Need in Their field

All seven participants confirmed the clinical need for trauma counselors. Ana reported that her background was in domestic violence and working with victims of sexual assault. She reported this was her primary motivation for enrolling in the trauma certificate program. Bea stated that their “big goal is to open a trauma treatment center.” Cat stated: “It was kind of a no brainer really. . . being in counseling, you're going to come across folks who have been through trauma. All the time.” Emma reported: “It's just very common, and it's very important. I think that makes it unique and builds the importance of it.”

Dan described how he was “predominantly interested in working in the military population.” He clarified that he “realized that the biggest issue that we're facing, at least as a military community, is suicide and suicide awareness as well as sexual assault awareness.” He added that those two things “came with trauma-informed care. And I knew that that was something I wanted to pursue, being able to work with these types of populations. So that's where I ended up.”

Frankie reported on the importance of trauma-focused coursework, “In all the other classes that we've taken, not the trauma courses, we do touch on trauma a little bit, but these classes were just trauma-focused, and that’s what we did. Trauma content.” He added, “We really start from scratch and look at all the background. I think that's so important to look at the clients’ different systems. . . their school system, the family, all the different levels and how they all impact each other.”

Irene talked about how she integrated approaches, “I use a lot of the expressive arts. If I have a youth that's had a trauma, I'll use some expressive arts that I learned. They've already experienced trauma and now you're trying to help them feel safe and process that using the expressive arts and building that relationship.”

Sub-Theme: Participants Learn to get Comfortable Addressing Trauma

Six out of seven participants reported that they were completely comfortable addressing trauma in counseling. Emma was the only participant who did not report being comfortable with trauma, she stated, “I’m learning to become comfortable with it.” Emma continued, noting that is what counseling can be for her, “learning to get comfortable with the uncomfortable.”
Ana stated that she felt “very well versed and very capable” as a trauma counselor. Bea reported that they felt “100% comfortable.” Bea added, “I think I have a special gift when people first meet me. They usually dump their whole life.” Frankie said he was “personally comfortable talking about [trauma]. It’s about finding a time in like a way to approach the conversation and when I feel like it's appropriate to do so with the client, I'm personally comfortable talking about trauma in trauma counseling.” Cat reported she felt “super comfortable.” Cat added:

> I have my own [trauma]. There are pieces of that. That I'm still unpacking to this day or things that I might have not explored. And, if I have somebody in the chair who starts talking about sexual abuse, for example, it may be hard, but I feel comfortable. I mean, we all have our blind spots.

Dan agreed with feeling “pretty well versed.” He added, “That's definitely a skill that I think comes with trauma. Trauma-Informed Care is being able to have those difficult

conversations. Knowing when and when not to talk about my experience [with trauma] and how to talk about it appropriately." He expanded on this:

> I try to be strategic about my disclosures with clients, with professors, and with other students. . . I think there is some value in saying that there is a shared experience. Maybe we don't know exactly what has happened or how it happened. And then how it comes down to, how does it impact that person? But we do understand what it feels like to have that sense of just something's wrong and I don't know how to say it to somebody so.

Irene described how at this point, "I feel very comfortable to provide that space that people need. You know, most importantly, just being a place where we can be safe and go from there wherever they want to go. I feel comfortable thanks to these classes." She talked about how she helped other interns, "I'm giving out read this text or read this book or just little things." She described a situation with an intern that did not do the trauma certificate, "the other intern that came out after a session and they were crying. And of course, that's going to happen to all of us. I get that." She spoke to the value of the trauma-focused coursework, "I know that particular client and their information. I think that I would have cried before getting this certificate, and I think that if I went and saw that client, I would have been able to provide what they needed."

Category Three: Academic Influences

Given the nature of the training on trauma counseling, it was important to explore how CES can develop a trauma-informed curriculum. What was especially important was how CES can develop the curriculum in the context of CITs who bring their own history of trauma, like all seven of the participants in this study. Category Three had three themes: Asynchronous Learning, Building Trust Virtually, and Making Connections. Building Trust had a sub-theme of Modeling the Relationship.

Theme Six: Participants Reported it was Ideal to do the Certificate Asynchronously

Four participants believed it was ideal to have asynchronous learning for the content: Ana, Bea, Dan, and Emma. Ana reported that because they we are not in-person "people are willing to engage more and say things they may not say in person. I don't know if everyone would feel okay in a class to walk away." She shared that online learning gave her the chance to process "what I was reading and what I was feeling without having some of those emotions held back as if I were in class. I wouldn't have been able to articulate my feelings and my thoughts if I were in class."

Bea reported value in being able to have discussions about the content in the trauma certificate. She also reported, "I'm a big writer, so if I have something that I need to discuss, I always journal it. It was not a big difference between the two [asynchronous vs. synchronous]." She felt she was "still communicating, and I had an outlet to communicate to either journal or [talk with my] classmates."

Dan discussed the virtue of the online, asynchronous, trauma certificate. Overall, he appreciated the asynchronous format because he could manage the emotional content of the course more easily than if it were face-to-face:

> If I was reading something heavy or dealing with this scenario that was very personal, it was nice for me to just take a second, pause the videos, or my reading. Maybe I would write down some thoughts about what was going on, why it was affecting me, and then take 10-15 minutes to maybe get up. Go get a glass of water or fresh coffee, or something, and have that mental reset and be ready to go again.

