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A Systemic Approach to the Development and Improvement of

Trauma Education and Training

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Abstract

A number of individuals are exposed to adversity (e.g., child abuse and neglect, parental substance abuse, mental illness, incarceration) early in life (Felitti et al., 1998; Centers for Disease Control [CDC] and Prevention, 2019). Moreover, over 70% of individuals worldwide will experience a traumatic event at some point in their lives (Benjet et al., 2016). Mounting research has documented that the effects of trauma exposure in childhood are not only immediate but also enduring, leading to lifelong health problems. At the same time, studies have suggested that there is a lack of systemic trauma education and training. This article will provide several suggestions to attempt to resolve the identified problem.

Keywords: *Trauma-informed mental health counseling, trauma training, trauma education, trauma-informed practice*



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Introduction

The World Health Organization (WHO) defines *mental health* as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community (WHO, 2001, p. 1). As the needs for mental health in the world have increased, global mental health has emerged as a formal discipline supported by evidence in the following four domains: the social determinants of mental disorders, the Global Burden of Disease (GBD) attributable to mental disorders, inadequate investment in mental health care, and the near-absence of access to quality care globally (Patel et al., 2018). In particular, emerging research has provided consistent evidence of the strong association between social disadvantage and poor mental health. For instance, poverty, childhood adversity, and violence emerged as key risk factors for the development and persistence of mental disorders (Patel et al., 2018). Poor mental health or mental disorders represent a complex challenge given their high prevalence and disability burden globally. However, pervasive stigma, outdated practices, and organizational fragmentation still result in inadequate responses by health systems to mental illness (Vigo, Kestel, Pendakur, Thornicroft, & Atun, 2019; Vigo, Thornicroft, & Atun, 2016).

The high prevalence of adverse childhood experiences and their lifelong effects on human development and chronic adult diseases among the general public living in the United States has been recognized as a public health issue (CDC, 2019; Felitti et al., 1998). The CDC - Kaiser Permanente conducted a study (i.e., Adverse Childhood Experiences (ACE) Study) from 1995 to 1997 with two waves of data collection. This is one of the largest investigations of childhood abuse and neglect, household



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challenges, and later-life health and wellbeing. Over 17,000 health maintenance organization members from Southern California receiving physical exams completed confidential surveys regarding their childhood experiences, and current health status and behaviors. Adverse Childhood Experiences (ACEs) were categorized into three groups (i.e., abuse, neglect, and household challenges). Almost two-thirds of study participants reported at least one ACE, and more than one in five reported three or more ACEs. The researchers suggest that experiences in adversity can increase the risks of injury, sexually transmitted infections, maternal and child health problems, teen pregnancy, involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide (Felitti et al., 1998).

Similarly, Florescu, Mihaescu-Pintia, Ciutan, Sasu, and Gașcă (2014) found that in the last century, many individuals living in Romania were confronted with a mixture of natural, historical, social, and economic traumatic events suggesting that there is a high level of trauma exposure in the Romania general population. Specifically, 41.5% of all respondents participated in the study reported one or more lifetime traumas with the frequency of traumatic events being 131.1 per 100 respondents (Florescu et al., 2014).

The findings from the ACE study caught the attention of healthcare professionals. Therefore, numerous subsequent studies have been conducted over the past few decades. For instance, Read et al. (2011) suggested in their study that approximately 66% of incoming college students in the United States reported lifetime exposure to a traumatic life event. In addition, the National Scientific Council on the Developing Child (NSCDC) in the United States was established in 2003 as a multidisciplinary, multi-university collaboration committed to closing the gap between what we know and what we do to promote successful learning, adaptive behavior, and sound physical and mental health for all young



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children (NSCDC, 2003). Furthermore, the Substance Abuse and Mental Health Services Administration (SAMHSA) as a US government agency called for healthcare entities to implement *trauma-informed care*, a term used to refer to “a trauma-informed approach to the delivery of behavioral health services, including an understanding of trauma and an awareness of the impact it can have across settings, services, and populations.” (SAMHSA, 2015, p. 7).

Trauma results from an event, series of events, or set of circumstances experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual wellbeing (SAMHSA, 2014, p. 7). Given the increased prevalence of ACEs in the United States, behavioral health services (e.g., psychotherapy and other behavioral health services, etc.) are recommended to be sensitive to the impact of trauma on the health of individuals, families, and communities (Felitti et al., 1998; Merrick et al., 2018).