Emma reported how the asynchronous format allowed her "to be able to process, read the material at my own pace where they feel comfortable versus in a public setting where they might not feel comfortable with the group." She also spoke to an element of privacy, adding that

students "might not want to have an emotional response in front of the class and the professor. They are my classmates; I don't want to come off as odd or anything."

Theme Seven: Building Trust Virtually

All participants reported positive things about the three faculty members who taught these courses. All participants reported it was helpful that the faculty members were available to process and consistently discussed their availability in the videos they put up online. Finally, most participants reported they enjoyed the weekly instruction sheets that laid out the expectations for the week; they felt the videos that explained each module were helpful.

Ana reported how the course acted as a safe entry point, "Having the crisis and trauma course helped break the ice. It helped me understand that trauma can be different types of things." She spoke specifically to the professors who were "always there to process. They want us to understand the importance of trauma counseling and the content of trauma counseling. They don't just want us to recite the information, they want us to understand why it is important."

Bea described their impression of the faculty members and their attitude as, "Hey, I'm your teacher. I really care about you. . . .you could tell that [the professors] really care about you. And [the professors] really cares about everyone. They are always there for you." They added, "Whether in the videos, the introduction videos or if you needed him, he would call you. And if you had a question, [the professors] were always there to answer your question right away."

Cat echoed similar sentiments about the professors, she described them as "always accessible" and "always responsive." She added, "If I had emails or questions. . . they were

always quick to respond and be honest in their response. [The professors were] accommodating if things came up in our own lives, they obviously understood. "She also mentioned the way they modeled counseling skills, "They talked about bringing their own personal stories of clients, past personal examples, and how they handled them and what they would do differently."

Dan expanded on this sentiment and reported "The biggest thing, I think, [is how the professors] have really guided a lot of what I do now. And the biggest thing was just being available to me to talk about how my process as a trauma-informed counselor was going." Dan described how they supported him in his career pathway:

> [The professor was there] to guide me to opportunities that are going to be beneficial for my career. [The professors] helped me get a job and that was such a great learning experience to do that for a year and a half and learn all the practical, real-world skills. Their only real job was supposed to be teaching me how to be a trauma-informed counselor. And the fact that I enjoyed that work and how they connected with me so well just really allowed me to dive in and get way more information on this program could ever possibly give me. Because there were opportunities that I was able to seek out at their recommendations.

Dan believed that the professors did "a good job of preparing me because I know [the professors were very thorough when writing up our weekly objectives." He described how the professors created safety by letting students

> Know ahead of time of a trigger warning on this video, or trigger alert warning on this chapter of the book, or anything [they showed in class]. I think there was a lot of emphasis on making sure that we knew what we were getting into and that we had resources available to us. Every syllabus had counseling resources and all the resources we could need.

Emma shared this sense of support from the professors. She noted, "how she and the professors "met for the first time and having that space to process the trauma certificate, to talk

about trauma, was helpful. The professors offered support if needed; all of them did and they tried to show us they care about us.: She added that the professors:

> Understood where we're coming from, and they made an effort to know that, to let us know that they care. So, I think that really helps, especially in the trauma class and they always end it with like if you have questions, we need to talk about anything to like to reach out to them to process.

Emma continued, reporting it was challenging during the week that focused on the trauma of September 11th, specifically to watch the videos of the people jumping out of the windows of the World Trade Center. She reported that it was very helpful to know what she was about to watch, that the professors gave away the ending of the video and discussed the trigger warnings before any video.

Frankie, too, reported how available the professors were, “You, as a student, even going through it all completely online, they just always said, “Hey, we're here.” The thing that I really liked [was that] they made weekly videos explaining the module. That was super nice and that was helpful.”

Finally, Irene reported: *“*Having gone through trauma, the structure [of the courses] helped me, because I knew what was going to happen.” It was clear from the interviews that the students appreciated the person-centered traits of the professors in the trauma certificate.

Sub-Theme: It is possible to Model the Relationship Asynchronously

Four of seven participants described how the Person-Centered traits of their professors helped them understand what person-centered counseling looks like (i.e., unconditional positive regard, accurate empathy, a non-judgmental approach). Ana reported that the professors were “very grounded and easy to talk to.” Bea reported, “The person-centered [traits], the empathy,

compassion for us to succeed, and the unconditional positive regard [the professors provided]. Everything combined, you always just felt like you were part of a family."

Cat reported, "It's fair to say the person who is teaching the trauma certificate is part of the reason why I just learning by example. . . that's the biggest way the certificate specifically impacted my understanding. She specified "how they suggest how you interact or respond to clients [with a history of trauma]." Dan echoed a similar concept of connecting theory and practice:

> The professors helped connect the trauma certificate to the clinical work. . . [the professors] let me sit on their open hours just see what they might have to say about this [clinical issue], and we're able to go through some of the course work that we've done before. And they might recommend" Hey, you should reread this part from the class that you took and see how that resonates with the [clinical] scenario that you're dealing with now.

Theme Eight: Students Applied what they Learned to Other Classes

All seven participants reported the classes were challenging academically. All seven also reported they applied the content from the trauma certificate to their other classes. Ana stated, "It's about the information; how that's integrated with the client and to the trauma narrative." Frankie added, "I was always applying the information and, once you learn it, it's always connecting." Bea echoed this thought, "Once you learn about that trauma component, it started applying to so many different areas. Yeah, absolutely. Trauma is the root of everything. I think being born into this world is a trauma." They continued, describing how "you go through circumstances and then if you're not loved the right way. . . it's all challenging." Cat agreed that she could apply what she learned:

> There were plenty of other classes that I would go into and talk about my trauma class and what we learned this week. What generational trauma is and how it actually impacts the Black community. I think specifically about what we're talking about or the LGBTQ+ community. I remember bringing this up in courses all the time and being like, I'm just going [to talk up] the trauma certificate. You guys should really take the trauma classes.

Dan agreed, saying, “Absolutely I apply [the trauma certificate to other classes]. The negative responses could be a result of trauma, and I don’t want to jump on that. That may make [the client] feel uncomfortable and they may not come back.” He echoed others who argued that “once you learn about that trauma component, it started applying to so many different areas”

Likewise, Emma said she applied what she learned, she said “It was always in the back of my mind with group counseling. I integrated it, but it was in the back of my mind. Topics that came up just like being like trauma [in other classes].” She admitted, “We don't know everybody's history in this group [class] right now and then thinking about that. I also consider [trauma] in my group sessions. But also counseling interventions. I kind of thought about how I haven’t explored this [trauma].”

Irene also spoke to the issue of integration. “I integrated it in a lot of ways. It was that in-depth, into the ways that I like to do counseling. So being focusing on that relationship and being client-centered. I really appreciated that.” She reiterated the importance of depth, “It was just so in-depth, how I like to do things. It also helps me sharpen things that I do with clients. It helped me to name and sharpen some skills that I do as being trauma-informed.”

Summary

This chapter identified the categories, themes, and sub-themes from this study. The category of Personal Effects on CITs had four themes: (1) Validating effects of Trauma the

Certificate, (2) Self-Care Training, (3) Awareness of Personal Triggers, and (4) Emotional Overwhelm. The category of Clinical Impact had a single theme, (5) Trauma Counseling as a Specialty; this theme had three sub-themes: psychological safety, clinical need, and comfort in addressing trauma. Category Three had three themes: (6) Asynchronous Learning, (7) Building Trust Virtually; Building Trust had a sub-theme of modeling the relationship, and (8) Making Connections.

CHAPTER V

DISCUSSION AND CONCLUSION

This phenomenological study explored the lived experiences of trauma counselors in training (CITs). The goals were to learn about how students interacted with their professors given that Counselor Education and Supervision (CES) is a relationship-driven activity (McAuffie & Eriksen, 2011). Also, of interest was how these students were affected psychosocially by the trauma certificate program given that 100% of the participants reported their own history of trauma. Finally, this study aimed to explore how professors were teaching the course; this was important considering the paucity of literature on trauma counselor training.

This study offers insight for researchers, CES faculty who may wish to develop a trauma certificate program, and clinical supervisors who are supervising CITs. The lived experience of these seven students from a medium-sized did midwestern university were captured from online synchronous interviews that explored 17 interview questions. Those were then distilled into eight themes and four sub-themes. This chapter explores the findings in the context of the existing literature. It discusses the clinical, pedagogical, and academic implications as well as recommendations for future research.

Connection to the Literature

The literature review presented a foundation for framing how trauma-informed counseling can be taught in CES. Studies suggested that CITs may not be adequately trained (Adams, 2012) despite the prevalence of trauma (Berger et al., 2016). Additionally, CITs need to be prepared for the effects of vicarious trauma, secondary traumatic stress, and burnout (Butler et al., 2016; Jenkins et al., 2017; Sommer, 2008). Furthermore, CITs are likely to do their practicums in a university clinic where they work with university students with a history of trauma (CCMH, 2019; Lauka et al., 2014). Finally, the ongoing global pandemic and the difficult socio-political environment speak to the need for strong trauma-informed counselors.

Discussion

The first theme was the trauma certificate validated and normalized the participants history of trauma in this trauma certificate. This is echoed in the literature. For example, Campbell (2004) reported the professor can encourage group reflection and group processing of the traumatic material to validate students' experiences during the class. Doing this can encourage students to process the traumatic content during class and professors should save time in class to process the content (Campbell, 2004). As students may not have the requisite coping skills to manage the effects of vicarious trauma, burnout, or secondary traumatic stress (Campbell, 2004).

The second theme was about self-care planning, and it is recommended that the training include a self-care plan as an assignment to begin the courses. This is reflected in the literature, as Land (2018) found self-care as a skill for the counselor in trauma counseling. Further,

Campbell (2004) also reported that the CITs may not have the requisite coping strategies and self-care strategies to emotionally distance themselves from the emotional experience of the traumatic narrative (Campbell, 2004). Thus, it is important to have self-care planning as a skill in this context. Further, offering this as an assignment encourages students to engage in their own self-care, as Dan reported that it was “hard to not do self-care when it’s written down.”

The third theme was an awareness of participants their own personal triggers for counseling. For example, Irene reported that “It really helped me iron out stuff that the regular program didn’t touch on. It wasn’t like I needed to go to a counselor!” and this highlights how students developed an awareness of their own triggers. This is reflected in the literature as, Gilin & Kauffman (2015) found that personal logs and journals can be used to record the positive experiences due to self-care and/or increased self-awareness. That self-awareness could be related to an understanding of their own personal triggers when it comes to trauma counseling. Furthermore, Adams (2019) found that professors encourage students to become aware of their own personal triggers when learning about trauma counseling. Doing so, helped those professors discuss how teaching using a trauma-informed approach cannot hurt anyone.