This widespread, public health concern has reached the field of mental health care as well as those who educate and train mental health counselors in counselor education and supervision graduate programs. In contrast, it is documented that comprehensive instruction on trauma has not been available in the curricula of professional education, and limited amount of research has been conducted on trauma training, leaving professionals (e.g., counselor educators) with a lack trauma competencies (e.g., awareness, knowledge, and skills) (Harris & Fallot, 2001; Kumar et al., 2019). This article will address the gap in trauma training systemically provided in counselor education curricula and the need for trauma training in counselor educators, counselors, and counselors in training living in the United States. The author will also suggest ideas for building a systemic platform to increase training opportunities for such individuals. The ultimate goal is to increase comprehensive trauma competencies



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in counselor educators and counselors so that they can better fulfil their roles to tackle the public health issue of high trauma exposure and experience worldwide as well as locally when providing trauma-informed educational training and clinical practices in educational or clinical settings, respectively.

Lack of Systemic Trauma Education and Training among Professionals

Until recently, trauma has generally not been taught in graduate programs in the United States despite the high prevalence of ACEs in the US general population, and lifelong effects on human development and negative consequences over the lifespan. Thus, mental health counselors and counselor educators may not have had pre-service opportunities for trauma training (Cook & Newman, 2014; Webber, Kitzinger, Runte, Smith, & Mascari, 2017). Cook and Newman (2014) noted, “most clinicians have only a cursory knowledge of trauma science and do not apply evidence-based psychosocial treatments and assessments for posttraumatic stress disorder consistently, if at all” (p. 300). In a similar vein, Kumar et al. (2019) reported in their study that academic training programs for mental health professionals rarely include comprehensive instruction on trauma, consequently leaving clinicians inadequately prepared to provide trauma treatment. Thus, most graduate students independently seek education in trauma and its treatment by gathering professional literature and attending conferences, workshops, and seminars (Cook, Simiola, Ellis, & Thompson, 2017).

Additionally, despite the growing need for trauma-informed services, limited scientific studies have been conducted on trauma education and training in the field of counselor education. In specific, the results of a content analysis conducted by Webber et al. (2017) in the *Counselor Education and Supervision* (CES) show that a very limited volume of journal articles were published in CES during the period of 1994 through 2014 using the following search terms: sexual abuse, abuse and maltreatment,



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intimate partner violence, post-traumatic stress disorder (PTSD) and other trauma, combat stress in military, mass trauma, refugees, and vicarious traumatization. Moreover, as of January 21, 2019, a limited volume of 15 search results were identified for the search term of trauma published in *Journal of Counseling and Development* (JCD) or CES, to list a few highly impactful counseling journals in counselor education. In reviewing journal article titles of CES published during the period of time 1968 through December, 2018, using the Wiley's online database, the author came to recognize that it was not until 2008 that a journal article on trauma, such as vicarious traumatization, trauma-sensitive supervision, and counselor preparation, was published for the first time in the journal.

This lack of trauma training and limited research conducted on trauma education in the field of counselor education raise a big question especially for counselors and counselor educators: "Are counselor educators trained and skilled as trauma-informed educators as well as trauma-informed counselors?" Counselor educators are expected to educate and train graduate counseling students to promote clinical competencies in such individuals in providing trauma-informed care. Those clinical competencies include the use of techniques, procedures, or modalities that must be grounded in theory or in an empirical or scientific foundation supported by the American Counseling Association's code of ethics (ACA, F.7.h., 2014). They may also be guided by the American Mental Health Counselors Association's (AMCHA) standards for the practice of clinical mental health counseling (2020) stating that faculty members teaching in the field of clinical mental health counseling or in a relevant field demonstrate expertise in content areas including trauma and its related forms (e.g., developmental, complex, situation, moral, or historical trauma, chronic or toxic distress, etc.). The same source also recommends trauma-informed care as recommended training. This preparation for trauma-informed practice is essential due to the high incidence of traumatic exposure in the US general population.



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Recommendations for Trauma Education and Training

In the following section, the author provides recommendations to attempt to solve the identified problem of a lack of systemic trauma education and training provided in countries such as the United States. These recommendations are organized at micro-, meso-, exo-, macro-, and chronosystem levels informed by the Bronfenbrenner's Ecological Model of Human Development (Bronfenbrenner, 1979; Meghan, Louise, Margaret, & Lara, 2019). Also, she presents the benefits and risks of each solution recommended.

Bronfenbrenner's Ecological Model for Trauma Education and Training

Urie Bronfenbrenner, American psychologist, formulated the Ecological Systems Theory to explain how the inherent qualities of an individual and his or her environments interact to influence how the individual grows and develops across the lifespan. This theory emphasizes the importance of understanding individuals in multiple environments in the attempt to understand the influence of the systems on their development. According to the theory, individuals typically find themselves enmeshed in various ecosystems, from the most immediate and direct institutions and groups to the larger social system, and then to the most expansive system which includes the overarching culture where they reside. Each of these ecological systems inevitably interact with and influence each other in all aspects of individuals' lives.

The Bronfenbrenner's framework involves five interrelating systems (i.e., *microsystem*, *mesosystem*, *exosystem*, *macrosystem*, and *chronosystem*) with the developing individual at the center of these intricately embedded systems. In Bronfenbrenner's book (1979), a *microsystem* is described as a pattern of activities, roles, and interpersonal relations experienced by the developing person in a given



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setting (e.g., home, day care center, and playground, etc.) with particular physical and material characteristics. A *mesosystem* comprises the interrelations among two or more settings or groups in which the developing person actively participates. An *exosystem* refers to one or more settings that do not involve the developing person as an active participant but in which events or situations occur that affect or are affected by what happens in the setting containing the developing person. A *macrosystem* refers to consistencies, in the form and content of lower-order systems that exist or could exist at the level of the subculture or the overarching culture along with any belief systems or ideology underlying such consistencies. Lastly, a *chronosystem* consists of the pattern of environmental events, transitions over one's life course, or changing sociohistorical circumstances such as wide-spread infectious diseases impacting the developing person's varying domains of life and the surrounding systems.

Microsystem-level Recommendations. It is recommended that academic training programs for counselors in training and counselor educators intentionally incorporate the existing guidelines and standards (AMHCA, 2020) for trauma-informed practice, codes of ethics, trauma competencies (Cook, Newman, & Simiola, 2019; Paige, 2015), and accreditation standards in designing or modifying their curricula in which trauma is infused across the curricula. In addition, the department and educational institution where those programs are housed should encourage their employees (e.g., counselor educators) to actively use the trauma literature as required educational materials in order to increase knowledge in trauma in such individuals. Also, counselor education programs are encouraged to financially support their counselor educators to actively participate and engage in international (e.g., International Society for Traumatic Stress Studies [ISTSS], National Child and Traumatic Stress Network [NCTSN], Trauma Research Foundation [TRF], or National Institute for the Clinical Application of



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Behavioral Medicine [NICABM], etc.), national, regional, or local organizations for comprehensive trauma training opportunities and continuing education at an individual level.

Potential risks of these recommendations include that it may require the expense of time and energy of individual counselors in training, counselors, and counselor educators as many of these individuals may already have demanding schedules at work. In addition, some counselors and counselor educators who are new to trauma conceptually may feel overwhelmed by the massive amount of trauma literature that is available mostly outside of the counselor education, training itself, or other relevant resources to sort out, navigate, process, and digest them in an effective way.

Mesosystem-level Recommendations. The entities, such as counseling organizations, academic educational institutions where counselor education programs are housed, and accreditation bodies, are recommended to understand the significant impact of their interrelations with one another to recognize the need for trauma education and training provided by systemically. Their collaborative efforts to create a systemic platform for comprehensive trauma education and training can benefit many counselors and counselor educators who seek training opportunities for increased trauma competencies. For instance, findings from a study by Cook, Rehman, Bufka, Dinnen, and Courtois (2011) suggest that almost 64% of clinicians that participated in the study had expressed interest in participating in educational endeavors to learn more about trauma-related clinical topics. Also, Young, Read, Barker-Collo, and Harrison (2001) noted in their study that respondents indicated that they would like to receive training in methods for accurately assessing a history of trauma. These findings seem to support the idea of creating a systemic platform to provide trauma training for professionals so that they are properly trained and competent in serving their roles as practitioners and educators in their educational and clinical endeavors. In the following section, the author will offer potential solutions in a



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sequence (i.e., recognition, awareness, and establishment phases) to help make systemic trauma training available broadly.

In the recognition phase, each entity, such as the accreditation body for counselor education programs, counseling organizations, and educational institutions can acknowledge the high prevalence of trauma exposure in the US general population as a public health issue in collaboration with one another, and how this leads to the following consequences: chronic adult diseases (e.g., substance use disorders or autoimmune diseases, etc.), compromised executive functioning [e.g., decision making], and subsequent poor academic performance (Shonkoff et al., 2012). Upon this increased recognition, it can help increase the awareness of counselor education programs about the importance of educating and training their graduate students about the prevalence and impact of trauma. In the action phase, they can work collaboratively to establish a systemic platform for trauma training for everyone.