The fourth theme is not currently in the literature and is a finding of this study. I did not realize that I assumed the content would overwhelm the students, until I started writing the results. I had assumed it may overwhelm the students because the literature reported it (Adams, 2018; Campbell, 2004; Black, 2006; Sommer, 2008). Teaching about trauma counseling may not re-traumatize a student or traumatize a student that may not have their own history. Given that 100% of these participants reported that they had their own history. What is stated in the

literature from is that teaching may emotionally overwhelm a student and students need to be prepared to manage the effects of learning about trauma counseling (Adams, 2018; Campbell, 2004; Black, 2006; Sommer, 2008). However, what is not stated is that teaching about the trauma content may not emotionally overwhelm the students and may be, because of the intentionality in how these courses were created. This is discussed later on in implications.

Theme number five was that Trauma Counseling is a different type of counseling because of the emotional salience for the client. This is reflected in the literature. The client may not be able to tolerate the therapeutic alliance due to a relational trauma (Schore, 2012) and it is important to empathize the need for a strong working alliance during trauma counseling training (Adams, 2019; Black, 2006; Land, 2018). Furthermore, Siegal (2012) discussed the "window of tolerance" as key to trauma counseling, because clients may not be able to tolerate the therapeutic relationship as it is outside their window of tolerance.

The first subtheme of theme number five was that participants learn about why trauma counseling requires psychological safety. To reiterate, all participants discussed psychological safety at some point during their interview and Bea reported that ""it takes time for that relationship to grow because of the safety needed." This is reflected in the literature. The field has known for around a decade that the relationship in counseling is a common factor (Lambert & Norcross, 2018) and trauma requires a strong working alliance (Cozzolino, 2016; Dahlitz & Hill, 2018; Siegal, 2012; Schore, 2012). Students picked up on this during the training, evidenced by this subtheme, and CES programs are thus encouraged to teach about the common factors and the reasons that psychological safety are needed in trauma counseling.

The second subtheme was a clinical need in the participants' field. This is reflected in the literature on the prevalence of trauma in the general society (Benjet et al., 2018; Kilpatrick et al., 2013), the prevalence at university counseling centers (CCMH, 2019) and the likelihood for the CES training clinic to work with a traumatized university student (Lauka et al., 2014). It also means that there is a rare opportunity for CES programs to teach about content that reflects a clinical need in the field. However, what is not in the literature is that the participants in this study, did choose to take four eight-week courses on top of the 60-credit hour degree. These eight-week courses were taken alongside their other coursework and faculty reported that there were around 150 students in the trauma certificate during their time teaching in it. Thus, it is recommended, that CES programs consider creating this specified training to meet the clinical need that students are interested in and willing to learn about, and also placate university stake holders with their curriculum enrollment numbers.

The last subtheme of theme number five was that students become to get comfortable in trauma counseling. This is because of the nature of secondary traumatic stress and how students learn to cope with potential vicarious trauma (Jenkins et al., 2017). However, the idea that self-care can prevent or protect against vicarious trauma, burnout, or secondary traumatic stress is complex and not well understood (Butler et al., 2016; Jenkins et al., 2017).

Theme number six, about participants ideally wanting the training online because they could engage the content at their own pace relates to teaching without traumatizing the student. Black (2006) argues that professors use techniques to not emotionally overwhelm students during classes, however, Black (2006) article was on synchronous in-person classes and the

trauma certificate here was 100% asynchronous online. Teaching about trauma in an intentional way, may help encourage a sense of control over the content, to manage the emotional experience. As Sommer (2008) argues that CITs need to be prepared to manage burnout, secondary traumatic stress, and vicarious trauma. This does relate to theme number six, however, it is not explicitly stated in the literature and is a new finding of this study. This will be explored in depth in the implications section.

The seventh theme, about building trust asynchronously is echoed in Dietrich & Bowers (2018) but is also not explicitly stated. Dietrich & Bowers (2018) found that students developed skills from an online synchronous counseling skills course and Holmes & Reid (2019) found that students learned just as much online. What is not as well understood, is how trust is built online in an asynchronous format. What is also not well understood, is how the perception of modeling can affect how trust is built online as well. Teaching in a way to facilitate control and encourage psychological safety xis one way to model how to build the relationship (Black, 2006). Finally, the eighth theme that students apply content they learned from other classes is well-established in the literature.

Implications

Implication One: Clinical Need

The first implication is clear. There is a clinical need both among the general population and at university settings for trauma-specific care. There was a clinical need before the pandemic and the socio-political events of the past two years. Many clients need this type of specialized

care and all the participants in this research study shared the view that there is a clinical need in their field. This is supported by the literature.

Benjet et al. (2016) found that 70.0% of participants reported exposure to at least one traumatic event as defined in the DSM-5 (APA, 2013); 30.0% of participants reported exposure to four or more traumatic events. Similarly, Kilpatrick et al. (2013) found 89.7% of U.S. citizens reported experiencing a traumatic event. Additionally, a survey of 16,000 Americans found that 55.0% of women and 66.8% of men reported physical or sexual assault (Tjaden & Thoennes, 1998). This speaks to the need for counselors to be trained during their degree program to meet the need of this clinical population.

Additionally, the Center for Collegiate Mental Health (CCMH) found that 41.4% of university students presenting to the counseling center reported a history of trauma (CCMH, 2019). Lauka et al. (2014) reported that 58.0% of CES programs have their own university-based training clinic and at least 60% of the clients are university students. This speaks to the clinical need at CES training clinics as well. Therefore, CITs need to be trained on trauma counseling during their degree given that they may meet a client who has experienced a trauma in their training clinic.