Analyzing potential benefits and risks of this recommendation, the hope is that it will benefit not only counselors and counselor educators in a short-term but also their current and prospective counseling students in the long-term. Yet, the recommendation may pose inevitable risks. First, it can be unnecessarily time-consuming to achieve the collective goals as the interrelations all involved at the mesosystem-level are required. Additionally, it may unintentionally cause conflict among those groups involved, which may result in a negative consequence, such as a failure to achieve consensus toward the collective goals.

Exosystem-level Recommendations. It is recommended that policy makers working at local, regional, and national governments in the United States collaborate closely with other stakeholders, such as the justice system, education system, and health care system to enact and implement a law that



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requires all individuals (e.g., children, adolescents, adults, and senior citizens) to be screened for ACEs as a public health response. This early identification of routine screenings should coincide with accordant early intervention within the health care space in equity. As an example, Gavin Newsom as California Governor appointed Nadine Burke Harris, who is a pediatrician, as California's first surgeon general in 2019. Since then, she has been supporting the implementation of AB-430 Early and Periodic Screening, Diagnosis, and Treatment Program that requires routine trauma screenings in health care in the state.

Additionally, another recommendation is to strengthen the infrastructure to target for prevention and promotion measures across one country as well as inter-countries (WHO, 2004). For instance, making effective programs and policies widely available would provide the countries and their communities with a spectrum of preventive tools to deal with mental disorders. Thus, it is important to develop an accessible and integrated system of international and national databases to provide governmental and non-governmental agencies with information on evidence-based programs and policies, their outcomes, and conditions for effective implementation (WHO, 2004). As an example, the CDC has made tremendous efforts in preventing ACEs in the United States. This was supported by data projecting that the preventive efforts could have reduced the number of adults with depression by as much as 44% or up to 21 million avoided cases of depression (CDC, 2019). Selective efforts made by the CDC include a) educating healthcare providers to recognize current risk in children and ACEs history in adults, and to refer clients to effective family services and support, b) improving school environments to lessen the impact of ACEs and prevent further trauma, and c) increasing access to programs that enhance parents' and youths' skills to handle stress, resolve conflicts, and reduce violence (CDC, 2019).

The importance of having an integrated system for routine trauma screenings, early intervention, and prevention and promotion measures in place cannot be emphasized enough, but it



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can pose a financial burden at each of the systems involved. Specifically, it may likely require a change to be made in the systems to have proper trauma screening, treatment, and management of stress-induced symptoms available to a wide scope of constituents. Making this change will likely require a large monetary investment.

Macrosystem-level Recommendations. According to the Global Burden of Disease 2017 study, substance use disorders rank fourth, depressive disorders rank fifth, and anxiety disorders rank seventh as causality of the most disability in the US general population participated in the survey. It is even shocking there was a 31.3% change in the prevalence of substance use disorders between 2007 and 2017 in the nation. Given mounting evidence suggesting the alarming prevalence of trauma exposure in the US general population and the association with these conditions in adults (CDC, 2019; Felitti et al., 1998; Shonkoff et al., 2012), it must call for a change in the cultural narrative that mental distress and disorders are viewed as a response to “social and societal pathology” rather than an individual problem. This change in perspective is timely and necessary as the US general population has experienced a number of major social and economic difficulties (e.g., terrorist attacks, economic recession, and natural disasters) especially over the past two decades with the impact of these stressors on larger portions of the population (Jorm et al., 2017).

In addition, this change may directly relate to the practice of mental health professionals such as counselor educators and counselors that include the provision of services (e.g., psychotherapy, diagnosis, clinical assessment, prevention and treatment). In particular, current diagnostic systems used in North America, such as the *Diagnostic and Statistical Manual-5* (DSM-5, American Psychiatric Association, 2013) do not appear to help understand the complex determinants of mental disorders that are too frequently rooted in social and societal factors (e.g., poverty, income inequality, humanitarian



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emergencies, or interpersonal violence) in the contemporary era (Patel et al., 2018). Despite this controversy in the mainstream diagnostic system, it still holds the predominance in its clinical use in mental health care in the United States (Kramens et al., 2019).

The recommended change in perspective on the determinants of mental disorders may bring about a few benefits. First, it may help promote the significance of collaboration among numerous stakeholders, such as local, regional, and federal governmental agencies, the educational system, justice system, and medical and mental health care to invest more in the social and physical environment to reduce sources of mental distress and trauma and to increase sustainability and safety in the environment for optimal wellbeing and mental health of everyone. Moreover, it may also help decrease the societal stigma against individuals with a mental disorder as it places the pathology of mental disorders in the unhealthy social and structural environment.