There is an opportunity for the field of CES to create training programs that reflect real-life needs for clients. There is a clinical need already in the general population and within universities as well. There is an opportunity here for CES to do something rare in academia, create a curriculum that reflects a need in the field.

Implication Two: Trauma Counseling is a Specialty

The CIT is also likely to come across a university student that has experienced a trauma and needs to be trained on how to treat a client that has experienced a trauma, simply because, trauma counseling is a specialty. Attempting trauma counseling without adequate training is unethical. It falls under the beneficence in the ACA code of ethics. I think CITs should be trained during the degree because I found that trauma counseling is a specialty. I also think that CITs need to be trained because I found that the CITs are likely to come across a university student that has experienced a trauma.

Furthermore, attempting trauma counseling without adequate training will re-traumatize a client and will drive that client away from mental health care. Counseling is already a vulnerable enough process for clients. For example, it does not need to be made more vulnerable, by an untrained counselor attempting to use CBT for a client experiencing traumatic experiences. Thought recording, in this type of counseling, is simply not going to be enough. The client has experienced the traumatic experience and writing down every thought is not going to help that client. The results are clear here. CITs need to be trained in trauma counseling because they may re-traumatize a client.

The same can be said for doing counseling without a safe psychological environment. If a client feels unsafe in a counseling relationship, for whatever reason, the counselor will not be able to explore the trauma. Further, it has been known for some time in the field, that counselors often over-rate the therapeutic alliance. It has also been known for years that microaggressions occur frequently in counseling as well. These two findings strongly suggest that counselors push their clients to explore a trauma before they have the proper relationship to do so. Therefore, I

think trauma counselors need to be trained during the degree on how to build a relationship with a client that has experienced a trauma. Because I found that the traumatic therapeutic alliance is delicate, requires a strong therapeutic alliance, and is simply different than non-trauma counseling.

The clinical need and the absence of a therapeutic alliance create the conditions for clients to be re-traumatized. Once this occurs, the client may decide not to come back to counseling. Or, if the client does come back, the next counselor must manage the issues created by the un-trained trauma counselor. That lack of trust, on top of the lack of trust, ripped away by the experience of trauma, creates challenging conditions for the trained trauma counselor. In very simple terms, bad counseling has made my life difficult for years.

It is because of these things that supplemental training should be a part of Continuing Education credits and hopefully, CACREP will consider this based on the current pandemic and horrendous socio-political environment. However, CES programs can offer this supplemental training to trained counselors already operating in the field. That would help create more trauma-informed counselors and protect clients from being re-traumatized.

Implication Three: The Traumatic Therapeutic Alliance

Trauma counseling requires a unique space for psychological safety. This therapeutic alliance is deeper and more significant than in other types of counseling. If the client feels unsafe in a counseling relationship, the counselor will not be able to explore the trauma.

Furthermore, it has been known for some time in the field, that counselors often over-rate the therapeutic alliance. It has also been known for years that microaggressions occur frequently

in counseling as well. The traumatic therapeutic alliance is delicate, that requires a strong therapeutic alliance that is different from the alliance in non-trauma counseling. Counselors must take extra time to build the therapeutic alliance, not push their clients to explore a trauma before they have the proper relationship to do so. Therefore, trauma counselors need specific training during the degree program in how to build a relationship with a client who has experienced a trauma. CITs' perceptions of modeling affect how they learn about the therapeutic relationship in trauma counseling. Modeling the relationship needed in trauma counseling must embrace person-centered traits; during the trauma certificate program, faculty must help students understand what a traumatic therapeutic alliance may look like.

This is supported in the literature, which suggests trauma counseling requires a more significant relationship than non-trauma counseling (Cozzolino, 2016; Schore, 2012; Siegal, 2012; Van der Kolk, 2014). In other words, the traumatic therapeutic alliance requires a safer therapeutic alliance than other types of counseling because of the very nature of the traumatic experience (Schore, 2012). The trauma itself may not allow a client to trust a counselor. The client may simply not be able to tolerate a therapeutic alliance. CITs need to be trained on the therapeutic alliance in trauma counseling because trauma counseling requires a stronger relationship than non-trauma counseling (Cozzolino, 2016; Schore, 2012; Siegal, 2012; Van der Kolk, 2014).

Implication Four: Tolerating the Traumatic Therapeutic Alliance

Trauma counseling, especially in relational traumas, can be much more vulnerable for clients who have experienced a trauma due to their experience of trust that has been ripped away

by trauma. Now I have the gall, as the trauma counselor (whether trained or untrained) to ask for that trust from a client? Especially as a cisgender male working with a cisgender female client that has been sexually assaulted, or vice versa?

These two questions have baffled me for years. I am so humbled, whenever clients began to trust me as their trauma counselor. However, I have also been trained in trauma counseling, and those that are not adequately trained may not prioritize trust as much as they should. Evidenced by the overrating of the therapeutic alliance. The burgeoning field of neuroscience has provided insight into the need for a strong therapeutic alliance but also pointed to how clients who have experienced a trauma (especially relational trauma) may not be able to tolerate the therapeutic alliance. Much less a counselor, whether trained, or untrained.

Furthermore, the burgeoning field of neuroscience has also provided insight into the need for a strong therapeutic alliance, clients that have experienced a trauma (especially a relational trauma), may not be able to tolerate a therapeutic alliance because of the anxiety of developing trust with any person. Much less a counselor, whether trained, or untrained.

Therefore, it is critical to be mindful of this as a counselor first. It is also important, as a supervisor, and as a professor, to be mindful of how to train CITs if clients are not able to tolerate a therapeutic alliance. Fortunately, the field has an answer to this issue, and that is to take a trauma-informed approach when training CITs. Further, Counselor Educators can model how to develop a relationship with a client that has experienced any trauma, much less a relational trauma. I think that CITs should be trained on how to develop this type of relationship because the burgeoning field of neurosciences are indicating that there needs to be a strong

therapeutic alliance for clients that have experienced a trauma. Especially a relational trauma. Because the client may not be able to tolerate the therapeutic alliance because of their history of trauma. I think that CITs should be trained on how to develop this type of relationship.

Implication Five: Intentionality in Trauma Certificate Programs

CES programs must train counselors on trauma. However, to do so effectively, CES programs need to be mindful of the lived experiences of CITs when learning about trauma. Butler et al. (2016) and Jenkins et al., (2017) explored LCSW students' history of trauma but they failed to address what to do next.

CITs need structure to their training because learning about trauma may re-traumatize a CIT (Black, 2006; Butler et al., 2016; Jenkins et al., 2017). However, what was left out was what to do next. Here, I argue that CES programs can intentionally develop the curriculum to minimize student anxiety and uncertainty. A trauma certificate is not the ideal environment for such uncertainty. This may be more ideal in a crisis course or a counseling theories course.

Instead, CES programs want to ensure that students can predict the environment in the trauma certificate. Because this is how trauma counselors conduct trauma counseling. The reason is twofold. First, it encourages a sense of control over the learning process, and second, is because it models how to set the conditions for predictability in counseling. The students need to be empowered because again, this is how trauma counselors conduct trauma counseling and again, this models how to do it with clients later. I think that CITs need structure to their training because I found that learning about trauma may re-traumatize a CIT (Black, 2006; Butler et al., 2016; Jenkins et al., 2017).

The structure also creates a sense of control over when to engage with the traumatic material. In other words, students that are parents may not want to listen to the video lecture on child abuse with their young children in the room. The structure also offers students the opportunity to engage with the content in a safe physical environment because students can stop the videos and physically walk away from the content to process it. These items model how to do these things with clients later. I think the CITs should have asynchronous training because I found that can facilitate a sense of control over when to engage with the traumatic material.

Implication Six: Self-Care is a Skill

Finally, self-care is a skill in the context of trauma counseling training. First and foremost, trauma counselors—whether trained or untrained—are least human beings. They potentially bring their own traumatic history, including failed and potentially traumatic romantic relationships or relationships with primary caregivers. Countertransference and transference were invented early on for a reason. We are human.

Second, there is the emotional salience of the trauma history. The traumatic narrative and the fear on the face of a sexual assault survivor, that is petrified to trust the counselor, is why self-care is a skill in this context. It takes a well-developed ability not to over-empathize with a client who has experienced a trauma. That ability is a skill in this context, and it is important to protect us against vicarious trauma. Vicarious trauma, secondary traumatic stress, burnout, countertransference, and transference exist for a reason. Counseling, especially trauma counseling, can remind us of our own history marred by lost relationships, failed dreams, and arguments with parents.

Therefore, it is an important skill to notice the emotional salience of the traumatic narrative, to manage it emotionally as a counselor, and to properly empathize with a client that is telling that story that creates that emotional salience in us. I think CITs need to be trained on how to manage vicarious trauma, secondary traumatic stress, burnout, countertransference, and transference, because in trauma counseling. Those issues are different. They are more salient, and CITs run the risk of over-empathizing with clients and becoming burnout.

Third, self-care is a skill in the context of clinical supervision. CES programs can supervise their students with the assumption that CITs may over-empathize with their clients and become trauma victims as well. Supervisors need to be on the lookout for CITs over empathizing with their clients and need to be well-read on the symptoms of vicarious trauma, secondary traumatic stress, and burnout. Burnout is high in this area for a reason. Trauma counseling is incredibly difficult and a vulnerable experience. Therefore, the supervisor needs to be aware of this vulnerability, ask about self-care, and hold CITs accountable to that self-care plan.

Fourth and finally, self-care is a skill in the context of trauma counseling. CES programs need to consistently refer to self-care as a mechanism to protect against burnout, secondary traumatic stress, and vicarious trauma. Especially in crisis or trauma work, CES programs need to offer this training and hold students accountable to their self-care plans early on, to set the stage for strong self-care when working in the field. Self-care needs to be modeled by professors. Self-care should be modeled in the syllabus by letting students know that emails are not checked over the weekend. Self-care plans should be a part of any trauma training.

Limitations

The first limitation for this study involved the incentive to conduct this study: A $20 Amazon gift card. This incentive was not originally planned to be such a high amount; however, after waiting for participants for eight months, the researcher increased the incentive to finish the study. The incentive had the potential to create cognitive dissonance and desire in participants to give the “correct” answer because they were being paid for their participation.