Despite these potential benefits, it is understandable that the change in perspective requires an extensive time and consensus among all stakeholders.

Chronosystem-level Recommendations. According to the Bronfenbrenner's Ecological Systems Theory, the chronosystem includes historical and temporal aspects of time and its effect on an individual's development (Meghan et al., 2019). In the context of establishing and implementing a systemic platform for comprehensive trauma education and training, it is important for us to identify and understand that certain individuals, families, and communities are more vulnerable than others for trauma exposure and experience. For instance, the U.S. Surgeon General stated in 2000 that racial and ethnic health disparities were likely due to racism (U.S. Department of Health & Human Services, 2000). Racial trauma, a form of race-based stress, refers to People of Color and Indigenous individuals'



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reactions to dangerous events and real or perceived experiences of racial discrimination (Comas-Díaz, Hall, & Neville, 2019). It is documented that racial discrimination has persisted in the United States historically, and unfortunately, there is a recent rise in hate crimes (Center for the Study of Hate & Extremism, 2018). Given the increasing vulnerability of the affected individuals, it is important to document the nature and consequences of racial discrimination and the factors promoting from racial trauma associated with these personal, vicarious, and collective experiences (Comas-Díaz et al., 2019). In a similar vein, it is recommended that a systemic platform for trauma education and training is inclusive of this type of trauma and its negative consequences in a short-term and long-term. Additionally, it should embrace and support scholarly and practical endeavors in the development and implementation of psychological approaches designed to help recover from racial trauma (Comas-Díaz, 2000; 2016; Comas-Díaz et al., 2019).

Needless to note, this idea can increase the quality of services provided by mental health professionals in the United States as they are trained and skilled adequately. It can also help bridge the gap in health disparities, which is a public health issue in the nation (CDC, 2013). In contrast, it inevitably comes with some consideration. By definition, racial trauma acknowledges the presence of racial discrimination against certain individuals and groups in the nation. However, not everyone appears to be on the same page on this matter given the increasing prevalence in hate crime on records (Center for the Study of Hate & Extremism, 2018).

Conclusion

Common mental disorders, such as depressive and anxiety disorders, remain a major source of disability globally (Jorm et al., 2017). Despite the concerning prevalence of mental disorders worldwide,



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it is documented that in industrialized countries, 36-50% of serious cases of mental disorders are untreated whereas in developing countries, the situation is even worse with 76-86% untreated (Jorm, et al., 2017). Additionally, it is documented that over 70% of individuals worldwide experience a traumatic event at some point in their lives (Benjet et al., 2016). Similarly, mounting evidence suggests that the US general population experiences adversity in early childhood at an alarming rate (CDC, 2019; Flaherty et al., 2009; Felitti et al., 1998).

In addition, emerging evidence suggests that the immediate and long-lasting effects of adversity experienced in childhood include an increase in the risks of injury, sexually transmitted infections, maternal and child health problems, teen pregnancy, involvement in sex trafficking, and a wide range of chronic diseases and leading causes of death such as cancer, diabetes, heart disease, and suicide in adults (CDC, 2019; Flaherty et al., 2009; Felitti et al., 1998; Shonkoff et al., 2012). Given the alarming prevalence of trauma exposure and experience, and its detrimental consequences in individuals, families, and communities affected, trauma-informed practice has been called upon.

In contrast, research has suggested that trauma has generally not been taught in graduate programs in the United States, and existing academic training programs for mental health professionals rarely include comprehensive instruction on trauma, consequently leaving clinicians inadequately prepared provide trauma treatment (Cook et al., 2017; Cook & Newman, 2014; Kumar et al., 2019; Webber et al., 2017). Additionally, limited scientific studies have been conducted on trauma education and training in the field of counselor education and supervision (Webber et al., 2017).

These issues can be troublesome not only at varying levels because mounting research supports that early childhood adversity, poverty, and violence are associated as key risk factors for the



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development and persistence of mental disorders, which in turn, are associated with loss of income due to poorer educational attainment, lower employment opportunities, and lower productivity (Lund et al., 2010; Patel et al., 2018). In order to help improve the quality of the mental health care in the United States, and to specifically tackle the identified problem of a lack of comprehensive trauma education and training provided systemically, the author provided several recommendations informed by the Ecological Model of Human Development in this article (Bronfenbrenner, 1979; Meghan et al., 2019).



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