The second limitation was that this study included only seven participants. The MA master’s program at the Midwestern University was large (i.e., 150 students) and many took the trauma certificate program. It would have been ideal to have more participants. This may have been an artifact of the pandemic; students may have had less emotional reserves to participate in research that they may have perceived as stressful

The third limitation is that there was only one non-White participant. It would have been ideal to include a more diverse group of participants. Furthermore, the participants were all between 21 and 50, also not very diverse. All students were in the Clinical Mental Health track, and it would have been ideal to have school counseling students as well. Future research should consider school counselors as well. The program at this Midwestern University also does not have a Student Affairs and College Counseling track. Finally, there was only one participant who identified their gender as Two-Spirit. Overall, it would have been a better study with greater diversity.

Recommendations for Future Research

The first set of recommendations focuses on the study population. This study should be replicated with CITs who have recently graduated, have a provisional license, and have taken the trauma certificate program. This would be an interesting exploration, given the development that takes place during provisional licensure. Researchers should examine the experiences of fully licensed counselors that took the trauma certificate program. It would be interesting to explore how the lived experiences of people with significant experience in trauma counseling differ from those who are newly initiated to the depth and breadth of trauma counseling. Finally, it would then be interesting to replicate this study with Clinical Supervisors to see what other things the burgeoning field of trauma counselor education can learn. Again, these findings would be interesting to learn about the trajectory of developing trauma-counselors.

The second recommendation is to further explore the perception of modeling, focusing on if and how CITs are picking up on the modeling. Future research could explore this for the entire program to increase participation, rather than limiting it to a trauma certificate. Future research could also explore if and how CITs exhibit the behaviors their faculty model (i.e., their professional disposition).

Third, this researcher recommends that a quantitative study should explore how a well-defined self-care plan influences students in the trauma certificate program at this midwestern university. This may help delineate if a strong self-care routine (and the many things that subjectively go along with that) can protect against vicarious trauma, secondary traumatic stress,

and burnout. This would be an important study, given the prevalence of trauma attributable to our current socio-political environment (Benjet et al., 2016).

Fourth, future works should also consider the role of online education, particularly the development of a relationship in an asynchronous online program and how these elements align with trauma counseling. Many programs are moving online, and it would be interesting to explore how relationships are developed online, as well as asynchronously.

Fifth and finally is the recommendation to continue to explore the burgeoning field of trauma counselor training. This field is in its infancy and there is very little work being done on the topic.

Conclusion

Previous studies have not yet explored the trauma certificate and trauma training at this midwestern university. To address this void, I explored the lived experience of the online, asynchronous trauma certificate to capture the participants' experiences and perceptions of the faculty of the course, the perception of the content in the course, and the delivery of the course asynchronously. My exploration used a phenomenological design to delineate themes based on 17 questions. I interviewed seven participants, all that have taken at least one trauma certificate (100% had four courses), and who were enrolled in either their practicum or internship. Participants were selected out of this inclusion criteria to capture the lived experience of the online, asynchronous trauma certificate.

My findings reveal the need for training, the ways CES can develop a program intentionally, the ways to model both the relationship and self-care and the reasons self-care is

important in this training. Participants in this study discussed major themes that helped create these larger implications and recommendations for future research was explored. Finally, the study itself filled a major void in how trauma counseling can be taught.

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APPENDIX A

RECRUITMENT EMAIL

Hi all!

My name is Mike Caverly, I'm a doctoral candidate at NIU and I'm in need of some participants for my dissertation study called "The Lived Experience of Trauma Counselors-in-Training." Your insight will be very, very, valuable.

In order to be eligible to participate, you need to have taken at least one class in the trauma certificate, or you need to be currently enrolled in the trauma certificate program. Also, you would need to be currently enrolled in your practicum or internship.

Participants will receive a $20 Amazon gift card for your participation. The online interview will take approximately 40-90 minutes and you will answer 17 questions.

Exclusion criteria include students that have not taken any of the trauma certificate courses, those that have taken classes in the trauma certificate but are not currently enrolled in the practicum or internship course.

If you would like more information about this study, please read the attached document and reach out to me if you have questions.

I really hope to hear from you soon!

Mike

APPENDIX B

INFORMED CONSENT

Consent to Participate in a Research Study

Study Title: The lived experience of learning trauma counseling
Investigators

Name: Mike Caverly, M.A_	Dept: Counseling	Phone: 815-753-1448
Name: Dr. Carter	Dept: Counseling	Phone: 815-753-1448

Key Information

- · This is a voluntary research study on how trauma counselors are trained during their Master's degree.
- · This one-day study involves a discussion about how the students are trained on trauma counseling during the MA and while enrolled in the trauma certificate or have been enrolled.
- · The benefits include to inform trauma counselor training and future training of MA students; the risks include potential issues if students have their own history of trauma.

Description of the Study

The purpose of the study is to explore the lived experience of trauma Counselors-in-training (CITs). If you agree to be in this study, you will be asked to do the following things: answer 15 questions about trauma counseling, skills, knowledge and awareness over about a one-hour meeting online via Electronic Format. The meeting will be recorded for transcription purposes. The involvement of the participant is kept with strictly confidential unless there is a risk of harm to the participant, others, children or the elderly.

Risks and Benefits

The study has the following risks. First, participants may have their own history of trauma and may not feel comfortable discussing trauma counseling or issues related to training. If you do not feel comfortable discussing trauma related content, then participation in this study may not be suitable. Furthermore, you are obviously able to decline to answer any question. The benefits of participation are to inform Counselor Education and Supervision (CES), to inform how CES trains counselors online asynchronously, how education can be improved, how supervision can be improved, and how training overall can be improved. This is beneficial as well for future clients that may be counseled by these students enrolled in the trauma certificate. Furthermore, this will be beneficial for counselors-in-training as it will inform their training.

Confidentiality

This study is kept strictly confidential unless there is a risk of harm to the participant, others, children or the elderly. We will not be collecting or retaining any information about your identity unless there is a risk of harm to the participant, others, children or the elderly.

The electronic software will be able to keep your name, information, the content of the interview, and the transcription.This is also not a counseling session and as such, I will not be using counseling skills because this is a study, not a counseling session. The records of this study will be kept strictly confidential. Research records will be kept in a locked file, and all electronic information will be coded and secured using a password protected file. The researcher will be the only one to have access to the recorded video (for transcription purposes only) and the video will also be password protected. The video will be kept on a secure computer and on a USB drive (as

a backup) and not kept online. The video will be destroyed at the end of the study. We will not include any information in any report we may publish that would make it possible to identify you.

Compensation

You will receive the following compensation for your time: a $20 Amazon gift card.

Your Rights

The decision to participate in this study is entirely up to you. You may refuse to take part in the study at any time. Your decision will not result in any loss of benefits to which you are otherwise entitled. You have the right to skip any question or research activity, as well as to withdraw completely from participation at any point during the process.

You have the right to ask questions about this research study and to have those questions answered before, during, or after the research. If you have any further questions about the study, at any time feel free to contact the researcher, Mike Caverly at mcaverly@niu.edu or by telephone at 815-753-1448 or Dr. Carter at adamcarter@niu.edu or by telephone at at 815-753-1448.

If you have any questions about your rights as a research participant that have not been answered by the investigators or if you have any problems or concerns that occur as a result of your participation, you may contact the Office of Research Compliance, Integrity, and Safety at (815)753-8588.

Northern Illinois University policy does not provide medical treatment or compensation for treatment of injuries that may occur as a result of participation in research activities. The preceding information shall not be construed as a waiver of any legal rights or redress which the participants may have.

Future Use of the Research Data

After removing all identifying information from your data, the information. could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from you.

Disclosure of Research Results to Participants

Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep, along with any other printed materials deemed necessary by the study investigators.

____ ____________________

Participant’s Signature Date

____ ____________________

I give my consent to be video and audio recorded, as appropriate, during the meeting online via TEAMS.

Participant’s Signature Date

____ ____________________

APPENDIX C

INTERVIEW QUESTIONS

Warm-up Questions:

1. Why the NIU counseling program?

2. What made you choose the trauma certificate?

Interview Questions:

3. What do you think makes trauma counseling a different and/or unique type of counseling?

4. Would you feel comfortable talking more about how this information has informed how you conceptualize your work with clients?

5. How has your involvement in the trauma certificate affected your overall counseling skills?

6. What skills do you find yourself using when doing trauma-informed counseling?

7. What was it like for you to learn this content in these classes in an asynchronous format?

8. How has the course work in the trauma certificate informed, and/or help you understand what a therapeutic alliance can feel like?

9. Was there anything your professors in your courses did, that enhanced the relationship you have with them? If not / if so / how did that work?

10. Do you find yourself integrating knowledge from the trauma cert to the other classes?

11. In learning how to do trauma counseling, you were exposed to traumatic content – that content can affect us as human beings and it can emotionally overwhelm or remind us of our own issues we all have. What was it like to experience the traumatic content in the classes, as opposed to your other classes?

12. What was it like to experience the traumatic content in the asynchronous class, as opposed to your other synchronous classes?

14: How did the course prepare you to interact with the traumatic material in counseling?

15. Was there ever a time you feel overwhelmed by the amount of traumatic narratives in the class?

16. How comfortable are you about addressing trauma in counseling?

17. Is there anything that you'd like to talk about that I didn't ask about?

APPENDIX D

IRB APPROVAL

Approval Notice Protocol Amendment

29-Jul-2021
Mike Caverly
Counseling, Adult and Higher Education

RE: Protocol # HS21-0367 "The lived experience of Trauma Counselors-in-Training" Dear Mike Caverly,

Your Protocol Amendment submission was reviewed and approved under Member Review procedures by the Institutional Review Board on 29-Jul-2021.

Proposed changes:

Change to incentive for taking part in the study

Please note the following information about your approved research protocol: Protocol Approval period: 13-May-2021 - 12-May-2022

If your project will continue beyond that date, or if you intend to make modifications to the study, you will need additional approval and should contact the Office of Research Compliance, Integrity, and Safety for assistance. Annual review of the project will be necessary until you no longer retain any identifiers that could link the subjects to the data collected.

It is important for you to note that as a research investigator involved with human subjects, you are responsible for ensuring that the project has current IRB approval at all times, and for retaining any signed consent forms obtained from your subjects in a secure place for a minimum of three years after the study is concluded. The committee also recommends that the informed consent include an acknowledgement that the subject, or the subject's representative, that he or she has received a copy of the consent form. In addition, you are required to promptly report to the IRB any injuries or other unanticipated problems involving risks to subjects or others.

Please remember to use your protocol number (HS21-0367) on any documents or correspondence with the IRB concerning your research protocol.

We wish you the best as you conduct your research. If you have any questions or need further help, please contact the Office of Research Compliance, Integrity, and Safety at (815) 753-8588.

Please see the RIPS website for guidance on the impact of COVID-19 on research(including face-to-face data collection) https://www.niu.edu/divresearch/covid /index.sht